

Leonard Cheshire Disability

Seven Springs - Care Home Physical Disabilities

Inspection report

Pembury Road
Tunbridge Wells
Kent
TN2 4NB

Tel: 01892531138
Website: www.leonardcheshire.org

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service:

Seven Springs – Care Home Physical Disabilities is a residential care home that was providing personal care for up to 32 people with physical disabilities and a range of other complex needs. At the time of the inspection 29 people were using the service. Most people lived in the main building and there were bungalows on site to promote independence for others. Some of the people had limited verbal communication due to their disabilities.

People's experience of using this service:

Although people were happy and relatives told us their family member was safe we found people were not always being kept safe. Medicines were managed safely and some risks had been identified with ways to mitigate them. However, people were placed at risk of potential harm from pressure ulcers and dehydration. People were placed at risk of ingestion of harmful chemicals when they were left unaccompanied around the home.

The provider and management had completed a range of audits to identify concerns and issues at the service. However, these had not always identified concerns found during the inspection. Additionally, when concerns had been found these had not always been resolved in a timely way.

People and staff felt there were enough staff except at weekends. The management were already in the process of trying to resolve this. Staff had received a range of training considered mandatory by the provider. However, there were occasions that training for staff had not been provided in line with people's specific needs.

Some people in the service lacked capacity to make specific decisions and there were systems in place to make them. When people were deprived of their liberty systems were in place to ensure it was lawful. People were involved in making choices about their day to day care and these were respected by staff.

People had care plans which were personalised and provided a range of information for staff to use to support their needs and wishes. There were good links with other health and social care professionals including access to onsite physiotherapists.

People were supported by kind and caring staff who knew them incredibly well. Staff respected people's privacy and dignity throughout the inspection. Good links had been developed with the community.

More information about the detailed findings can be found below.

Rating at last inspection:

At the last inspection, published on 4 November 2016, this service was rated good.

Why we inspected:

This was a planned inspection based on previous rating.

Enforcement:

We have made one recommendation about staff training being in line with people's needs.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 around safe care and treatment and good governance.

Details of action we have asked the provider to take can be found at the end of this report.

Follow up:

We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe

Details are in our Safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement ●

Is the service caring?

The service was caring

Details are in our Caring findings below.

Good ●

Is the service responsive?

The service was responsive

Details are in our Responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led

Details are in our Well-Led findings below.

Requires Improvement ●

Seven Springs - Care Home Physical Disabilities

Detailed findings

Background to this inspection

The inspection:

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

This inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service for people with physical disabilities.

Service and service type:

Seven Springs – Care Home Physical Disabilities is a 'care home' for people with physical disabilities and other complex related issues. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

This inspection took place on 21 and 22 February 2019 and was unannounced.

What we did:

The provider had not completed a Provider Information Return (PIR) since April 2016. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. During the inspection we got up to date information in line with this. We looked at other information we held about the service and provider before the inspection visit. We also contacted health and social care professionals who were in regular contact with the service.

We spoke with six people who used the service and one relative. Some people had limited verbal communication so we had informal interactions with them and carried out observations. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, deputy manager and seven members of staff including care and auxiliary staff. We spoke with one health professional and one volunteer.

We looked at four people's care records in various depths. We observed care and support in communal areas. We looked at four staff files, information received from the provider, staff rotas, quality assurance audits, staff training records, the complaints and compliments system, medication records and environmental files.

Following the inspection, we asked for a number of documents and follow ups to some things we found.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- People were placed at risk of ingestion or contact with potentially harmful substances. On two occasions cleaning trolleys were left unsecured and unaccompanied. One senior member of staff informed us this was a practice they were aware of and trying to change. A room containing a cupboard with more chemicals in and a machine which was potentially dangerous was also found unlocked. The registered manager told us they would be closely supervising specific staff and would raise the concerns with all staff to make them aware of the dangers.
- People were not always protected from the risk of potential harm from pressure ulcers. Air mattresses to reduce the risk were not having the settings routinely checked unless the person was seen by district nurses. We found two people's mattresses significantly incorrectly set and both people were at high risk of pressure ulcers. Although no pressure ulcers were on the people, one of the people had previously had one. This meant they were placed at potential risk of more pressure ulcers developing.
- One person recently had a significant pressure ulcer. They had been referred to the district nurses and through treatment the wound had healed. Staff had followed instructions about helping the person to be repositioned in line with guidance. However, their records did not consistently record their wound care. Nor did they demonstrate district nurses were contacted in a timely manner when initial signs were showing. Following the inspection, the provider shared more information to show us they did have some systems to monitor the treatment wounds received from district nurses.
- Risks to people in relation to dehydration were increased because systems were not always in place. Two people were currently having their fluid intake recorded daily. Guidance was not in place for staff to follow in people's care plans. As a result, records did not demonstrate the daily intake was being checked in line with the recommended daily target. This meant there was no way of monitoring if people were receiving enough fluid and were placed at increased risk of infections. Other people who had capacity and mobility to drink were not having their fluid intake monitored if a risk was identified. One person had records of two admissions to hospital due to infections.

Concerns were found around risks not always being managed around pressure ulcers and dehydration and potentially harmful substances not being stored safely.

This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some risks to people had been identified and ways to mitigate them found. This included how to safely transfer a person from their bed to their wheelchair. Clear guidance was in place for staff to follow such as

which slings to use.

- People were protected from the spread of infection because staff had access to a range of personal protective equipment such as gloves and aprons. These were accessible in every person's bathroom.
- Special bags were used to transport soiled clothes and bedding to the laundry to reduce the spread of infection.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe living at the home. One person said, "Lovely" when we asked if they were safe. They explained if they did not feel safe they would have not lived at the home for such a long time. People were supported by staff who understood how to recognise potential abuse and who to report concerns to.
- All staff were aware who to raise concerns with externally if they were not managed internally.

Staffing and recruitment

- People were supported by enough staff to meet their needs and wishes. One person indicated their call bell was always answered in a timely manner. Another person told us two staff always came to help them. They agreed they always came quickly.
- Staff had some mixed opinions about whether there were enough staff. They agreed during the week there were good levels. Although at weekends there were shortages with specific auxiliary staff such as dining room support. As a result, care staff were having to complete additional tasks. The registered manager explained some key staff had recently left at the weekends. They were currently recruiting for their replacements.
- People were supported by staff who had been through a robust recruitment process. This ensured they were suitable to work with vulnerable people.

Using medicines safely

- People's medicines were managed safely. One person told us they always had their medicines on time. They explained if they were in pain staff knew they would ask for additional pain medications. Another person agreed their medicine was always on time and staff helped them.
- Practice observed of staff administering medicine was safe and following best practice. Medicines were stored securely.
- A new electronic system had been put in place. Most senior staff administering medicines were confident to use it. However, some staff lacked confidence about processes on it around 'as required' medicine. The registered manager assured us all senior staff administering medicine would receive further training on the new system.

Learning lessons when things go wrong

- Systems were in place to review accidents and incidents. Significant ones were shared at provider level so all managers could learn from the incidents.
- One person had been involved in an accident in the community. As a result, their transport wheelchair had been taken out of use until it was checked to ensure it was safe. The person had been supported to hospital to make sure they were not harmed. Additional equipment was sourced for to ensure increased safety for the person in relation to travel on a bus.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience

- People were supported by staff who had received a range of training to meet some of their needs. One person said, "Oh yeah" when we asked if staff knew how to use the equipment to help them transfer between their bed and wheelchair.
- However, areas of concern found during the inspection had not always been reflected in staff training. For example, people were found at risk of pressure ulcers and no training had been provided for all staff in relation to this. Only one out of four staff told us they had received training in epilepsy. Records shared reflected what we were told. This meant the staff were not always giving training to meet more specific needs of the people living in the service. Following the inspection, the provider informed us some staff had received specific training such as pressure care as part of a health and social care qualification.

We recommend that the provider finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living at the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- When people moved into the service, where possible, they were involved in their assessment. One person told us they were asked about their needs. Where a person was unable to verbally communicate then other important people to them were consulted. One relative told us since their family member moved into the home they had noticed an increase in mobility and independence. This reflected the plan being followed.
- People were supported when required to have regular mobility assessments from the physiotherapist. This was important to make sure their individual programme was appropriate for them.
- People with mobility issues had equipment adapted to meet their needs. One person had an alternative to a call bell to ensure they could call for help if required.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat a healthy balanced diet. One told us about their food preferences and said staff were aware of what they do not like to eat. During lunch it was clear people were enjoying the food.
- At the end of the meal staff were observed asking people their preferences for the next meal. The member of staff asking always bent down to the level of the person. They waited for a response and respected people's different ways of communicating.

- There were occasions at the meal people who were less able to feed themselves lacked meaningful interaction from the staff. The registered manager explained at times this was to respect people's preferences of how they liked to be supported or in line with their needs to reduce the risks of choking.

Adapting service, design, decoration to meet people's needs

- People could personalise their bedrooms in line with their hobbies and interests. One person had many bookcases full of books. They told us they loved to read. Other people had their football team colours and logos around their bedrooms and on their bedroom door.
- Bedrooms were adapted in line with people's needs. Some people had specialist television remote controls which had large buttons and were on a stand. Other people had specialist swing doors to their bathrooms so they could independently access it in their wheelchairs.
- People and relatives were sad the hydrotherapy pool was not in use at the time of the inspection. The registered manager explained there were plans to reopen it. However, at the moment it was unsafe to be used which is why it was closed.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People had access to a range of health and social care professionals to meet their needs. This included a physiotherapist and their assistant who worked in the home. This was important due to the complex physical needs people had.
- One health professional told us, "I think they are good" and continued, "They will phone if any problems". The health professional confirmed staff followed advice they provide to meet someone's care needs.
- People participated in exercises led by the assistant physiotherapist during the inspection.
- When people's health declined medical professionals were sought. One person told us they received a visit from their doctor if they were too unwell to go to the doctor.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

- Staff would always seek consent from people prior to supporting them.
- Records demonstrated when people lacked capacity then current best practice had been followed.
- When it was required, people had access to advocates to represent their views when decisions were being made.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- People who required DoLS in place had them either applied for or authorised. One person with incredible

complex needs had extensive notes to demonstrate how every option had been considered. Many other health and social care professionals had been involved to make sure it was in the person's best interest.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

- People were supported by kind and caring staff. One person told us, "On the whole they [meaning staff] are very good". Another person said, "Everyone listens to what I say every time".
- Relatives were positive about the service their family members received from staff. One relative told us everything is, "Brilliant". They continued, "The staff are approachable, extremely courteous and respectful".
- During the inspection people were supported by staff who were tentative to their needs and demonstrated compassion. One person called out in a corridor for help. Immediately three members of staff were with them and discretely found out what support they required. Throughout they were reassuring the person and accompanied them to their bedroom to continue the support.
- People had their cultural and religious needs respected.

Supporting people to express their views and be involved in making decisions about their care

- People were encouraged to make choices and these were respected by staff. A variety of communication strategies were in place for people who had difficulty with verbal communication. One person had been using eye pointing to make choices. This meant they communicated by indicating their preferences with their eyes. When their needs changed again their care plan was updated with their new method using eye movements.
- Another person was making choices by holding two tennis balls; one was in each hand. One member of staff gave each tennis ball an option. They then waited for the person to move the ball with their choice. Once this happened the member of staff patiently checked they had listened to the correct choice.

Respecting and promoting people's privacy, dignity and independence

- People's preferences were respected around intimate care. If people expressed a choice about the gender of staff to support them this was met. It was documented in people's care plans.
- People's privacy and dignity was respected at all times. Staff knocked on doors before entering them. If people required support with intimate care then respect was shown. For example, one member of staff came out of a bedroom explaining too many staff were in there. The staff had all gone to help and they wanted to respect the person's private space.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People could access a range of activities to meet their hobbies and interests. Two people went to the shops and out for lunch during the inspection. They were excited they were going and it was clearly an enjoyable activity for them. Another person told us they went to the theatre and shopping.
- Many people attended activities at the day centre on site during the day. They could participate in a range of activities including craft, storytelling and well-being sessions. People told us, "I love it" and, "They [meaning the staff] are doing amazing job" when talking about the day centre with us.
- People had care plans which were personalised to their individual needs and wishes. Most people and relatives were aware of the care plan and the contents in it. One person told us they contributed to their care plan with the support of their family member.
- Care plans contained important information for a person to provide guidance for staff. Staff were familiar with the care plans and could tell us specific information about each individual.
- People and those important to them were involved in reviewing their care needs outlined in their care plans. One person told us they were asked about their care and once a year they would review their care plan with staff. Another person and their relative explained how they had been involved in reviewing their care.
- When people's needs had changed most care plans had updates in them to reflect the new support needs. Examples of this were around mobility needs and communication methods.
- Information was shared to people in a variety of ways to meet their individual preferences. This meant the service was respecting the Accessible Information Standard. For example, some people wanted important documents read to them, whilst others wanted copies left with them so they could refer to it.

Improving care quality in response to complaints or concerns

- People knew how to complain and most felt listened to. One person said, "There is a leaflet with the details in" for how to complain. Other people told us they knew who to complain to but never had a reason to.
- The provider had systems in place to manage complaints. They encouraged people and their relatives to feed back. One complaint from a visitor to the service had been managed in a timely way through the providers more formal system. Full written feedback was provided to explain the situation to the complainant.

End of life care and support

- People were supported to have a dignified death in line with their preferences and needs.
- Strong links had been developed with the local hospice so those with specific illnesses resulting in declines in health could be supported.
- No one was receiving end of life care at the time of the inspection.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- One concern which should have been shared with the Care Quality Commission had not been done in line with statutory requirements. This meant other bodies were less able to monitor people's care and safety.
- Some of the concerns raised during the inspection such as pressure care and monitoring fluid intake had not been identified by the management or at provider level. For example, in the 'Managers Self Health Check' completed in February 2019 it stated information from professionals had been copied into care plans. This was not the case for people with pressure care risk. Nor did the daily records have information in relation to fluid monitoring recommended by professionals. Following the inspection, the provider shared some additional information about how professional's information was recorded in people's care plans to cover some of the concerns found.
- There was a lack of awareness at management level about what constitutes current best practice in relation to the complex people they supported at the home. For example, the management had no systems in place to monitor people with specialist equipment in relation to pressure care. Following the inspection, the provider shared information in relation to annual mattress services and the registered manager told us there were emergency plans in place if equipment failed. The registered manager also told us they had implemented a system to monitor air mattresses since the inspection.
- The management had not always identified specific training all staff required to keep people safe and meet their needs. For example, not all staff had received epilepsy training or pressure care training.
- The management were not always able to produce information promptly to the inspection team. There were occasions when documents had to be asked for multiple times during and after the inspection. Following the inspection, the provider sent some further information to demonstrate checks they completed on the water. Following the inspection, the provider sent some further information to demonstrate checks they completed on the water.
- When shortfalls had been identified by external contractor's action had not always been taken in a timely manner. For example, a fire risk assessment completed in June 2018 noting 14 actions. Seven of these were in progress and overdue whilst two had not been started.
- There were a range of audits completed at both provider and management level. Some of these audits had identified actions which had been taken. However, there was a lack of ownership about who was responsible for resolving the issues, what actions had been taken and when. Examples of this were found with the hoist sling checks and the wheelchair checks. This meant there was potential for actions not being completed and people could be placed at risk of harm from faulty equipment. Following the inspection, the

provider shared information about the checks specialist companies complete every six months for hoist slings and the liaising they completed in relation to wheelchair faults.

The lack of robust quality assurance meant people were at risk of receiving poor quality care and should a decline in standards occur, the provider's systems would potentially not pick up issues effectively.

This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- When incidents or accidents occurred, the management demonstrated an understanding of their obligations to inform people and their representatives. This was in line with the Duty of Candour to be open and transparent.
- Staff were clear about the staffing structure in the service and were positive about the support they received. One staff member said, "I do feel supported at this home, particularly by the Manager. There is a good team ethos". Others said, "Good teamwork and morale overall" and, "The home seems to be better organised now with clearer policies and procedures".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The registered manager told us they had an open door policy so people could freely raise concerns.
- People and relatives were mainly positive about the registered manager and service. One person with support from their relative explained the registered manager was accessible.
- There were regular meetings where people could share what was going well and what needed to improve. Most people were felt valued at these meetings. One person said, "Everyone listens to what I say, every time". They continued to tell us they regularly attended the meetings.
- However, one person was not as positive and did not feel involved or listened to. They explained they had stopped attending resident meetings because "Nobody listened. They [meaning the management] said everything is fine, when nothing is fine".
- Staff were positive about the accessibility of the management. They said, "There is an open door policy" and, "The manager is accessible". All staff felt listened to and could contribute to the service.
- Regular separate staff meetings were held for the different levels of staff. This meant staff could find out current key information, any areas of practice which needed to improve and could raise suggestions.

Working in partnership with others

- External providers had been used to complete audits in specialist areas. For example, to check fire safety equipment and the local pharmacy to monitor medicines.
- Staff and the management had built positive relationships with other health and social care professionals. Examples of these relationships were seen throughout the inspection.
- Links had been built with parts of the community so people could access them. For example, people could go to the theatre and access local amenities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure care and treatment was provided in a safe way for service users.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure the systems in place to monitor the quality of care were operating effectively to ensure compliance.