Parkcare Homes (No.2) Limited

Eastleigh House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Eastleigh House is a 'care home'. People in care homes receive accommodation and nursing or 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.

Eastleigh House accommodates a maximum of 10 people who have a learning disability, Autism and complex needs, in one adapted building. There were nine people resident at the time of the inspection, with ages ranging from mid 20's to mid 50's.

The care service had not been developed and designed in line with the values that underpin Registering the Right Support and other best practice guidance, as it was registered prior to this guidance. These values include choice, promotion of independence and inclusion, so that people with learning disabilities and autism can live as ordinary a life as any citizen. A statement from the provider organisation about Registering the Right Support included, 'The staff team will support and enable people to maximise their potential for independence, supporting them to develop daily living skills and achieve fulfilling lifestyles.'

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The inspection took place on 27 September 2018. It was announced so that people using the service could be helped to understand the reason for the visit.

At the last comprehensive inspection in February 2016 the service was rated Good overall, because we found no concerns. At this inspection we found the evidence could no longer support that rating and now the overall rating is Requires Improvement.

Hygienic practice was compromised because a partly adapted cellar was used as the laundry. Surfaces were not readily cleanable and would harbour dust. Neither did risk management ensure an effective cleaning regime in the cellar/laundry. We have made a recommendation.

There was a breakdown in the staff, management relationship. Staff said they felt undervalued and not listened to. Whilst they had the opportunity to make their feelings clear through an independently commissioned, and confidential staff survey in March 2018, staff said they did not trust that the survey was independent. No action plan was produced following the survey results but a 'Listening group' so as to hear first hand staff views, was held in September 2018, the arrangement having fallen through on two previous occasions. This was only attended by staff on duty at the time. Some staff told us they valued their time off and did not feel prepared to use it returning to their work place.

The provider representative was unaware of negative staff feelings, and lack of staff trust. They said the registered manager had their full support, but the concerns raised by staff were of deep concern, unacceptable to the organisation, and would be addressed as a priority.

Current staffing arrangements were inconsistent due to high levels of staff sickness and the need to replace staff who had left. This had the potential to increase risk. The provider and service management had identified sickness as a problem to be addressed. To this end they were about to try a revised staff rota and new staff were being recruited. The registered manager worked to maintain safety by filling staffing gaps, through asking staff to work extra hours, using agency staffing, and personally helping provide necessary care.

People using the service were unable to tell us their experience of living at Eastleigh House but their family members spoke very highly of the care provided and the registered manager. One said, "I can talk to the (registered manager) about anything. I can ring her any time and she will always listen."

Our observation showed that people were relaxed and confident in staff's company. Records, and family and professional feedback, showed that people received the care and support they needed. In particular, staff understanding of people's communication and interpretation of their needs and emotional state meant people's behaviours were expertly interpreted. One person's family member said, "They look after (the person) well. I don't worry when I leave them. They seem quite happy." Staff's ability to communicate with people effectively meant their views were sought and choices taken into account.

People's health care needs were understood and met. Where people benefitted from external professional input into their health needs, this was in place.

People's family members said they felt the service was safe. Recruitment, medicine management, financial management and the approach to the safeguarding of people using the service, promoted people's safety. The premises were kept in a safe state, with plans in place for improvement.

People's legal rights were understood and protected. Where restrictive practice was used, the minimum to keep a person safe and promote their dignity and well-being was applied. This had been agreed through best interests meetings and legal authorisation.

There was a clear culture of compassionate care and support. The service was said to work to the six C's: care, compassion, competence, communication, courage and commitment, and this was evident.

Staff were well trained, competent in their work and praised the training arrangements.

Support plans and records were detailed, comprehensive and of a high standard, thus helping to promote the high standards of care and support staff delivered.

People's family members felt that any complaint would be properly dealt with.

People's nutritional needs were taken into account and they received a variety of balanced meals and drinks.

Attention was given to providing people with activities of interest to them, and from which they might learn skills. The premises included an activities room and a second, safe, kitchen.

There were comprehensive systems in place to monitor events at the service, both at provider and service level, and a clear organisational structure.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Safety was compromised.

Difficulty cleaning the laundry room, it being a partly adapted cellar and not readily cleanable, could adversely affect hygiene.

Staff sickness, changes in staff and fluctuating staffing levels had the potential to affect safety. This was known by management and steps were being taken to correct the problem.

People were fully safeguarded from abuse and discrimination.

People's medicines were well managed on their behalf.

The premises was kept in a safe state and adapted as needed to promote independence and meet people's diverse needs.

Is the service effective?

Good

The service remains effective.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service remains responsive.

Is the service well-led?

Requires Improvement

The service had not continued to be well led because of a breakdown in staff/management trust, and communication.

There was a strong culture of compassionate, support and care.

There were systems in place within the service and at provider level to monitor events and follow up on concerns.

Eastleigh House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 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 Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 27 September 2018. We gave the service 48 hours' notice of the inspection visit so that any preparation to help people using the service engage with the inspection, could be put in place. The inspection was completed by one adult social care inspector.

The people living at the home had a learning disability and had limited verbal communication. In addition, some people were living with an autistic spectrum disorder, which affected their desire to engage in the inspection. They were unable to share their experiences with us. During our inspection we met each of the nine people living in the home. We spent time in the dining room and lounge room observing staff interactions with people and saw how people spent their time. We used the principles of 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.

Before our inspection, we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since their registration. A notification is information about important events, which the service is required to send us by law. We reviewed the information the provider sent us in the Provider Information Return, dated January 2018. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection, we spoke with eight staff members, three people's family members, the registered manager and a representative of the provider. We looked at two records, which related to people's individual care needs. We viewed three staff recruitment files, training and supervision evidence and records associated with the management of the service. This included policies and procedures, people's and staff feedback. We received feedback about the service from two professionals external to the service.

Requires Improvement

Is the service safe?

Our findings

The service was not as safe as it had been.

The part of the premises used by people was clean and appeared hygienic. Staff said they had the personal protective clothing they needed, such as gloves, for when handling soiled items, for example. Staff received training in infection control. However, the laundry room, a cellar, was not fully adapted for use as a laundry, and, although appearing superficially clean, did not have readily cleanable surfaces. Risk assessments included 'The laundry area is cleaned regularly' and 'The cellar floor should be mopped daily with sanitiser'. Although it was clear that effective cleaning of the room (floor, pipework, walls) for example, would be both difficult and time consuming, and did not happen on a regular basis there were arrangements which ensured staff would not have to handle soiled material.

We recommend that the service review risk management around cleanliness in a care home laundry having sought advice and guidance from a reputable source.

The registered manager and provider were struggling to meet staffing needs at the service. This had the potential to reduce safety. We were told that people using the service were funded for one staff to one person, two staff to one person, or sometimes, three staff to one person at different times of the day and depending on what activity a person was engaged in. One person was funded for three staff between 4pm and 8pm. Most staff did 12 hour shifts. A staff member said staffing requirements were generally set for nine support workers between 8am and 2pm, 10 support workers between 2pm and 4pm, and 11 support workers from 4pm. Three staff supported people at night. The staffing rotas showed that staffing varied from this. On Monday 24 September between 8am and 2pm there were seven support workers and between 2pm and 8pm there were six support workers, for example. We were told by staff and people's families that the management helped support and care for people, in addition to the rota'd staff. Agency staff were employed to meet some staffing shortfalls.

One support worker said staffing levels were "Not great recently.". All spoke of staff leaving and staff sickness, some which was long term. A senior staff member told us, "We are managing" referring to staff sickness. However, the registered manager said the week commencing 17 September there were 48 hours sickness and the week commencing 24 September 2018 there were 151 hours staff sickness. This showed staff sickness continued to affect the staffing arrangements. The registered manager said there were 186 hours worth of staff currently progressing through recruitment. However, staff told us staff were continuing to leave and sickness was an on-going problem.

Two staff said they felt the standard of care had deteriorated. For example, there might be a lack of staff able to drive the vehicle, affecting who could use it and when people could go out. They said that staff sickness was increased because of the pressure they were under to take on extra shifts. A third said, although the staffing levels could be a problem, "We manage. It's okay." One said, "The staffing arrangements are good." One person's family member said, "Staffing was really bad about six months ago, which was unsettling for people, but lately it is a bit better." We saw that a revised rota was about to be tried and staff had been

asked to comment about it. One had said the new rota might reduce the current staff stress.

Staff told us peoples' care remained good, and family members said how (their relative) was not demonstrating behaviours indicative of stress and anxiety. We saw that staff were able to respond to peoples' needs in a timely manner, such as providing drinks and preparing food. This showed that staffing levels had not adversely affected safety.

The provider organisation had arrangements in place to ensure the premises were kept in a safe state, servicing and maintenance, for example. A maintenance staff member was on hand to deal with any maintenance issues and ensure safety improvements were made as necessary. The registered manager was aware of people's deteriorating physical health and understood where adaptation was needed to promote people's independence and wellbeing. For example, one person's mobility had reduced and so physiotherapist advice was sought in relation to their using the stairs safely.

People using the service were unable to tell us whether they felt safe at the home. We spent time with people observing their interactions with staff. We saw people accepting physical contact from staff and accompanying staff around the home for various activities. This indicated people felt safe in the staff's company. One staff member said, "It is my job role to challenge poor practice."

People were protected from abuse and harm. Staff said they had received training in protecting people from abuse and they knew what action to take should they have any concerns over a person's welfare. They knew who to contact both within the organisation and outside of it.

The registered manager had completed advanced training in protecting people from abuse and had appropriately contacted the local authority safeguarding team. We were told, and staff confirmed, that safeguarding was discussed at regular intervals, such as meetings and staff supervision. A 'Speak out' hotline poster was displayed which provided staff with a number to contact if they had any concerns.

When asked about protecting people from discrimination, staff told us, "You have to be vigilant on people's behalf." People's family members felt it was a safe service. One said, "They protect (the person)."

Recruitment arrangements protected people. These included pre-employment checks including references from previous employers and Disclosure and Barring Service (DBS) checks. A DBS check helps employers to make safer recruitment decisions by providing information about a potential staff member's criminal record and whether they are barred from working with certain groups of people.

Risks to people's health and safety were detailed in their care files. These included where anxiety or distress, might put the person, or others, at risk. Staff were competent in their understanding of how to provide people with structured routines, and the time they needed to absorb and make sense of information, or requests. Key words were used, which were familiar to people. Staff said they were trained in using physical intervention, such as touch guidance to support a person to move away from others to a quiet place, to reduce potentially aggressive episodes. The registered manager said they followed the principles of 'positive behavioural support', concentrating on people's abilities and using their proven coping strategies to reduce triggers that may lead to anxiety, self harm and potentially aggressive behaviour. One person's family member said, "(The person) has practically stopped self harming now." This showed the effectiveness of the staff's approach to their care.

Other risks to people's safety were also identified, falls, choking and car use, for example. An incident whilst in the car had led to a review of safety whilst travelling. That danger was now removed as lessons had been

learned from that event.

People were protected by the way their medicines were handled. No person using the service was safe to administer their own medicines and so this was done for them. Medicines were kept securely in a locked cupboard. The temperature of the room was monitored once a day, but, following our feedback, a 24 hour temperature monitor was quickly introduced. Records were clear and complete and staff understood how to administer medicines safely. The registered manager was proactive in ensuring medicines were reviewed and people were closely monitored if a change in medicine was prescribed.

People's money was safely managed on their behalf. The home held some money for people's day to day spending. Receipts were obtained for all money spent and these were signed by two staff. The registered manager confirmed either families or the Court of Protection were involved in approving expenditure.

Good

Is the service effective?

Our findings

The service continued to be effective.

The service provided coordinated and person-centred care and support when people moved across services. This included a well planned transition, over many weeks, to support a person to move to Eastleigh House from another residential care service. The person's family said, "The transition was amazing. (The registered manager) went out of her way."

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA).The 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Staff clearly understood the importance of seeking people's consent and offering them choice about the care they received. Where people lacked capacity to make some decisions, the staff were clear about their responsibilities to follow the principles of the MCA when making decisions for people in their best interests.

MCA assessments were clearly documented and DoLS applied for appropriately, decision to reside at the home for care and treatment and use of physical intervention, for example. There was good recording of decisions made in people's best Interests, involving people that knew them best, such as family members, and health care professionals. A professional advocate told us, "They advocate very well and are supportive of my visits." This showed that the service recognised the importance of working in people's best interests, whilst recognising their right to involvement in decision making.

New staff completed an induction programme where they undertook essential training and worked alongside an experienced member of staff. They were also enrolled to undertake the Care Certificate. The certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. The provider organisation used the Priory Academy, with over 40 relevant subjects, from which to train staff. The registered manager said the subjects were "constantly evolving". A senior staff member said, "The training system works well. It keeps you up to date with changes. Recent safeguarding training we had was really, really good." One person's family member said, "They look after (the person) well."

There were systems in place to supervise and support staff in their roles. This included regular face to face meetings with line management and an annual appraisal.

Plans were in place to make structural changes, which would improve people's lives through increased access to areas of the premises, such as the second kitchen and garden areas. The registered manager

recognised that people's needs would change and those changes needed to be accommodated within the premises.

People's nutritional needs were taken into account and each person had a specific support plan in place around diet and hydration. One person's family member said how their family member had a much healthier weight since living at Eastleigh House. Another said they were concerned about weight loss and had spoken to staff about this. The registered manager said that GP advice was sought regarding any weight change. We saw that people were encouraged to eat and drink healthily. Where there was a risk of choking, professional advice was being followed. People's personal food and drink preferences were known to staff and a varied diet was available to them.

People's health care needs were met. A health care professional said, "The staff follow advice. They work really hard to follow instructions. They are very good at contacting us and (the registered manager) is good at communicating and is very accommodating." Records showed that external, professional advice was sought and people's health care needs were understood and their welfare promoted.

Good

Is the service caring?

Our findings

The service continued to be caring.

People were unable to tell us if they felt the staff were caring but we observed that people were relaxed in staff company. One person's family member said, "The carers treat (the person) as a normal person. The staff are always doing something with them", "(The person) always seems happy" and "They look after (the person) who seems quite happy."

A health care professional told us, "They have done extremely well with (the person), who used to just sit in their room and rock, but now goes into the day room."

People were supported by staff who knew how best to achieve results which positively improved people's wellbeing. For example, one person's family member said how two support workers, who were supporting a person during hospital investigations, sang to them as they went under anaesthetic.

People using the service had built positive relationships with the staff. We observed a staff communicating with one person. From that communication the person held their hand and kissed the side of their face. The staff member rubbed their hand and the person smiled at them, a personal connection having been reinforced.

Positive relationships were formed between people using the service. One person would always wait for another when out together in the community, for example.

Staff felt that the care they provided was of a high standard and they demonstrated genuine fondness and caring for the people they supported. Staff were rightly very cautious with regard to disclosing personal information about people and they did not enter a person's room without knocking and waiting for a reply.

People's dignity was upheld, in the way they were supported to present themselves, for example.

Staff showed competence in communicating with people and were able to describe how people's views were sought, through understanding individual's body language, for example. Care plans provided comprehensive information on effective communication with each person. People had also been supported to complete a questionnaire, providing feedback about the service.

Good

Is the service responsive?

Our findings

The service continued to be responsive.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

People receiving support had limited verbal communication. Communication was through sign language, pictorial methods, gesture and objects of reference. Some communicated using their tablet, and social stories. This is where a personalised events can be communicated visually, so as to help a person make sense of a situation. Each person had a communication dictionary and care records contained clear communication plans explaining how people communicated, including how to identify pain, where people could not express this verbally. The registered manager told us they had commissioned training to further develop staff's understanding Staff were able to communicate with, and understand each person's requests and changing moods, as they were aware of people's known communication preferences.

Staff described how they enabled people to process information for "perhaps over an hour", as this was what some people required for effective communication. The importance of key words was understood and used as part of regular communication.

Each person had a detailed, comprehensive care plan in place, following assessment, with the involvement of the person where possible, their family members and appropriate health care professionals. The plan covered each aspect of the person's emotional needs, such as what might cause them anxiety or distress. Detailed information was in place for staff on how they could prevent distress, and how they should respond to heightened situations. Preferred routines, health care needs, aspects of safety and assessments of risk, were in place and clearly accessible. Plans were reviewed regularly.

People were supported to engage in meaningful activities, which they enjoyed. A activities room, with exercise bike and cross trainer, also included computer games and large chalk boards. Some enjoyed regular outings in the service vehicles. One particularly liked the garden, which included fruit plants, vegetables and a garden shed. There had been gardening competitions. Others enjoyed sitting at a café watching the traffic. Some went swimming, whilst others liked to go shopping, or enjoy a massage. There had been visits to local venues, such as the zoo. Some attended 'dip and dine' sessions at a local centre, whilst one person was a regular at local football matches. People were encouraged to learn skills. To that end a second kitchen enabled people to cook in a safe kitchen environment.

Staff said that people would be unable to make a formal complaint but they would know if a person was unhappy and would take steps to solve any problem. Staff were clear that they would not tolerate bad practice and any concern relating to people's welfare they would follow up. People's family members felt confident that any complaint would be followed up. The service had a formal complaints policy in place.

The service had received three complaints in the 12 month period up to the provider information we received. The Care Quality Commission has received no complaints about the service.

The service was aware of their responsibility to meet the diverse needs of people using the service and promote their human rights. This responsibility was met through the service mission statement, core values and strategic action plans, such as adaptation to the building. The registered manager said, "Any required equipment or adaptation needed is actioned in a timely manner to prevent any restrictions on people."

Staff were confident that people's rights were promoted regardless of their diverse, individual needs. For example, staff understood the importance of people having private time. To this end one person had a sound monitor for night time safety. This meant that staff did not need to enter the person's room and disturb them.

Requires Improvement

Is the service well-led?

Our findings

The service was no longer well led because there was a breakdown in staff confidence in management.

There was a registered manager. They were registered with the Care Quality Commission in November 2012. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We spoke to staff both during and following the inspection visit. They felt a detachment from the management. Comments included, "The managers are segregated from the support workers", and "I am argued with and not listened to." Some said they did not feel valued. The registered manager and provider representative told us that a staff survey, March 2018 had been undertaken by an external company and so each staff member who responded, was completely anonymous to the registered manager and provider organisation. However, staff did not believe the survey results were anonymous and worried of the consequences of being open and honest. This indicated there was a breakdown in trust.

Following the March staff survey the provider arranged for a person from head office to visit the service to talk to staff at a 'Listening group' so as to hear first hand what staff thought. We were told that, due to unforeseen circumstances on two occasions, this meeting did not take place until 5 September 2018. The registered manager said that no staff, other than those on duty, had attended that meeting. Staff said the invitation to the group would be posted in a rota file and some had been contacted by SMS about the occasion. However, some staff told us, "I never really heard about the listening group" and "I knew nothing about the listening group." Others said they valued their time off and did not feel prepared to use it returning to their work place. We asked the registered manager for an action plan following the results of the staff survey, but they said none was available, other than a document called 'What we did' following the listening group. The listening group had identified pay discrepancies, and unfilled staff roles in housekeeping and cooking, as issues staff had raised.

We saw that management had tried to address staffing issues, trialling a new rota for example. They said that most staff wanted to work 12 hour days, so they had more full days off, but staff told us they barely had half an hour off in that 12 hours and felt the working arrangements were adding to staff sickness.

The provider representative told us, "The Registered Manager has the full support of an HR Business Partner for this region where she can refer any particular/ difficult staffing issues." Oversight of the service was at regional, divisional and group level. The provider representative said they visited the service every four to six weeks and would say hello to staff. We fed back our findings to them and found them unaware of staff feeling and keen to take appropriate action. They said, "It is absolutely unacceptable that staff should wake up feeling worried or unhappy about going to work." They said staff trust would be addressed immediately and in an open and honest way. The provider had staff support systems in place, for example, an Employee Assistance Helpline.

People's family members spoke highly of the registered manager. Asked if the registered manager was available and approachable, we were told by people's family members, "Brilliant" and "I can talk to the (registered manager) about anything. I can ring her any time and she will always listen." The views of people using the service and their family members, were regularly sought through the provider organisation quality monitoring arrangements and the availability of the registered manager.

The service was said to work to the six Cs; care, compassion, competence, communication, courage and commitment. By following these, staff developed and instilled a culture of compassionate care and support. Staff demonstrated compassionate care and support, but communication within the service needed to be addressed. One person's family member raised communication as an issue, saying, "Sometimes staff don't communicate with each other; things are not passed on. Not everybody knows what's going on."

People had links with the local community, most choosing to access it on a daily basis for activities they enjoy. The registered manager said that preparations, prior to a visit, helped to make visits successful. For example, one person liked a particular café and the café staff now understood the person's needs and served them first.

The registered manager told us resources and support were available from a 'Management and Quality Development Team', to develop and improve the service. Provider led inspections had been completed regularly by an internal compliance team and financial auditors visited the service regularly and unannounced. Incidents, including the use of restrictive practices, and accidents were passed to head office for analysis and the registered manager was expected to respond quickly to any questions raised. They said staff meetings gave staff an opportunity to discuss any staff issues and as a place for suggestions and ideas, should they wish to contribute. Staff had been asked to comment about proposed rota changes and we saw there were responses to the proposed changes. Other systems included a 'learning summary', used to monitor staff training and in-house audits, included a monthly medicine audit. This showed there were arrangements in place which should ensure a safe and well managed service.