Care Quality Commission

Achieve Together Limited

Holly Tree Cottage

Inspection report

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24 August 2023

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Holly Tree Cottage is a care home providing personal care for up to six people with a learning disability and/or autistic people. At the time of the inspection six people were living at the home.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support: Staff recognised signs when people experienced emotional distress. Each person's care and support plan explained how staff should respond and how to avoid the need for restricting people's freedom. One person's plan had not always been followed by staff. This had placed both the person and staff at risk.

Right Care: The care and support provided was effective in supporting most people at times of distress. However, it was evident 1 person's current and changing needs, in relation to their distress, could not be safely met at Holly Tree Cottage. The manager and the provider were taking action to address this issue.

Right Culture: Staff recognised incidents and reported them appropriately and managers investigated incidents and shared lessons learned. Staff took part in post incident reviews, after they had supported people experiencing emotional distress.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 13 August 2022).

Why we inspected
We undertook this targeted inspection to check a concern we had about how people who experienced emotional distress were supported by staff. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Holly Tree Cottage

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

This was a targeted inspection to check a concern we had about how people who experienced emotional distress were supported by staff.

Inspection team
The inspection was carried out by 1 inspector.

Service and service type
Holly Tree Cottage is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Holly Tree Cottage is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been appointed and will be registering with the CQC.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 18 August 2023 and ended on 1 September 2023. We visited the home on 24 August 2023.

What we did before the inspection
We reviewed information we held about the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We met 4 people using the service. We spoke with 5 members of care staff (including agency staff), the manager and the acting deputy manager. We viewed all communal parts of the home and 1 person's own room. We looked at 3 people's care and support plans, incident reports, investigation outcomes and staff meeting minutes.

Inspected but not rated

Is the service safe?

Our findings

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

At our last inspection this key question was rated requires improvement. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check a concern we had about how people who experienced emotional distress were supported by staff. We will assess the whole key question at the next inspection of the service.

Systems and processes to safeguard people from the risk of abuse
• Staff recognised signs when people experienced emotional distress. Each person's care and support plan explained how staff should respond and how to avoid the need for restricting people's freedom.
• One person's plan had not always been followed by staff. Staff felt they had needed to intervene in an unplanned way due to the increased intensity and frequency of the person's distress, as planned responses had been ineffective.
• During one incident this person had been secluded in their own room for a significant period of time. In another incident, staff had used an unplanned physical intervention without any safeguards in relation to this being in place. Unplanned restrictions and seclusion place both the person and staff at risk. They may also breach the person's human rights.
• The consensus within the staff team was this person's current and changing needs could not be safely met at Holly Tree Cottage. The staff team were doing their best but factors, such as the environment, made it very difficult to provide safe and effective support.
• One staff member said, "We all want the best for [name], but he is in the wrong place. The environment is too small for him and he does [adversely] affect some other people here who are doing brilliantly otherwise." Another staff member told us, "We are trying to provide the best care we can. He is very challenging, even when in a good mood it's very difficult. He is just not in the right place." These views were shared by all staff we spoke with.
• We discussed this with the manager who agreed with the views of the staff team. They confirmed this person needed a more suitable service and the process of finding one had begun. Whilst they remained at the home, new interim plans were being discussed and agreed with other health and social care professionals involved in this person's care. Once agreed, these will be put in place to try to ensure each person's welfare, safety and quality of life until a move takes place.
• Other people's plans we looked at were being followed and were effective in supporting people at times of distress. We noted some people's periods of distress had reduced.

Learning lessons when things go wrong
• The service recorded any use of restrictions on people's freedom, and managers reviewed use of restrictions to look for ways to reduce them. However, additional restrictions were currently being considered for 1 person due to the intensity of their distress. This would be used as a last resort if, and when this was agreed by those involved in this person's care. It would be a temporary measure until this person

moved to a more suitable service.
• Staff recognised incidents and reported them appropriately and managers investigated incidents and shared lessons learned.
• Staff took part in post incident reviews, after they had supported people experiencing emotional distress. These reviews considered the incident and what could be learnt. One senior staff member said, "I will talk to staff after incidents, time to assess and reflect. I ask, how did they feel, offer praise and see what we can learn from the incident."