TTCC Limited

Tarry Hill

Inspection report

3 -7 Cale Road
New Mills
High Peak
Derbyshire
SK22 4LW
Tel: 01633 746440
Website: www.hcsolutions.co.uk

Date of inspection visit: 21 July 2015
Date of publication: 07/10/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This unannounced inspection was carried out on the 21 July 2015.

Tarry Hill provides accommodation and personal care for up to twenty two people living with learning disabilities. At the time of the inspection there were fifteen people living in the home most of whom had very complex needs including autism.

The service had a registered manager in post. 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 skill mix of staff was not sufficient to keep people safe. Risk assessments had been carried out but not all staff had read and understood them.

There were no consistent systems in place to capture and ensure new information was used to keep people safe.

Summary of findings

Whistleblowing information was available to staff and they knew how to use it.

Medication was administered, recorded and managed appropriately.

The staff did not have appropriate training, supervision and support. They did not always understand their training and roles in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People had their nutritional needs supported. There was a variety of food available and people were included in shopping and menu planning.

People were supported to access health and social care professionals on a regular basis. People were supported to pursue their hobbies and to continue their relationships with their family members and friends.

People or their relatives were involved in the decisions about their care and their care plans provided information on how to assist and support them in meeting their needs. However relatives did not have confidence in the care plans as they felt they were not always part of the continued planning of care. This meant relatives felt marginalised.

Staff were caring, kind and compassionate but were not always skilled enough to promote people's independence. Most of the people who used the service did not have verbal communication skills and relatives and representatives did not always feel listened to nor did they feel their opinions were respected.

The service was not managed in an inclusive manner that invited people, their relatives and staff to have an input to how the home was run and managed.

The service did not have effective systems in place to assess, review and evaluate the quality of service provision.

We found three breaches of the Health and Social Care Act and you can see what actions we told the provider to take at the back of the full version of this report.

Summary of findings

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.

There were enough staff to provide the support people needed, staff were not always aware of how to mitigate people's individual risks. Safe recruitment practices had not always been followed.

People and their relatives told us that the home was safe.

Medicines were managed safely.

Staff were aware of safeguarding and whistleblowing guidance. This enabled the staff to raise concerns when people were at risk of abuse.

Requires improvement

Is the service effective?
The service was not always effective.

The staff had not received regular training and supervision to enable them to effectively meet the needs of the people they supported.

Staff did not fully understand their responsibilities under the Mental Capacity Act 2005 (MCA), and the associated Deprivation of Liberty Safeguards (DoLS).

People were supported to eat sufficient and nutritious food and drink. People had timely access to appropriate health and social care support.

Requires improvement

Is the service caring?
The service was not always caring.

Staff were kind and caring but did not always recognise or understand people's methods of communication. This compromised people's dignity and independence.

Relatives were encouraged to visit whenever they wanted.

Requires improvement

Is the service responsive?
The service was not always responsive.

People did not always receive appropriate care that reflected their individual needs because staff did not have a good understanding of how people's support should be provided.

Complaints were not responded to in a manner that respected the complainant and investigations left many people unhappy with the results.

Requires improvement

Is the service well-led?
The service was not always well led.

The systems in place to review the quality of the care were not effective.

Requires improvement

Summary of findings

There were no effective systems in place to capture people and staffs' views and knowledge.

The service was not managed in an open and transparent manner.

The staff and relatives did not have confidence in the registered manager and found communication with them difficult.

The provider did not promote an open and person centred culture.

Tarry Hill

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 is 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 21 July 2015 and was unannounced. It was conducted by two inspectors.

We reviewed the inspection history of the service and the information we held including notifications received from the provider. This refers specifically to incidents, events and changes the provider and registered manager are required to notify us about by law.

Most of the people who lived in the home had limited communication skills and were unable to talk to us. They had very complex needs and most of them had one to one time with staff so that their needs could be met. We spoke with two people who used the service, 10 relatives, two healthcare professionals, four members of staff and the registered manager.

We reviewed three people's care records and medication records. We looked at records relating to staff support and records relating to how the safety and quality of the service was monitored.

The home was divided into five houses. A small number of people, usually two or three people lived in each house.

Requires improvement

Is the service safe?

Our findings

People were not always protected from avoidable risk as the provider did not ensure that the staff had the necessary competency and skills to care for people. Most people living at the home had complex needs and limited verbal skills. Therefore they were not able to ask for their needs to be met or guide staff on how to care for them. The provider had sufficient numbers of staff on duty, however the skills mix was not enough to keep people's safe at all times because of the high use of agency staff. The agency staff were not given enough time to read and understand people's care plans and risk assessments. The registered manager told us that they tried to use the same agency staff who knew the people they cared for. However we did not see confirmation of this during our inspection. Discussions with staff, relatives and a review of rotas confirmed this. This meant that a consistent service was not always offered to people. This may have had a detrimental effect on their safety because staff who were unaware of their needs were providing care and support to them. For example, an untrained and inexperienced member of staff was part of the working team on their second day of employment. There was no system in place for a senior staff member to assess their skills and competency. The registered manager was unable to assure us that the staff team had the skills and knowledge to keep people safe.

People were not always protected from the risk of employing people who were not suited to care for them. We found that the provider's procedures for recruitment of staff were not always followed. While checks were carried out on staff work histories, identity checks and criminal records checks, the registered manager had employed a staff member without having seen the results of their Disclosure and Barring Service (DBS) check. This staff member had been involved in delivering personal care to one person. This could have put people at risk of unsuitable people caring for them.

Staff did not feel listened to and said their experience was not used by the registered manager to Ensure people were supported safely. For example, staff told us they were directed to take people out who they knew do not get on together. This caused conflict between people living at the home and created a situation that could have placed people at risk. We spoke to the registered manager about this and were told that if it was not done this way, people would not get out as much. However, the registered manager had not considered the risks involved in taking people out in this way. This approach to care put people at risk especially when they were taken out by agency staff who did not always recognise when people were becoming distressed.

Personalised risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. People had personalised risk assessments. The assessments identified the people at risk, the steps in place to minimise the risk and what action staff should take should an incident occur. We saw that where people demonstrated behaviour that had a negative impact on themselves or others, the assessment included information on what might trigger such behaviour, and steps that staff should take to defuse the situation and keep people safe. Risks in relation to restrictive interventions (where staff restrain a person for their own safety) and behaviour management strategies were in place. Incidents of where a person was restrained were recorded and the registered manager was aware of all incidents that had occurred. These incidents were reviewed and changes to the person's care plans and risk assessments were made if necessary. This ensured, where possible, measures were put in place to prevent incidents that could cause injury.

We saw that there was a current safeguarding policy, and information available to staff. The staff we spoke with told us that they had received training on safeguarding procedures and were able to explain these to us, as well as describe the types of abuse that people might suffer. One member of staff said, "I would not let it go until I was sure something was done." The staff knew who to go to outside the organisation should they need to. Records showed that the staff had made relevant safeguarding referrals to the local authority and had appropriately notified CQC of these when required. This meant that staff knew their duty of care to keep people safe.

Each house had its own emergency bag that was kept with the fire panel. The bag included a working torch, 'high vis' jacket, contact details for in emergency and PEEP's (personal emergency evacuation plans). This meant the provider had considered how to protect people in an emergency. Staff we spoke with were aware of these bags and what to do in an emergency.

Requires improvement

Is the service safe?

People's medicine was administered by staff who were trained to do so. Staff responsible for the administration of medicines had completed training in the safe handling and administration of medicines. The registered manager told us the staff had also been registered to attend a more comprehensive medicines training. The service had implemented a pharmacy pre-filled pod type medicines system. This system meant each person's medicine was safely administered and easily audited. People who were prescribed medicines as and when they required them, had an up-to-date protocol in place. This meant that people were assisted to take their medicine as prescribed by their GP.

Requires improvement

Is the service effective?

Our findings

People received care from staff who had not always been trained to meet and recognise their needs. The provider had identified failings in training and the registered manager told us that the provider expected the majority of staff to be up to date on their training. At the time of the inspection only a third of staff had achieved this. This meant that two thirds of staff did not have the training the provider considered necessary to deliver safe and effective care. Discussions with staff and a review of records supported this.

We spoke with staff about the training and support they had received. Staff did not always feel they had the appropriate skills and expertise to provide effective care to people, and in particular how they should manage people's anxieties and behaviours. They said that when they were based in individual houses they got used to people's behaviours and had figured out a way to care for them. However, when they were required to care for people they did not know well they struggled to care for them effectively. They said that this was due to lack of training and knowledge in areas such as autism awareness and how to manage behaviours that challenged. Staff said that this was particularly difficult if they were working with agency staff who did not know people or their needs. During our inspection we found a staff member who had no experience in the care of people was given responsibility for caring for people with complex needs without any training. This may have put people at risk of receiving poor or inappropriate care.

Staff said that they were not always supported to deliver care effectively. Supervision was not carried out on a regular basis and annual appraisals had not been carried out on all staff. This meant that staff did not have the opportunity to discuss their training needs and discuss any problems they may have in caring for people. People were at risk of receiving ineffective or unsafe care because staff did not have adequate training or support.

This was a breach of **Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The registered manager understood her role in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. They had applied for DoLS appropriately for people using the service. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves to their care, or make specific decisions about this. However, staff spoken with showed a variable level of understanding of the principles of the MCA and DoLS. They were unable to tell us who was subjected to a DoLS and what impact this had for the delivery of their care. This lack of understanding of the training they had completed put people at risk of poor and inappropriate care and their legal rights not being promoted.

People told us that the food, "Was really good and we decide what we eat." One person showed us the menus for the week. Each house had its own kitchen. People were assisted to plan meals that promoted their health and to shop for food. We saw menus displayed and people told us that they had decided on these meals and that they enjoyed their food. Staff made mealtimes enjoyable by ensuring they cooked or assisted people to cook food they enjoyed and promoted their health. In each house the staff and the people ate together and this created a family atmosphere. People's nutritional needs were monitored and advice and guidance was sought from dieticians when necessary. This ensured people were supported to eat a healthy balanced diet.

People's physical health was supported and the home had regular visits from the local GP surgery. Health care professionals who visited the home said that their instructions to promote people's health were usually followed. However, they said on occasion the communication systems in the home were not always thorough and this meant that they had to follow up regularly to ensure the people's health and welfare needs were being responded to properly. This may have put people's health at risk.

Requires improvement

Is the service caring?

Our findings

Staff were kind and compassionate, however some staff we spoke with had only a basic understanding and awareness of how to effectively communicate with people living at the home. This meant staff were not always responding to people in a way that promoted their well-being and meant people's dignity and independence were sometimes compromised. The relatives we spoke with supported this and one said they sometimes found [relative] "Alone and upset in their room." They said that this was usually when agency staff were on duty and had not being given enough information to meet [relative] needs.

Staff did not always show empathy or understanding for the difficulties some people experienced with changes to their usual routines. For example, changes were made to care delivery without input from people or their relatives. One relative told us "This was important as [relative] was living with autism and found change extremely difficult." Some relatives told us that they no longer trusted the provider to care for their relative and they called on a daily basis to ensure their relative was cared for. They said this was mainly due to the number of staff who did not know the person well caring for them. This caused distress to people and having unfamiliar staff who could not understand and respond to people's needs had not always been recognised as having a detrimental effect. The relatives said that this put the progress of [relative] back.

Staff we spoke with confirmed this was happening. This meant that the provider had not always ensured people were cared for by staff that could understand the needs of the people living at the home.

The high turnover of staff and the use of agency staff impacted on people's independence and confidence. Six relatives told us that their [family member] had deteriorated in the last six months and one said, "They were at their wits end on how to ensure that [relative's] condition did not deteriorate further." A high number of families had started procedures to move their family member out of the home. All agreed that the staff were kind and caring, however this was not sufficient to ensure people were cared for in a manner that promoted their dignity and independence.

People we spoke with commented positively about the staff that supported them. They told us that the staff were kind and caring. A visiting parent said, "Even though agency staff do not always know [relative] needs, they are always kind and caring."

People's relatives were welcomed in the home at all reasonable times. One relative told us that the permanent staff usually listened to their relative and assisted them to make their own decisions. Another said. "Staff are there to give you an update on how [relative] was doing." However another relative told us that they made requests that were seldom met. This included ensuring their relative was ready to go out. This was important because of time limitations and meant that their time together could be cut short.

Requires improvement

Is the service responsive?

Our findings

Staff told us that there were some people living at the home who could become anxious and distressed. The care plans provided sufficient information detailing people's reasons for becoming anxious and the steps staff should take to reassure them. However, the staff we spoke with had only a basic understanding and awareness of how to support people during these times and did not have sufficient experience to be able to respond appropriately.

People who used the service were not always able to contribute to their care plans. Therefore relatives had a high input into them. The care plans were informative and gave good directions to staff. However they were bulky and the information was not always readily available to the staff team. This was important because of the high use of agency staff who needed ready access to people's identified needs. There was no system in place to capture staff's knowledge of people and to incorporate it into their care plans. Handovers were patchy and information that was passed on at hand over was not always used to update people's care plans. For example, staff who worked with certain people for long periods of time knew their needs, wishes and habits really well. However this information was not always used to inform the person's care or develop other staff members understanding of how to support people.

All of the relatives we spoke with told us that they were not kept up to date on their relatives' care and said that they could not be sure the care plans reflected people's needs and wishes. A relative told us that [relative] had deteriorated and was now notably 'less happy' we noted that this was not recorded in their care plan. Another relative said that due to staff changes [relative] had spent more time in their room as staff changes made them anxious. Staff we spoke with confirmed this. This meant that the care plans did not always reflect the needs and wishes of people.

Staff turnover was high. Therefore the use of agency staff was high and this meant that people living with autism who found changes difficult to cope had an inconsistent response to their needs. They did not have continuity of care they needed to promote their emotional wellbeing. One relative told us that they found their relative in an agitated state in their room. They said that this usually happened when [relative] was rushed or was cared for by staff who did not understand their needs. Staff who knew this person confirmed this had happened. Another relative told us that they were now looking for an alternative home as they no longer had confidence in the provider to meet the needs of [relative]

There was limited evidence that people consistently received appropriate care that met their needs and reflected their preferences.

This was a breach of **Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Where possible people were assisted to pursue their hobbies and interests. For example, one person liked to spend time in the 'outdoors' and they were supported to have a camping holiday. Others liked to spend time at sport centres and spend time with their family and they were supported to do this.

The provider had a complaints process in place. Written complaints were responded to according to the provider's policy. At the time of the inspection there were two complaints that had been escalated to the provider to respond to. More informal complaints were not investigated. Relatives we spoke with told us, "Speaking to the manager was pointless." One relative told us that speaking to the registered manager was so upsetting they no longer spoke with them. We spoke to the registered manager about this and they acknowledged that some relatives were not happy with the care provided and had complained. They had not recognised the relatives concerns as complaints and therefore had not investigated them. This meant that the opportunity to learn from informal complaints and concerns and the opportunity to support families and people and to improve the service had been missed.

Requires improvement

Is the service well-led?

Our findings

There was no consistent approach to quality assurance to ensure effective development and improvement of the service. There was a lack of managerial oversight of the service as a whole and the registered manager was unable to provide an assurance or demonstrate how they identified where improvements were needed across the service. During our inspection we identified a number of shortfalls which had not been acted on or responded to by the provider. For example, the provider had identified issues with staff training but there was no action plan in place to respond to this. We found people were supported by staff that had not been effectively trained and supported and people's well-being and safety was compromised as a result.

There was no clear vision for the service and because of this staffs' morale was low and the turnover of staff was high. This lead to a high use of agency staff and inexperienced staff. There were no effective systems in place to ensure new staff had easy access to the information they needed to care for people or effective training.

The registered manager did not have a clear overview of the service or people's needs because they did not have a system in place to capture or to listen to the views of people, their relatives and the staff team. One staff member told us "There was a lack of staff direction" and that staff "do not get enough information to do a good job.

Systems for improving the service through auditing and monitoring were not effective and it was unclear in some areas as to what actions had been taken. For example, whilst there was a complaints system in place, informal complaints were not responded to or resolved to the satisfaction of the complainant. There was no evidence to show that the registered manager or the provider had monitored these to reassure themselves that effective action had been taken.

There were quality assurance audits in place. However, these had failed to recognise the issues raised in this report. For example, care plans were reviewed on a regular basis, however people who knew the people best were not always involved in the reviews of care. Due to a high number of inexperienced and poorly trained staff, people had not always received care that was appropriate to meet their needs. Quality assurance systems were ineffective because they had failed to identify this as an issue and as a result of quality of service people were receiving had not been improved.

This was a breach of **Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People's relatives did not have confidence in the management of the service and some were in the process of finding a new service for their family member. Although the registered manager acknowledged relationships had broken down in some cases, they had not taken any action to cultivate better relationships.

Relatives felt excluded from any input into the running of the home or the care their family member was receiving. This left them concerned and worried about the quality of support being delivered.

Staff also told us they had limited opportunities to be involved in the development of the service and gave us examples of when they had not been listened to with regard to people's care and support. Staff did not feel they had received adequate training or support and as a result morale was low. There was limited evidence that the service had developed an open or transparent culture.

We noted that the registered manager had reported relevant incidents of concern to the local authority and to the Care Quality Commission as required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found the registered person did not ensure that people had their care delivered by staff who were effectively trained to recognise and meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found the registered person did not ensure that people consistently got personalised care that met their needs and wishes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected people against the risks of inappropriate or unsafe care, as there was no effective system in place to assess and monitor the quality of the service provided.