Pendleton Care Limited

High Barn

Inspection Report

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Summary of findings

Overall summary

High Barn is a care home that can accommodate up to four people with learning disabilities. The home specialises in the care of younger adults with autism, however we found no specialist support was provided for people with a learning disability or autism.

The home was a large detached property with secure garden space to the side of home. Facilities included a communal lounge, a separate dining room and kitchen. All bedrooms were single occupancy. One bedroom with an en-suite was situated on the ground floor in order that people with physical disabilities may also be accommodated.

High Barn had new manager who was registered with the Care Quality Commission in March 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

We found the location was not meeting the requirements of the Deprivation of Liberty Safeguards. Whilst proper policies and procedures were in place and training had been provided to staff in the Mental Capacity Act (2005) and deprivation of liberty safeguards (DoLS), staff spoken with were not able to demonstrate a good understanding. This did not ensure people's rights were protected and promoted. This meant there had been a breach of the relevant regulation.

We found the care records did not provide information about the individual needs of people to help guide staff in the delivering of people's support. This meant there had been a breach of the relevant regulation. We saw the care records were securely stored when not in use ensuring confidentiality was maintained.

For some people communication and decision making was difficult. People expressed themselves through gestures and facial expressions. We saw staff assisted people who used the service in making decisions and choices where possible in a kind and respectful way.

During the course of our inspection we saw people were not offered any meaningful, stimulating activities or variety to their day. In the main, people were left to their own devices either in the garden or watching television. This meant there had been a breach of the relevant regulation.

Suitable arrangements were in place with regards to protecting people from abuse or unlawful practice. Recruitment procedures were in place so that only applicants suitable for employment were offered work at the home.

New staff received mandatory training as part of their induction programme. A programme of on-going training and development was in place. However staff spoken with had not received training in specific areas of support. This meant staff did not always have the necessary skills required to meet people's needs. This meant there had been a breach of the relevant regulation.

Staffing levels at certain times of the day were insufficient. This meant people's safety could be compromised and choices of spontaneous activities were limited.

Checks were made to the premises and servicing of equipment ensuring people living at working at the home were safe. However systems to monitor the quality of care and support people received needed improving. This meant there had been a breach of the relevant regulation.

We found the home was warm and clean. The communal areas and corridors were in need of decorating and refurbishment to ensure people who used the service lived in a comfortable, well maintained environment.

Records showed the Care Quality Commission had been notified of any incidents that could affect the health, safety and welfare of people.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Adequate safeguarding procedures were in place. Staff with whom we spoke had a good understanding of the whistle blowing procedures and who to speak to if they had any concerns. Safeguarding adults, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLS) training was provided. However staff lacked sufficient understanding in the MCA and DoLS procedures ensuring people's rights were properly promoted and protected.

Information was not available in the care records to guide staff in the safe delivery of care and support. This meant people were at risk of not receiving the support they needed.

Sufficient staffing levels were not provided at all times in order to ensure people received safe and adequate levels of support.

Suitable arrangements were in place with regards to the appointment of new staff ensuring only suitable candidates were appointed.

We saw medicines were stored securely within the home and that suitable arrangements were in place when people required medication whilst away from the home.

Are services effective?

Individual care records were in place for people living at the home. Records seen were incomplete and conflicting about how people wished to be supported. There was no evidence that personal preferences had been taken in to account.

Some people living at High Barn would not be able to express their personal needs, preferences and choice and relied on staff to assist them with decision making. Only one member of staff spoken had an understanding of what individualised care entailed. This meant that people's choices and preferences were not met.

Systems were in place with regards to training. Some of the training had been updated annually as required. We were told that specialist training needed to support people living at the home would be provided. However we found that the staff on duty did not have the knowledge and skills required to support people effectively. We saw staff received supervision meetings. These meeting enabled staff to discuss any concerns they may have or developmental needs.

Summary of findings

Are services caring?

Staff were aware of the basic needs of people as most of them had lived at the home for some time. Staff respected people's dignity when carrying out personal care tasks. This was done in people's bedrooms or in the bathroom.

We saw individual needs and preferences were not always recorded in the care records we inspected. Therefore people's choices were not always respected.

At times we saw staff did not always make best use of their time and were distracted from offering quality time with people living at the home. Staff were seen sitting together rather than engaging with people who used the service.

Where people could give consent staff asked permission from people who used the service before entering their private space to ensure their privacy was maintained.

We saw people had access to healthcare agencies ensuring the needs of people were appropriately met. Staff were available to assist people to attend appointments as required.

Are services responsive to people's needs?

We spoke with an independent advocate who was involved in making important decisions in the care and welfare of one person. We were told by the advocate they thought High Barn was responsive to meeting this person's needs.

People had varying needs and abilities and required different levels of support from staff to participate in activities both in and away from the home. However current staffing levels meant that staff were not always able to accommodate this, particularly in the evenings when only one member of staff was on duty. We saw no meaningful activities for people within the home during our visit providing any stimulation or variety to their day.

The home had a complaints procedure for people who lived at the home and for relatives to raise any concerns. For some people living at the home this would be difficult to access due to their lack of capacity and communication difficulties they have. Some people would have to rely on relatives who could act on their behalf.

Are services well-led?

The manager of the service had been in post since March 2014 and was registered with the Care Quality Commission (CQC).

The manager notified the CQC of any incidents or accidents at may occur in or out of the home.

Summary of findings

Some systems were in place to monitor and review the quality of the service provided however these were not effective in identifying improvements needed. Safety checks to the premises and services were carried out ensuring people were kept safe.

We were told by staff they had raised some issues senior management but they were not responsive to complaints and concerns raised by staff.

An effective system was in place with regards the reporting and responding to complaints or concerns made by people who use the service or their relatives. No issues had been received by the home or CQC other the last twelve months.

Whilst adequate staffing levels were available during the day to meet people's care needs the manager did not ensure effective support and supervision was provided to people engaging them in meaningful activities.

Summary of findings

What people who use the service and those that matter to them say

We spoke with three people who lived at the home. There were no relatives visiting at the time of our inspection. Due to the varying needs of people, they were not able to talk to us in detail about their experiences of living at the home and the care and support they received. We observed through people's body language, gestures and actions that people were comfortable in the presence of staff.

We spoke with the advocate for one person who told us "Staff at High Barn are caring and responsive to people's needs".

One person told us, "My life here is spent in my bed, my money, my phone and X box, I don't get bored. I have a front door key and I let myself in and out. I am here because of my social worker, if I had been paid my benefits today I would be drinking at my pub".

High Barn

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 of the Health and Social Care Act 2008. It is also part of the first testing phase of the new inspection process CQC is introducing for adult social care services.

The inspection team was made up of an Inspector and an Expert by Experience who had experience of caring for people with learning difficulties. For some inspections we incorporate a Short Observational Framework (SOFI). This is a specific way of observing care to help us understand the experience of people who could not speak with us. For this inspection a SOFI was deemed inappropriate and intrusive in such a small home.

At the time of our inspection four gentlemen were living at the home. We met and spoke with three people who used the service during our visit. We also spoke by telephone with an independent advocate who supported one person when making decisions about their care and support. One person was out of the home all day attending a local day centre.

We visited High Barn on 1 April 2014. We spent time speaking with people as well as observing care. Observing the care and support helped us understand the experience of those people who were not able to talk to us. We looked around the home, including some bedrooms, bathrooms and communal areas. We spent time speaking with the manager and staff, looked at people's care plans and other records relating to the management of the home and the conduct of the service.

The CQC carried out a scheduled inspection on 29 May 2013. The home was not meeting one of the required standards with regard to records. A further inspection was carried out on 14 January 2014 to check the outstanding action. We found improvements had been made and the standard was met.

Before our inspection, we reviewed the information we held about the home such as statutory notifications. We also spoke with the local authority who commissioned services for people living at the home to seek their views about the service. They sent us a copy of their action plan which had been sent to High Barn following their most recent quality monitoring visit in July 2013.

Are services safe?

Our findings

Staff told us they had undertaken training in areas of protection. This included the safeguarding of vulnerable adults, Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs). Staff spoken with were confident in the procedures to follow if they had any concerns or suspected abuse was taking place. We had been notified by the manager of three safeguarding referrals made to the local authority safeguarding team in the last 12 months. These had been appropriately dealt with by the home, incident reports were completed and people's records completed.

We were concerned about the staff's understanding of the MCA and DoLs. Whilst staff confirmed they had undertaken a one day training session on the MCA, from our discussions and observations we found these were not understood or being properly implemented. This meant there was a breach in the relevant regulation (Regulation 23(1)(a) and the action we have asked the provider to take can be found at the back of this report.

We saw a generic mental capacity assessments form had been placed on the care records we looked at. Information was incomplete and therefore it was unclear why the assessments were required to demonstrate that the person's capacity had been properly assessed. These records had been signed by the manager. This did not demonstrate decisions were made in the person's best interest. This meant there was a breach in the relevant regulation (Regulation 18) and the action we have asked the provider to take can be found at the back of this report.

We looked at the care records of all the people living at the home. We were told some information was held electronically and some information was in paper copies which were in the process of being transferred to the electronic system. Eventually all records would be held electronically. At the time of our visit the computer system was unavailable so we could not check what information was documented regarding people's care and support needs. We saw some documentation was incomplete or lacked sufficient detail to guide staff, for example in one person's file we saw information indicating that the person had no verbal communication or capacity, whilst further information stated the person could be involved in decision making.

The records for another person contained information relating to a previous placement at another service. We were told this person was not staying at High Barn on a permanent basis and that some information was on the computer. However this information could not be accessed during the inspection.

We saw people's care records were not sufficiently detailed or up to date to guide staff as to the actions required to meet people's needs. They did not accurately reflect people's needs and aspirations. This meant there had been a breach of the relevant regulation (Regulation 9(1)(b)(i)(ii) and action we have asked the provider to take can be found at the back of this report.

We discussed with the manager the overall standard of décor in the communal areas and corridors. We were told an upgrade was planned. We spoke with all the staff on duty. One staff member told us, "The staff tell the management it does not feel homely here but nothing changes".

We saw the paintwork around the home was badly chipped and one door upstairs had a broken cracked panel. The bathroom door upstairs had no lock to offer people privacy and dignity when bathing. Doors should be fitted with suitable locks that can be over ridden by staff in the event of an emergency. The cupboard on the upstairs landing where the medication cabinet was stored required painting inside. There was no programme of decoration in place to ensure people who used the service were able to live in a well maintained home. We were told by the manager that improvements would be made once annual budgets had been agreed. This meant there had been a breach of the relevant regulation (Regulation 15(1)(c) and action we have asked the provider to take can be found at the back of this report.

We saw that people's bedrooms were decorated with bright colours with appropriate fixtures and fittings. People's rooms had been personalised with their own belongings and mementoes of their choice.

On arrival at the home we rang the doorbell to gain entry. The front door of the home was locked at all times for people's safety and to prevent unwanted people entering the home. The home was situated very close to a busy road which meant that some people could potentially be at risk

Are services safe?

if they went out of the home unaccompanied due to their lack of road safety awareness. We were told only one person went out of the home unaccompanied and this did not present any road safety issues.

We looked around the home and the garden area. We were advised at our inspection in May 2013 that the number of people to be accommodated at the home was to be increased from three to four people. In light of this the manager's office was moved to a metal structure situated in the garden which was detached from the main building.

In June 2013 as part of the registration process to increase bed numbers the provider sent us a copy of the homes fire risk assessment. This did not take into consideration fire safety arrangements for the external metal structure. There were no arrangements in place to safeguard important information in the event of a fire. The fire alarm system from the home was not linked to the manager's office, therefore staff using the manager's office would not be alerted to a fire in the main building should one occur.

The lack of a fire alarm system in the manager's office could see the destruction of important information and equipment. Advice regarding this matter should be sought from the Fire Authority. This meant that there had been a breach in the relevant Regulation 15 (1) (c) and the action we have asked the provider to take can be found at the back of this report.

Inside the home we saw some safety precautions were in place, for example a waist high gate was fitted across the kitchen doorway to prevent one person accessing the kitchen where it was deemed a risk area for them. This did not prevent other people who lived at the home accessing the kitchen area. We saw doors that needed to be locked, for example the cellar door, cleaning cupboards and the medication cupboard were kept locked and staff carried keys with them. Some people who lived at the home expressed a wish for their bedroom door to be locked and were provided with a key. Bedrooms were not fitted with a call assistance system; however we saw evidence that staff made regular checks when people were in their bedrooms. We noticed there was only one handrail on the stairs. Some people living at the home had limited mobility and may benefit from a second handrail being fitted against the stair wall to assist them up and down a steep staircase. The home does not have a passenger lift so people who used the service needed to able to use the stairs safely.

We were told there was no staff room for staff to take a break away from people using the service. Staff told us there used to be a staff room but this was now registered as the fourth bedroom.

We observed some people living at the home displayed repetitive behaviours and made numerous demands on staff. Staff had no respite time away from people, particularly for evening and night staff who worked alone.

The company had recruitment policies and procedures in place. Criminal record checks carried out by the Disclosure and Barring Service (DBS) were completed prior to people commencing work. Other information included an application form, references and other forms of identification. These checks ensured that people working at the home had been recruited appropriately.

We asked about evening/night staffing levels and were told from 6.00pm in the evening there was only one member of staff on duty and throughout the night, which was a waking night shift. This was a cause for concern for staff who said that should a serious accident occur they may not be able to call for assistance, such as contacting the on call person. This could be potentially dangerous to the injured person and may result in people who used the service being left unattended. There was no backup plan in place should this type of incident occur. We saw there was an adequate number of staff on duty during the time of our visit.

We found the arrangements for the management of medication was safe. Medicines were in a locked metal cabinet attached to the wall inside another locked cupboard. We were told there were no controlled drugs within the home. We saw people's Medication Administration Records sheets (MARs) had been completed. Suitable arrangements were in place for people to take medication with them should they go out for the day or on weekend home visits.

We saw evidence of regular servicing of mains and equipment. Certificates were up to date and valid, for example landlords gas safety certificates, water testing, electrical installations and portable appliance testing to ensure the safety of people living and working at the home.

Are services effective?

(for example, treatment is effective)

Our findings

People living at High Barn had varying needs and abilities. Some people relied on staff to enable them to express their needs, preferences and choices. The records for one person showed an independent advocate was involved and acted on their behalf when important decisions needed to be made regarding their care and welfare. This helped to promote the rights of the person. However we found no evidence in people's care records to show people had been consulted with or involved in the planning and reviewing of their care and support. We were told by one person, "I do not know about my care plan, what is a care plan? No one has gone through this with me; I am here because of my social worker".

A member of staff told us they had seen people's care plans and told us about the diagnosis of one person. Another person entered the room and the member of staff continued to discuss personal information in front of them with no consideration about confidentiality. The staff member told us, "I have read the care plan but I have not seen a person centred care plan. I would not know where it is".

We observed one person comment and gesture to staff. However the staff member told us they did not know what this meant and gave other examples of people's communication and behaviours which they did not understand. The staff member told us there was no specific plan in place to guide staff in effective methods of communication with people. Suitable training should be provided to staff so that they are able to safely deliver the care and support people require taking into consider their individual needs and wishes. This meant there was a breach in the relevant regulation (Regulation 23(1)(a) and the action we have asked the provider to take can be found at the back of this report.

We received information from the Rochdale Council following their quality monitoring visit in July 2013. This highlighted the lack of meaningful activities provided so that people become more socially integrated in the local and wider community. We saw no evidence during our inspection to demonstrate that recommendations made by the council had been actioned.

One person had recently moved from another service to High Barn. This had been arranged by the person's social worker and was seen as a temporary measure until more suitable accommodation could be found. It was unclear from the person's records how it had been determined that a placement at High Barn was suitable for this person. We saw this person was self-caring and could go out unaccompanied and use public transport. We observed at times this person became agitated with another person living at the home and was heard to raise their voice to them. We saw staff did not respond to the raised voice and offer any reassurance or guidance.

We discussed with the manager and staff if the placement was suitable for this young person as there was no one else with their abilities and communication skills for them to relate to living at the home. We were told by staff, "I don't why they have been placed here, and it's not the right environment. They are much more able than the other people living here". This meant there was a breach in Regulation 9(1)(a) in relation to the assessment process and the action we have asked the provider to take can be found at the back of this report.

We saw evidence that people had access to health care services such and GPs, hospital appointments and dentists to maintain their health and wellbeing.

Staff told us the mandatory training was on-going and any specialist training required to meet people's needs would be provided as required. One person told us they had undertaken an induction training on commencing work this included an insight into the Mental Health Act and Mental Capacity Act, safeguarding, nutrition and hydration, medication and health and safety. The training was delivered by a combination of training sessions and electronic learning.

Staff told us they received formal supervision and appraisals where any issues of concern and further development or training could be discussed. We saw evidence to support this in the staff files we looked at.

Are services caring?

Our findings

We spoke with two people who used the service, one person had excellent communication skills and was able to speak with us. We were told the staff were “alright” and they were able to come and go as they were able to go out unaccompanied. The second person spoke to us about how they spent their day; they went out with staff and had use of their own vehicle.

We saw people had access to GPs, podiatry services and other health care services when required ensuring their health care needs were appropriately met. Staff provided support to these appointments. Staff were heard to offer reassurance to one person who had a dental appointment, which was the cause of some anxiety. Staff explained clearly and slowly about the appointment and what it entailed. This seemed to help reassure this person.

We observed staff attending to peoples care needs as required. Some people required help with decision making and staff assisted kindly with this. We saw people were nicely dressed and groomed. The manager was also seen to be kind and caring when responding to people’s needs when required. However we found that staff did not make good use of their time choosing to chat with colleagues rather than engage or encourage people in meaningful activities.

We were told some people maintained regular contact with their families and home visits were encouraged and supported by the staff.

One person had access to advocacy services who acted on their behalf and assisted them with decision making when required. They told us they were happy with the services this person received.

We saw individual care records were in place with regards to people living at High Barn. For one person their care records related more to their previous placement. Care records were easily accessible for staff should they need to refer to them albeit at the time of the inspection the computer system was not operating. Care records were held electronically and some paper copies were also available. Some people living at the home would find it difficult to contribute to their care records and relied on staff to act on their behalf.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We asked staff how people living at the home spent their time. We were told one person attended a local day centre every day and at weekend they spent time at the family home.

Where possible people were encouraged and supported by staff with daily living tasks for example keeping their bedrooms clean and tidy.

We were told some people had time allocated for one to one trips and outings. For some people the assessed risks associated with these activities required two members of staff. Two people had their own mobility cars and we saw one person going out for a drive with staff. Some people liked to go shopping with staff and visit local places. For one person, crowded places were overwhelming and caused upset. Therefore more suitable outings such as trips to local parks and moorland spaces were planned. However staff told us these were ad hoc and not provided on neither a regular basis nor where suitable alternative activities considered offering variety and new learning experiences.

During our visit we noted that one person walked for hours around the garden without any staff intervention or interaction. There was no seating in the garden to offer rest to this person. There was nothing in the garden to occupy this person or engage them in any activity. This meant there had been a breach in the relevant Regulation 17(2)(g) in relation to the provision of appropriate opportunities and support to promote autonomy, independence and community involvement and the action we have asked the provider to take can be found at the back of this report.

On examination of staff rotas and in discussions with staff we found that the staffing levels were reduced from 6.00pm in the evening to one member of staff who provided support for four people. This meant any spontaneous activities outside of the home that people wished to take part in could not be supported. This may be restrictive to people who may not want to be confined to the home from early evening due to staffing levels.

For some people who used the service it would be difficult for them to express any concerns or complaints. Some people would have to rely on family or advocates to act for them. We saw there was a suggestions box in the hallway for people to post any suggestions about the service. We were told by the manager there had been no complaints or concerns raised about the service. No issues had been raised directly to the CQC.

Are services well-led?

Our findings

The registered manager had been in post since March 2014. The manager told us that any comments and concerns raised by staff in relation to the environment and evening staffing levels had been raised with senior management but that progress was slow in addressing these issues.

From our discussion with staff we were told morale was low. We were told by staff when they had visited some of the company's other homes these were well maintained and furnished and provided a good standard of accommodation for people. We were told very clearly by two members of staff they felt ignored by senior management because any issues brought to their attention were not responded to.

Staff told us the manager had an 'open door' policy where they could approach her at any time with any issues or concerns.

We saw that staff were not proactive in offering support to people and whilst basic needs were met such as offering food and drink or personal care, little was offered with regard to meaningful staff interaction or stimulation for people. Staff need to be clearly supported and directed by the manager so that staff understand what is expected of them and people receive a quality service which meets their individual needs.

We saw some systems were in place to monitor and review the service provided, for example, medication was checked, fire appliances and fire drills had been carried out and reviews of care records had been undertaken. We were told by the manager the home also received visits from head office to check that the manager operated effective systems. However we found systems to identity shortfalls in the planning of people's care and support were not in place. It was unclear how staffing levels had been determined or if these were kept under review considering the individual needs of people. This meant there was a breach in the relevant regulation (Regulation 10(1)(a)(b) assessing and monitoring the quality of service provision and the action we have asked the provider to take can be found at the back of this report.

Prior to the inspection we spoke with the local authority commissioning team. They carry out contract monitoring visits on an annual basis. The last visit at High Barn was completed in July 2013. The team provided us with an action plan which had been sent to the home detailing their findings and the improvements needed. We found that some of the improvements required had not been addressed by the manager and provider with regard to providing meaningful activities for people.

The Care Quality Commission had been informed of any incidents or accidents occurring within the service as required by current legislation. These had been received in a timely manner.

There was a company complaints procedure available should people need to raise any areas of concern. It was recognised that some people living at the home would need some assistance in raising a concern or rely on others to advocate on their behalf. A copy of the complaints procedure should be made available for people to refer. We had not been made aware of any complaints or concerns raised by other healthcare professionals or by family members.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 (1)(a) HSCA 2008 (Regulated Activities) Regulation 2010 Care and Welfare of service users. How the regulation was not being met: The registered person had not carried out an assessment of the needs of all service users.

Regulated activity	Regulation
	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare How the regulation was not being met: The registered person had not taken proper steps to obtain people's consent and act in accordance with their wishes. Regulation 18

Regulated activity	Regulation
	Regulation 15(1)(c) HSCA 2008 (Regulated Activities) Regulation 2010 Safety and suitability of the premises. How the regulation was not being met: People who use the service were not protected from the risks associated with unsafe or suitable premises because of inadequate maintenance and the use of a metal structure in the garden area. Regulation 15 (1) (c)

Regulated activity	Regulation
	Regulation 23(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers.

This section is primarily information for the provider

Compliance actions

How the regulation was not being met: The registered person had not taken proper steps to ensure that people were protected against the risks of unsafe or inappropriate care as staff did not fully understand their responsibilities in safeguarding people's rights. Regulation 23(1)(a)

Regulated activity

Regulation

Regulation 17(2)(g) HSCA 2008 (Regulated Activities) Regulation 2010 Respecting and involving service users.

How the regulation was not being met: The registered person had not taken as far as reasonably practicable made suitably arrangements in relation to the provision of appropriate opportunities and support to promote autonomy, independence and community involvement

Regulation 17(1)(g)

Regulated activity

Regulation

(Regulation 10(1)(a)(b) HSCA 2008 (Regulated Activities) Regulation 2010 Assessing and monitoring the quality of the service.

How the regulation was not being met: The registered person had not taken proper steps to regularly assess and monitor the quality of the service and manage risks relating to health, welfare and safety. Regulation 10(1)(a)(b)