Maven Healthcare (Leicester) Limited

Hunters Lodge

Inspection report

26 Berridges Lane
Husbands Bosworth
Lutterworth
Leicestershire
LE17 6LE

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05 June 2018

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25 July 2018

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**

Summary of findings

Overall summary

We inspected the service on 5 June 2018. We contacted the provider 24 hours prior to our inspection to ensure someone would be at the service when we visited. Hunters Lodge 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. Hunters Lodge accommodates up to 17 people and is designed to meet the needs of people with a learning disability. On the day of our inspection 12 people were using the service.

The care service has been developed and designed in line with the values that underpin Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. The aim is that people with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The service had a registered manager in place at the time of our inspection. 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. At the time of our inspection the registered manager was on leave.

This was the first inspection of this service under its current registration.

At this inspection we found that the behaviours of one person using the service, which posed a risk to staff and other people using the service, had not been safely managed by the provider. This was having a significant impact on every aspect of the service and this is reflected in this report. Incidents had not been notified as required by law and as a result CQC had not been made aware of the level of risk at the service at the time of our inspection.

People were not always able to spend their time in ways they would have chosen to due to the risk posed by one person who used the service. These behaviours, which staff struggled to manage, were impacting on people being enabled to remain as independent as possible and, at times, people using the service did not feel safe.

Staff had not been adequately trained in providing safe support for people and staff felt they had not always been adequately supported in their roles.

There were enough staff at the service to safely meet people's needs although staff's time was often taking up managing one person's behaviours and this restricted the amount of time they were able to spend with other people.

Care and support plans contained relevant and up-to-date information on risks associated with the delivery

of people's support and were written to reflect people's personal needs and preferences.

People were protected against the risk of infection as we found the service to be clean and hygienic. People received their medicines safely and there were plans in place for any potential emergency situations.

People's consent was sought by the service and the principles of the Mental Capacity Act 2005 had been followed.

People's nutritional risks were assessed and planned for and people had a choice in what they had to eat and drink. People had access to various healthcare professionals to maintain their health and well-being.

There was a management structure within the service and people and their relatives felt they could approach the management of the service should they need to raise any issues. However, there had been a lack of action in relation to concerns raised by staff, people and their relatives in relation to risk associated with one person's behaviours at the service. These were beginning to be addressed following our inspection as we raised a safeguarding concern about this.

You can see what action we told the provider to take at the back of this report.

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

The service was not consistently safe.

People were not adequately protected from the risk of abuse due to a lack of appropriate action in relation to incidents which had taken place. People did not always feel safe at the service.

Staffing levels were adequate to meet people's needs although staff time was taken managing the behaviours of one person.

Risk assessments we looked at had been reviewed and up-dated and provided guidance for staff on keeping people safe.

Staff were safely recruited at the service.

Medicines were safely managed and people were protected from the risk of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People were cared for by staff that needed further training to do this safely and effectively.

The principles of the Mental Capacity Act 2005 had been followed at the service and best interest decisions had been made or documented. However, restrictions were being placed on people due to the behaviours of one of the people using the service.

People were supported to eat and drink enough to maintain a balanced diet.

People's health and well-being was continuously monitored.

People's needs were met by the design and decoration of the premises.

Is the service caring?

Requires Improvement

The service was not always caring.

People were limited in how they were able to spend their time.

People were involved in the planning and delivery of their care and support.

People were not always given information in ways they could understand.

There were regular meetings for people who used the service and this allowed them the opportunity to contribute to how the service was being run.

People's privacy was respected.

People were supported by kind and compassionate staff who maintained people's dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were restricted in how they could spend their time and we found people engaged in little or no activity during our inspection. Staff did not always have the time to support people in activities they would enjoy and some activities which enabled people to remain independent had been removed from people.

People received care that met their needs and had plans of care that were updated as their needs changed.

People and their relatives had information on how to make complaints.

People would be supported to plan and make choices about their care at their end of life.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had failed to make the required notifications to CQC for a number of safeguarding incidents at the service and incidents were not being effectively monitored to protect people.

Staff had not been adequately supported and trained to safely manage the behaviours of people using the service. There had not been adequate action taken by the provider in relation to staff and people using the service expressing concerns about

this.

Audits were carried out in relation to medicines, care plans and the premises.

Hunters Lodge

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.

We inspected the service on 5 June 2018. We notified the provider of our inspection 24 hours prior to our visit. We did this to ensure that someone would be at the service when we visited. The inspection team consisted of an inspector, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with three people who used the service and the friends and relatives of three people who used the service. We spoke with the deputy manager, two team leaders and two support workers. Following our visit we spoke with the commissioners of the service and the local authority safeguarding team due to concerns we identified during our visit. We also spoke with the registered manager following our visit as they were on leave at the time of our inspection.

We looked at the care records of four people who used the service, medicines records, staff recruitment and training records, as well as a range of records relating to the management and running of the service including audits carried out by the registered manager.

Requires Improvement

Is the service safe?

Our findings

We reviewed incidents which had taken place at the service and, from looking at daily records and incidents logs, found that one person using the service regularly reacted in a challenging way to other people using the service. These incidents constituted abuse in many instances. Some of the people using the service did not feel safe due to the behaviours of a person who used the service. During our inspection we observed this to be the case and saw one person get very distressed. We found incident reports which involved people using the service being subject to abuse. Although the service had referred some of these incidents to the local authority, we found that insufficient steps had been taken to protect people due to a lack of staff training and a failure to take robust measures to protect people. One person's relative had provided feedback to the service which indicated that their relative did not feel safe, "[Name of person] doesn't feel as safe as they used to. Not only [person's name], other residents also. I am concerned about [person's name's] happiness and safety."

We also saw records of incidents where staff had been subject to physical attacks. We discussed this with staff who confirmed that they were regularly hit. One staff member told us, "I'm always expecting the unexpected" and "We've had girls in absolute tears." We asked staff about training in relation to managing behaviour which may be challenging and were told that no training had been delivered in this area. One staff member said, "I think we need more. I don't think we have the training we need. Nothing around restraint." When we reviewed staff training records they confirmed that staff had not been trained in this area and that they were struggling to manage some of the behaviours they and people at the service were being subjected to. This put people using the service and staff at on-going risk of abuse.

Some of the staff we spoke with could not recall having any safeguarding training, however training records provided to us by the registered manager following our inspection confirmed that staff had been trained in this area. Staff were not always clear on the processes of reporting safeguarding concerns.

The provider had failed to adequately protect people from the risk of abuse. The above evidence is a breach of Regulation 13 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

At the time of our inspection there were sufficient staff to safely meet the needs of people using the service. However, staff we spoke with did raise concerns about the time they spent managing one person's behaviours and we observed throughout the course of our inspection that this consumed a significant amount of staff's time. Staffing levels had not been adjusted to allow for this as the person was not being given one to one care. One staff member spoke of the person who was displaying behaviours which may have been challenging for staff to manage, "It's taking all my time." Another staff member told us, "It's the amount of time it takes to deal with one incident." There were a number of people engaged in little or no activity during the course of our inspection due to staffing pressures at the service. We raised this with the provider following our inspection who assured us they would look at this.

Risks associated with the delivery of people's care and support had been assessed and continuously

reviewed and updated by the service as people's risks changed. Risk assessments gave clear guidance for staff on how to mitigate risks associated with people's care and support to enable them to keep people safe. Care and support plans were regularly updated and did provide sufficient information for staff to deliver people's care and support safely. Staff were aware of risks associated with the delivery of people's care and support and worked with people to minimise these risks.

The provider followed safe staff recruitment procedures. Records confirmed that Disclosure and Barring Service (DBS) checks were completed and references obtained from previous employers. The provider had taken appropriate action to ensure staff at the service were suitable to provide care to vulnerable people.

There were systems and plans in place to ensure people were safe in potential emergency scenarios. We found robust plans in place to provide guidance to people and staff in the event of any emergency affecting the service. There were also grab sheets in place should people need an emergency hospital admission.

There were robust arrangements in place for the safe management of medicines. Staff had received training and demonstrated they were knowledgeable about how to safely administer medicines to people. One person told us, "I'm glad they [staff] look after my medication." Records showed that people received their medicines at the prescribed times. There was guidance in place for those as and when needed medicines which clearly outlined for staff when people may need this type of medication. Medicine administration records clearly indicated that people were given their medicines on time and these records were regularly checked by the registered manager to monitor for any discrepancies.

People were protected from the risk of infection as the provider had infection control procedures that staff followed. We found the home to be clean and hygienic at the time of our inspection and staff described following safe infection control procedures when delivering care and support to people. People and their relatives told us the home was clean. Relevant staff training in infection control and health and safety took place at the service.

Requires Improvement

Is the service effective?

Our findings

Staff were not always skilled in delivering care and support to people safely. Staff we spoke with felt that they would benefit from more training in relation to managing behaviour which challenged and told us that this was an issue for them on a daily basis. One staff member said, "We've asked for certain training." Training records we looked at reflected that staff were not trained in key areas of care and support delivery despite them dealing with behaviours which may have been challenging to manage on a daily basis.

Staff had regular meetings to discuss their roles and to provide them with the necessary support. There were regular staff supervisions and appraisals and staff felt they could approach the management at the service should they need to. We found there to be an open culture where issues could be discussed. However, staff felt that issues around the behaviours of a person using the service had not been fully address. One staff member said, "We bring it up every staff meeting. I think we're getting a bit fed up now." Although we found these issues had been raised, there had been a lack of action by the provider and registered manager in order to ensure staff felt supported and adequately equipped to carry out their roles.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found where needed people's capacity to make decisions in relation to their care and treatment had been assessed. We saw that best interest decisions were documented and made in consultation with people's representatives where needed.

The provider had made suitable DoLS applications to the relevant authorities and these had been authorised where necessary. People told us they were asked about consent to care and treatment where they were able to give this and we observed people being given choice and staff asking for consent during our inspection.

People were assessed for their nutritional risks to help maintain their health and well-being. People received food and drink that met their individual needs. People were able to choose what they ate and drank and there were systems in place to support people to do this. Support staff and team leaders prepared the meals at the service and we found that there was always a choice on offer for people. Fresh fruit and vegetables were in stock at the service and people had nutritious and healthy meal options on a daily basis.

The provider and the staff working at the service had a good understanding of people's conditions and any health-related implications of these. Staff ensured that people maintained their health and well-being by following plans of care. People's health and well-being was continuously monitored. Any medical conditions

people were living with were detailed in their care records and care and supported was delivered in line with these. For example, people with type I and II diabetes were given an appropriate diet and had regular health screenings in relation to this. During our inspection a team was assessing someone's nutritional needs as the result of a referral by the service. People with more complex medical needs were treated by staff who had been trained in specific health tasks and signed off by the appropriate health professional to ensure this was being done safely.

The premises were designed to meet the needs of people currently using the service. Bedrooms and people's personal living spaces reflected their individual needs and preferences and provided warm and comfortable spaces for people. Communal areas were designed to provide a pleasant and welcoming environment for people and we observed people using communal areas of the home as they chose to. There were pleasant outside spaces which people could access and enjoy. The premises were in the process of having some improvements to further enhance people's living environment.

Requires Improvement

Is the service caring?

Our findings

The service ensured that people lived fulfilling lives and worked to enrich people's experiences by providing activities which may have been of interest to them. However, this could be limited at times due to staffing levels and a lack of transport for people. One staff member told us, "It'd be nice to get people out more." We observed people sat for long periods of time during our inspection with little or no interaction from staff. Some of this was due to the demands of one person using the service and staff trying to manage their behaviours.

Care records were written respectfully and they considered how the service could work to maintain people's dignity. People's bedrooms reflected their personalities and staff worked hard to ensure people's personal preferences were respected. Some of the ways in which people were able to maintain their independence and spend their time had been restricted at the service due to the risk posed by one of the people using the service and their behaviours. For example, one person using the service enjoyed spending time on the floor. However, staff were not able to facilitate this activity for this person due to the behaviours of another person who used the service. This was a restriction placed on one person due to the behaviours of another.

There was evidence that people were involved in the day to day running of the service. There were meetings held for people who used the service and we saw that people were able to express their views in relation to how the service was being run. People were given some information in a format which would assist their understanding. However, improvement was needed in how people menu choices were communicated to them.

People's privacy was respected at the service. People had personalised bedrooms and were able to access these whenever they wanted to. Some people chose to lock their rooms when they weren't in them and this was respected at the service. People had space within the service to spend time with relatives and friends should they choose to.

Staff we spoke with were kind and compassionate towards people and knew people well. One staff member said, "These guys are like family now. You get to know them." Staff described working well as a staff team and felt that people's needs were met at the service. We observed staff speaking with people and saw that they were kind and that they communicated in different ways for different people. Staff had fun and joked with people in ways they enjoyed which created a very positive atmosphere within the service.

Requires Improvement

Is the service responsive?

Our findings

During our inspection we observed several people using the service sat for long periods of time with little or no staff interaction or stimulation. One person in particular who did not communicate verbally and who was not mobile was not interacted with for long periods of time. When we asked what the person enjoyed doing we were told that they enjoyed being on the floor on a mat. Staff informed us that this was not possible at the moment due to the behaviours of one person who used the service and the risk this posed to the person. One staff member said of this restriction on the person who enjoyed being on the mat but was unable to, "It's really sad."

There were other ways in which people had been prevented from doing things they enjoyed and which encouraged them to remain independent. Some daily tasks people enjoyed had been taken away from them due to the risk it posed. The service had not taken adequate steps to allow people to remain independent and to do the things they enjoyed. There had not been sufficient action taken to address the ways in which the behaviours of one person using the service had impacted on the lives of other people within the service.

Staff we spoke with felt that more activities could be offered to people using the service and two staff spoke to us about there being a lack of transport to facilitate this. Although some people using the service had their own vehicles, some people didn't and staff told us this restricted how much people could do. One staff member told us, "To me it's important that residents get out and that sometimes can be restricted by staff and the fact that we don't have a company vehicle." Although some people were out at day centres when we inspected the service, several people were sat engaged in little or no activity for prolonged periods of time. One person, for example, watched the same film over and over again throughout the day and although this may have been their preference, there was little interaction with staff. We raised with staff that we felt this person may be cold and staff then provided blankets for this person. Staff lacked time to spend with people due to their time being taken up by managing the behaviours of one person using the service. This had an impact on how other people spent their time and them receiving care and support to meet their individual needs.

People's individual needs were not always being met at the service and this had not been adequately addressed by the provider. The above evidence is a breach of Regulation 9 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

People's needs were assessed before they used the service to ensure that the service could meet them. Staff created people's initial care plans which were updated as their needs changed. People and their families and friends provided information about their lives which helped staff to relate to them; staff talked to people about their interests and their families.

People expressed their likes, dislikes and preferences in their care and support plans. Staff told us this enabled them to provide care that met people's preferences. For example, the plans we looked at described what time people liked to get up in the morning, whether they liked a regular routine and the kind of ways

they liked to spend their time. For example, one person's support plan stated, "[Service user name] likes to wear their watch every morning when they get up." Each person's care plan reflected their individual needs and preferences which staff followed. This supported staff to provide personalised care. Processes were in place to identify people's diverse needs, and ensure that no discrimination took place.

The service needed to improve in order to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. We found that people were not always given information in ways they could easily understand, for example the food menus were in small type face and would be difficult to read and understand for people who used the service.

People felt confident that they could make a complaint or raise any issues should they need to. The provider had procedures in place to record and respond to people's concerns. There were no formal complaints for us to review at the time of our inspection.

People had the opportunity to discuss with staff what it meant to be at the end of life. People could express their own preferences in how they wanted their care to be provided when they were at end of life and we saw evidence from family members and health professionals that the service had respected these.

Requires Improvement

Is the service well-led?

Our findings

Staff we spoke with told us that they were struggling to cope with one person's behaviours at the service and we saw this was the case. People and relatives told us that this was having a significant impact on how people lived their lives and how they felt about living at the service. There had been a lack of action to address this by the provider and the registered manager. Although action had been taken by referrals being made to health professionals, the abuse towards staff and other people using the service had been going on for some time and there had been a lack of action in terms of protecting other people who used the service.

Staff told us they could approach the management of the service should they need to. However, staff did raise that they were struggling to manage the behaviours of one person using the service who was regularly physically aggressive with them. Staff did not feel adequately trained and supported in dealing with this and it was having an impact of staff's morale. One staff member told us, "It's a lot of pressure on us and it's not fair on the other residents." We saw staff struggling to cope with managing this person's behaviours throughout our inspection and found that staff had not been adequately trained to do this safely. This issue had not been adequately acknowledged or addressed by the registered manager or the provider at the time of our inspection.

Systems were in place to obtain feedback from people using the service and their relatives. We looked through this feedback which identified that two people felt uncomfortable at the service due to some of the behaviours of another person using the service. This had resulted in some restrictions in how people spent their time and what they were able to do at the service. There had been a lack of action to address this to improve the lives of people using the service.

Following our inspection, we reported the concerns to the commissioners of the service and action was taken to address the situation. However, prior to this we concluded that insufficient action had been taken to ensure people's well-being and safety at the service.

Action had not been taken to mitigate the risk posed to people and staff at the service and to improve the quality of the service. The above evidence is a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The provider had not made the required statutory notifications to CQC in relation to safeguarding incidents which had taken place at the service. During our inspection we identified numerous incidents which had taken place at the service by looking at daily records and incident logs. Many of these incidents posed a risk to people who used the service and involved allegations of physical abuse. We discussed this with the registered manager following our inspection who told us that they had not been aware of this requirement and that they would ensure the notifications were made to CQC in the future.

This is a breach of Regulation 18 of the 2009 Registration Regulations, Notification of Other Incidents.

There was a registered manager at the service. A registered manager is a person who has registered with the

Care Quality Commission (CQC) 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 registered manager was also the provider.

The registered manager was not at the service at the time of our inspection, however, we spoke with the deputy manager and a team leader who provided leadership within the service and who knew people who used the service well. There was a clear management structure in place at the service which was focussed on meeting people's needs and ensuring people were well cared for.

There was a staff induction taking place at the time of our inspection and we found that staff were provided with a full and detailed induction to ensure they could deliver care and support to people safely and effectively. Regular staff meetings were held and it was clear from staff meeting minutes that staff would be able to raise any issues they may have.

The provider monitored the service regularly to assess the quality of the care and support provided, for example they carried out audits of medicines, care records and staff performance. Regular checks were carried out on the premises and we saw evidence of fire tests as well as tests on the gas and electrics. We found that the monitoring of incidents was not being done effectively and that further improvement was needed in the recording, reporting and monitoring on incidents which took place at the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of numerous allegations of abuse which had taken place at the service as required by law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always receiving care and support to meet their individual needs and preferences due to restrictions placed on them. These restrictions were as a result of the behaviours of a person at the service and this had not been adequately managed at the time of our inspection. People were not always able to spend their time in ways they would have liked.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Adequate steps had not been taken to protect people from the risk of abuse following numerous incidents which had taken place at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The provider had not taken adequate steps to mitigate the risks to people using the service at the time of our inspection. Incidents had not been fully reported and acted upon to ensure people's safety and to improve quality at the service.