Striving for Independence Homes LLP

Honister Gardens Care Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 6 February 2015, at which we found three breaches of legal requirements. This was because the provider did not have appropriate arrangements in place to manage medicines; care plans were not always updated when people's needs changed; there were ineffective quality monitoring systems and irregular supervision and appraisal of staff.

Following the comprehensive inspection, the provider sent us an action plan to tell us the improvements they were going to make. We undertook a focused inspection on the 1 July 2015 to check that they had followed their plan and to confirm that they now met legal requirements. We found the provider had started to address the shortfalls, but they had not all been completed.

The provider sent us another action plan on 22 July 2015. We undertook another comprehensive inspection on the 24 July 2015 to check that the provider had fully implemented their action plan, to confirm that they met legal requirements and because of safeguarding concerns that had been reported to us.

You can read the report from our last comprehensive and focussed inspection, by selecting the 'all reports' link for 'Honister Care Home' on our website at www.cqc.org.uk'.

Summary of findings

Honister Gardens Care Home provides accommodation for up to four people with learning disabilities. At the time of our visit there were three people using the service.

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

At this inspection we found the provider still did not have effective systems in place to monitor the quality of service delivery.

People were not protected from the risk of financial abuse because the provider did not ensure there were safeguards in place to protect their financial interests.

People were at risks of contracting illness due to inadequate infection control systems.

The provider did not have effective systems in place to ensure there were sufficient numbers of experienced staff deployed in the service. Some staff raised concerns about low staffing levels.

We saw that personal and confidential information about people and their care and health needs were not always kept securely.

People had access to external health and social care professionals; however information provided from these professionals to the service was not always followed up and adhered to

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We also found that people were not always supported with activities and we have made a recommendation in this area.

There were suitable arrangements for the recording of medicines received, storage, administration and disposal of medicines.

People had access to external health and social care professionals. There was evidence that people were referred to specialist services when required.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?

Inadequate

The service was not safe.

There were not enough staff to provide care and support to people when they needed it.

We found that the provider did not take measures to safeguard people who were at risk of financial abuse.

There were risks to people of contracting infection due to inadequate infection control systems.

There were suitable arrangements for the recording, storage, administration and disposal of medicines.

Is the service effective?

Requires improvement

The service was not effective.

We saw the food available in the cupboards and freezers were from basic food ranges and may not have met the nutritional needs of people.

People were not always supported to make decisions in relation to their care and support.

People had access to external health and social care professionals. There was evidence that people were referred to specialist services when required.

Is the service caring?

Requires improvement

The service was not always caring.

People's dignity was not always respected. We observed people during lunch time eating; wearing large bibs. The service did not use serviettes, or adapted crockery and cutlery to enable people to feed independently where appropriate.

People's privacy was respected. Staff were aware of the importance of ensuring that people's privacy was protected.

Staff spoke with people using the service in a respectful and dignified manner.

Is the service responsive?

Requires improvement

The service was not responsive.

People did not have access to regular and appropriate activities to provide them with mental and emotional stimulation.

Care plans were limited and did not always adequately guide staff to enable them to respond to people's requirements.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

There was lack of managerial oversight given that the registered manager did not always have a visible presence in the home.

The systems in place to monitor the quality of the service were not effective and there was a lack of open and transparent culture.

A lack of thorough audits in the service meant concerns we identified had not been picked up and rectified.

Honister Gardens Care Home

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 24 July 2015 and was unannounced. The inspection team was made up of one adult social care inspector, a second 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, in this case people with learning disabilities.

Before the inspection we reviewed the information the Care Quality Commission already held about the home. We contacted the local authority safeguarding and commissioning functions and they shared their current knowledge about the home.

We spoke with six members of staff as well as the two directors of the service and a healthcare professional. We looked at all care files as well as other records and audit documents. We looked around the building and with permission from people, also looked at their bedrooms.

Some people had complex needs so we used the Short Observational Framework for Inspection (SOFI) to observe the way they were cared for and supported. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Before our inspection the provider notified us of a safeguarding matter that related to the safekeeping of people's money. This had been reported to the relevant authorities. As a result the local authorities were in the process of taking responsibility for people's money and arranging advocates for people. The provider still had responsibility for the safekeeping of people's money in the home on a day to day basis and we looked at these arrangements.

At this inspection, we observed although staff had completed safeguarding training and were aware of how to report any signs of abuse; we found people were at risk of financial abuse. There were no adequate systems in place for the safe handling of their money. The provider did not ensure there were safeguards in place to protect people's financial interests. People who lacked capacity to manage their own money were not assessed in accordance with the code of practice of Mental Capacity Act 2005. This law sets out the requirements of the assessment and decision making process to protect people who do not have capacity to give their consent. For example, until recently, one of the directors was an appointee for managing money belonging to three people living at the home even though no mental capacity assessments for this decision had been completed to make sure the best interests of people were fully considered.

We also saw that each entry on the individual account record was not countersigned to provide a witness to each transaction. We looked at transactions for the past month and none were countersigned by the person using the service, or where the person was unable to sign, a second signature was not sought from another staff member. In addition, the money tins belonging to people were not subject to a regular audit or checked at regular intervals by the responsible person.

The provider failed to protect people from abuse and to have systems in place to prevent the abuse of people using the service.

The above is evidence of a breach of Regulation (13) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is considering the appropriate regulatory response to resolve the serious issues we found in respect of this regulation.

People living at the home were not safe because they were not protected against the risks from an unsafe environment.

There were no sufficient arrangements to deal with emergencies to reduce risks to people. The provider showed us evidence they carried out fire drills regularly, but there were no emergency evacuation plans in place for each person. A plan of the layout of the house was on the wall by the main door to assist emergency workers if required. However, assessments about people's support needs in respect of evacuation (Personal Emergency Evacuation Procedures) were not available. Staff told us that they had received training in fire safety, and their training records confirmed this. However, they gave different descriptions of the action they would take if there was a fire. The provider could not find the fire risk assessment, which meant it would not have been made available to the fire service in an emergency.

It was recorded that the emergency light were not working. The record was not dated and there was no record of any action taken to repair the emergency light so that it worked in the event of a fire to assist evacuation. The registered manager stated that she was unaware of this defect.

We found that people were not protected from the risk of infection. The Department of Health guideline 'The Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance' states in relation to criterion 2 'all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition". Our observations showed the provider had not followed this guideline. We looked at all shared areas of the home and found appropriate standards of cleanliness and hygiene were not maintained in some areas.

We read an inspection report of the home by the Local Authority Environmental Service following the Local Authority Environmental Service inspection on 10 June 2015. This identified areas which required attention, including replacing worn chopping boards, ensuring staff wore aprons when handling food, and monitoring and recording fridge temperatures. The timescale for

Is the service safe?

addressing these shortfalls was written in the letter from the inspecting officer as 'immediately.' However, we found on 24 July 2015 that you had not taken action to address these identified shortfalls.

Risk assessments did not contain sufficient detail to guide staff in providing safe care for people. For example, we saw instructions from healthcare professionals on how to support a person with diabetes were not always followed. We read instructions contained in the care plan of this person, which stated that the blood glucose was to be checked once every week. However, we saw from blood glucose monitoring diary of this person that glucose monitoring had been stopped on 6 June 2015. The deputy manager told us he was not aware that staff had stopped monitoring this person's glucose levels. After checking with the registered manager, the deputy manager told us blood glucose was meant to be checked when the person was showing signs of weakness and dizziness. However, when we spoke with the registered manager, she verified that staff should have checked blood glucose levels at least once every week. This person was at risk of their blood sugar levels being outside safe levels without regular monitoring.

We also found the environment was in need of repair and refurbishment. There was a bare wire exposed on the hall ceiling by the handrail of the stairs and we saw were cracks in the wall of the stairs, next to the light switch. The radiator cover in the living room was broken.

There were no unpleasant odours in the home apart from at the top of the stairs. The corridor area by the registered manager's office was sticky to walk on. The downstairs carpet was dirty, and there were stains on the furniture where people sat for much of their day. There were dirty marks on the woodwork. No cleaning schedules were available to show when the carpet was last cleaned. There was a chart near the lift for a deep clean to be completed by 30 July 2015 this had not been followed. We saw that the freezer needed cleaning and defrosting. When we asked the registered manager we were told they had ordered a new fridge-freezer. We saw this was delivered on the second day of our inspection.

This meant the registered person had failed to maintain the property, keep the environment safe for people and keep it clean.

This was a breach of Regulation (12) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the recruitment and selection policies were followed when new staff were appointed. Staff were required to complete an application form, shortlisted, and had a formal interview as part of the recruitment process. Written references from previous employers had been obtained and checks were made with the Disclosure and Barring Service (DBS) before employing any new member of staff.

However, there were insufficient numbers of experienced staff deployed in the service to provide care for people. There were three people living in the home, supported by two staff on duty. One person receiving care was assessed as needing one-to-one care at all times. During the two days of inspection this person was not engaged in meaningful activity. The care staff on duty were required to administer people's medicines, do the laundry, assist people with activities, serve meals and snacks as well as provide general care and support and there was a risk staff would not be able to meet this person's need for one to one support.

On several occasions during our inspection no staff were in the lounge where most people spent much of their day. We observed throughout the day that people's needs were not met in a timely manner and that staff did not have time to support them with activities. On the first day of the inspection, two people were sitting in the lounge. One was asleep in the chair; the other was waiting to go out. We were told by staff the person had a scheduled activity to go for a bus ride but there were no sufficient staff to take the person out. We observed that the person waited an hour before a care staff who was working from the home of the provider arrived to take the person out on a bus ride.

At this inspection a member of staff told us some staff worked shifts in succession without having sufficient rest in between. Staff rotas showed that frequently staff worked long hours with minimal rest. At times they worked a shift from 9pm-9am; followed by a shift on the same day from 4pm-9pm; then sleep over from 9pm-5am, followed by an early shift from 5.30am -9am; then a night shift from 9pm-9am. The registered manager told us the reason staff

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Is the service safe?

were working these shifts in close succession was because the service was short staffed. This was due to staff from Honister Gardens providing cover for another service which was also short of staff.

We concluded that there were insufficient skilled staff to provide the care and support that people needed.

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

There were suitable arrangements for the recording of medicines received, storage, administration and disposal of medicines. This was covered in the provider's policy and procedure for the administration of medicines. People received their medicines safely, when they needed them. Medicines were given out to each person from blister packs. We saw that each pack was organised into sections; each marked with the day and time when tablets should be taken. A member of staff explained, the blister packs ensured correct doses of medicines were given at the right time. The Medicines Administration Records (MAR) had been correctly completed; there were no gaps in all MAR examined.

Medicines that were to be administered 'as required' (PRN) were included on the medicine MARs and there were appropriate guidelines for their administration. The guidelines covered relevant information such as, 'reason given by GP for the PRN medicines', 'how much PRN medicines can you take in a set period' and 'when to take PRN medicines'. In one example, we observed a member of staff giving PRN medicine in line with the instructions given about how and when to take it.

Requires improvement

Is the service effective?

Our findings

At our inspection of this home in February 2015 we saw that staff were not receiving regular supervision and appraisal. At this inspection we saw evidence from staff personnel records that supervisions had been carried out monthly. This was also confirmed by staff. Appraisals had also been completed for staff who had worked with the provider for at least a year. Staff meetings had been held monthly. The minutes of meetings indicated that staff had been updated regarding management issues and the care needs of people.

The registered manager told us people had 'a fresh cooked meal twice a day' however at this inspection we noted a lack of fresh ingredients. Although people were supported to eat regular meals, there were limited types of foods available. For example we did not see any vegetables, either frozen, tinned or fresh available in the kitchen. There were only two items of fruit available when we arrived at the inspection however when we raised this concern with the registered manager later that day staff went to purchase more fruit and vegetables.

People's choices in relation to food were not always taken in to account. The pictures on the breakfast menu did not match the breakfast choices made by people using the service for the day. For example, the type of egg planned on the menu was boiled but scrambled egg was offered to people. The deputy manager was unable to explain the reason for this.

We looked at how people who lacked the capacity to make certain decisions were being supported. The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The DoLS are part of the MCA and aim to protect people who may need to be deprived of their liberty, in their best interests, to deliver essential care and treatment, when there is no less restrictive way of doing so. Any deprivation of liberty must be authorised by the local authority for it to be lawful. Four people were under DoLS, and we saw the provider had followed the correct process to gain authorisation. Staff we spoke with said they had received the relevant MCA and DoLS training and we confirmed this from records.

Although MCA 2005 code of practice had not been applied in respect of people's finances, we saw that people's capacity to make decisions about other aspects of their care had been assessed separately. There were assessments about people's capacity to understand the implications of health related treatment; about clothes and food choices, and about their care plans.

We saw evidence from staff personnel records that supervisions had been carried out monthly. Staff confirmed that this took place and we saw evidence of this in their personnel records. They told us about the induction and training programme they had received which included first aid, food hygiene, medicines, manual handling, safeguarding adults, health and safety and infection control. Staff meetings had been held. The minutes of meetings indicated that staff had been updated regarding management issues and the care needs of people.

We looked at training records for the home to see if the provider made arrangements for staff to have the necessary skills to do their job. There was an induction programme and on-going training programme to ensure that staff had the skills and knowledge to effectively meet people's needs. We saw evidence care staff had completed training, including challenging behaviour, MCA 2005, health and safety, infection prevention and control and safeguarding. However, training was predominantly provided via on-line sources, and there was no mechanism in place to ensure staff understood and retained their learning. We found the knowledge of staff in specific areas such as DoLS and MCA 2005 variable, with some needing more prompting for correct answers.

People had access to external health and social care professionals. There was evidence that people were referred to specialist services when required. We saw evidence that people had dental appointments and saw chiropodists and GPs as needed. For example, people had attended appointments, including diabetes reviews, GP health check-up, and hospital appointments. However, we saw that their Health Action Plans (HAP) had not been completed. HAP is a personal plan about what a person with learning disabilities can do to be healthy. It lists any help people might need to keep healthy, such as what services and support people need to live a healthy life, healthy foods and when to go for check-up. There was a risk that some people's health needs might not be met.

Requires improvement

Is the service caring?

Our findings

There was a lack of consistency in the way that staff responded and interacted with people who lived at the home.

We observed how staff interacted with people. In one example, we observed staff did not always talk with people to let them know what they were going to do. For example, one person was wearing a jacket waiting to go out for a bus ride. The registered manager asked staff to clean this person's coat. The person was not asked if they wanted their coat cleaned. The staff member went and found a cloth and started to clean the coat in front of everyone without communicating with the person or asking them to move to a more private area.

People's dignity was not always respected. We observed people eating lunch wearing protective clothing designed to keep their own clothes clean, in the style of a large bib; however the service did not use serviettes, or adapted crockery and cutlery to enable people to feed independently and reduce the risk of food spillage.

People's privacy was respected. Staff were aware of the importance of ensuring that people's privacy was protected. They informed us that they would knock on doors before entering bedrooms and close the curtains if necessary, which we observed during this inspection.

We saw some examples of staff being kind and caring to people. For example, a member of the staff went to find out what a person needed when they heard them shouting. We had been informed the person did not like visitors, and we saw staff went to reassure the person and explained why we were at the home.

All bedrooms were for single occupancy. This meant that people were able to spend time in private if they wished to. All bedrooms had been personalised with people's belongings, such as photographs and ornaments, to assist people feel at home.

People or their representatives had signed their care plans. We noted that a relative of a person had attended care reviews. The registered manager stated that residents' meetings had been held, and we saw from minutes that each person met with their keyworker monthly.

There were arrangements to meet the varied and diverse needs of people. Care records of people contained details of people's religious and cultural background, their interests, and activities they liked. We noted that grab rails were available in the toilets and stair cases.

We saw documented evidence of consultation with people. One relative informed us that they had been consulted regarding the care provided.

Requires improvement

Is the service responsive?

Our findings

At our comprehensive inspection of 6 February 2014 we had concerns that people who used the service were not offered sufficient stimulating activities in-house and in the community. We also found care plans were not always updated when people's needs changed. At our focused inspection on 1July 2015 we found that the provider had taken action to address some of the shortfalls in relation to the recommendation we made.

We found that although each person had a personal support plan which set out their capabilities, needs and preferences, including hobbies and interests, their social needs were not always being met. We observed people sitting in the lounge with very little or no stimulation. There was no evidence that specific activities for people to take part in had been set up. During the inspection one person was in the main lounge. This person stayed in the chair for most part of our inspection; they slept and watched television. When we tried to engage with this person, one staff told us, "you will have to speak up. They are hard of hearing" We asked if the person wore a hearing aid, "No you have to speak up", the staff member told us. We observed that the volume of the television was low and hardly audible to us and would have been difficult for the person to hear. Staff had told us this person 'enjoyed dance movies', but we did not see this being offered to them to watch. We found there was a lack of structured activities for people to engage in and enable them to focus on their strengths and aspirations and therefore improve their wellbeing.

Each person's file started with an accessible but detailed personal portrait which set out important information about their backgrounds and lives, what people could do for themselves, how they communicated, the kinds of decisions they could make about their care and their support needs and preferences. These pen portraits gave a good sense of each person which helped staff care and interact with people living at the home. For example, one portrait described how the person preferred to change their own bed linen and described their hobbies. This person was able to tell us about their hobbies which matched the information from the file. The information was dated.

We saw that a statement of purpose and details about the home were made available to each person in their room along with a complaints policy written in relatively easy read style. The provider had also put in place a pictorial version of the complaints procedure. This was on display in the communal area of the home which helped to make it accessible to people. The complaints procedure included details of who people could complain to if they were not satisfied with the care. We asked the director if any complaints about the service had been received and the director showed us one complaint, which we saw that action had been taken to investigate the complaint and make improvements.

We recommend that the service seek advice and guidance from a reputable source, around activities for people with learning disabilities.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found people were not safe because the provider did not have effective systems in place to monitor the quality of service delivery. At this inspection we found the provider still did not have effective systems in place to monitor the quality of service delivery.

We found that audits were undertaken to review the quality of care provided. This included auditing care records, medicines management, infection control processes and health and safety systems However; we were concerned about the effectiveness of these audits because they had not identified some shortfalls that we identified at this inspection. These quality checks had failed to identify that Health Action Plans were still incomplete since our last inspection, that mental capacity assessments had not been considered in some aspects of care, gaps in the management of people's finances and the absence of personal evacuation plans for people. Therefore, whilst there were systems in place to review the quality of the service these were not sufficient to ensure high quality care was provided and that risks to people's safety and welfare were mitigated. The management team had also failed to check that the audits were robust and accurate.

Staff told us they needed more direction to enable them to work effectively. However, the registered manager did not provide a continuous active role in the home on a day to day basis. The registered manager told us she visited the home at least five times a month on average. She told us she had delegated responsibility to a deputy manager because she also provided interim management at another of the provider's homes. However, the delegated arrangement was not monitored for effectiveness to give reasonable assurances to the registered manager that the deputy manager was performing as expected. With limited monitoring there was a risk any deficiencies in the arrangement were not identified in a timely manner and rectified. The provider did not give assurances that the service would be properly managed during the absence of the registered manager.

Accidents and incidents were not analysed for possible trends in order to reduce re-occurrence. At this inspection we saw there was a process in place to record and report incidents. We asked the registered manager to check for accidents and incidents within a specified time period using the service reporting system. We found they were unable to do this and were not sure where the information was stored. We asked about the arrangements in place with regards to managing incidents and how such incidents were monitored and managed to help reduce risks. We saw that although incidents were recorded there were no formal processes for auditing to help look for trends and patterns. On the second day of this inspection the director showed us nine incidents January 2015; four of which were falls relating to one individual. However, follow-up actions were minimal or not evidenced. There was no evidence that these incidents had been thoroughly investigated and analysed to minimise re-occurrence.

We saw that personal and confidential information about people and their care and health needs was not always kept securely and in a way to protect their privacy and confidentiality. The lockable cupboard containing care plans was not always locked. We saw one care plan was left out on a desk along with a number of other folders that contained confidential information. We also saw a medical appointment letter relating to a person who used the service was pinned up on the notice board in the recess area that was accessible to everyone. In another example, a fluid chart for one person was left on the coffee table in the lounge area. We raised this concern with the registered manager.

This was in breach of regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from staff relating to the administration of the service. We spoke with staff about how the home was managed. Some staff told us they felt they could talk to management if they had any concerns, but some told us they had raised concerns with the registered manager and that changes had not been made to improve things. For example, staff told us they had complained that the staff rota was not being produced on time but changes had not been made to improve things. At this inspection we saw that the rota for the following week had not been produced.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Systems were not in place to ensure people were always protected from abuse and avoidable harm.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, killed and experienced staff were not deployed in the service.**