Care In Mind Residential Services Limited

The Hollies

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected The Hollies 14 July 2017 and it was an unannounced inspection. The home provides accommodation and specialist mental health support for up to four young people with complex mental health presentations. At the time of our inspection one person was living at the home. This was the home's first inspection.

The home had a registered manager in place. 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.

Medicines were not consistently managed to protect people from the risks associated with them and to ensure that people received them as prescribed. Other risks which could cause harm to people and others were not always adequately managed. People were not always protected from harm and abuse because safeguarding procedures were not always followed. There were enough staff to meet people's needs but the high turnover of staff meant that people were not always supported by staff who understood their risks well. The support systems and structures in place to manage the home were not always effective in ensuring that it was a safe environment for people and staff.

People were supported to make choices about their care and what they wanted to achieve. They had clear goals for recovery and independence which were regularly reviewed. Staff knew the plans and provided support in line with them. They had planned time with healthcare professionals to review their health and wellbeing as part of their support. People consented to the plans and understood why they were making certain decisions.

Staff received training and guidance to ensure they had the skills to support people well. They had positive, caring relationships with people and respected their privacy and dignity. People were supported to develop and maintain important relationships.

There was a complaints procedure in place and any received were responded to in line with it.

We found one breach 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 the 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

People were not always protected from harm because safeguarding procedures were not always followed and risk was not always adequately managed. Medicines were not always managed to ensure people received them as prescribed and that they were stored safely. There were enough staff deployed to meet people's needs and safe recruitment procedures were followed.

Is the service effective?

Good

People consented to their care and support and staff were aware of our how to assist people if they were unable to make those decisions. Staff received the training and support that they required to ensure that they had the skills to support people. Peoples were supported to maintain a healthy diet and to manage their healthcare needs.

Is the service caring?

Good

People were supported by staff who cared about them. Their privacy and dignity were respected and they were encouraged to develop and maintain important relationships.

Is the service responsive?

Good

People were supported to develop plans to reach their goals for recovery and increased independence. Staff understood the plans and followed them with people. Complaints were managed in line with the provider's procedure.

Is the service well-led?

Requires Improvement

The systems and structures in place to manage the home were not always effective because the provider could not always provide enough support to the manager and staff when incidents occurred.

The Hollies

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.

One inspector and a specialist adviser completed this unannounced inspection on 14 July 2017. The specialist advisor was a social worker with expertise in mental health including services for young people and adults in the community. On this occasion we had not asked the provider to complete 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. We gave the registered manager the opportunity to share this information with us during the inspection.

We used a range of different methods to help us understand people's experiences. We spoke with one person who lived at the home. We also spoke with the registered manager, the deputy manager, the managing director and one care staff. We spoke with a clinical health specialist who supported people who lived at the home by telephone during the inspection. We also spoke with a further three care staff and one team leader by telephone after the inspection. We had email contact from one additional member of care staff who chose to give us their feedback in this way. We spoke with one further community professional by telephone after the inspection to gain further feedback.

We reviewed care plans for one person to check that they were accurate and up to date. We looked at staffing records to ensure that they were receiving the support they needed to do their jobs well; for example, training and recruitment records. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Requires Improvement

Is the service safe?

Our findings

People's safety was not always fully considered because safeguarding procedures were not always followed. When we spoke with staff and reviewed records we saw that there had been incidents, which included alleged abuse. They had not been reported as safeguarding concerns to the local authority. The manager told us, and records confirmed that they had investigated the incidents internally. However, the nature of some of the concerns required that they should be reported and reviewed by an independent body. After the inspection we asked the manager to share the information with the relevant parties as required; which was completed.

The risks associated with medicines were not always managed to ensure that people were protected from harm. There had previously been incidents when people who lived at the home had been able to access locked medicine cabinets. They were able to obtain additional medicines which meant that they could behave in a way which caused harm to themselves. The provider had not made any changes to the administration procedure or the storage of medicines after this. There were further incidents when other people were able to repeat the same behaviour and cause themselves harm.

When we reviewed the administration of medicines we saw that it was not always clear when people had last taken their prescribed medicines because the recording was not always maintained. When people had not taken their medicines for several days this had not been shared with other staff who could provide guidance. We saw that guidance for medicines said, 'Do not stop taking your medicine suddenly'. This was particularly relevant because the decision to not take medicines may have influenced the risk of other activities. When we checked the stock of medicines we found that it was not correctly recorded and we could therefore not be certain how much medicine people had taken. We also saw that excess medicines were stored which increased the risk to people because of their assessed likelihood to access additional medicines to harm themselves.

This evidence represents a breach in Regulation 12 (1) of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

The provider encouraged ownership of risk by the people who lived at the home so that they could learn to manage it themselves and become more independent. We saw that this had a positive impact on some aspects of people's health and wellbeing. However, there were other behaviours which could put other people and staff at risk which were not always managed.

There were enough staff to effectively meet people's needs when we did the inspection because the number of people living there had reduced recently. However, staff we spoke with told us that there had previously been a shortage of staff and the manager confirmed that they had recently recruited new staff. The provider's therapeutic care model relied on staff knowing people well and developing relationships with them. Staff we spoke with recognised that the number of staff leaving did impact on their ability to manage risk with people. One professional we spoke with confirmed that there were staff who did not seem to

understand people's risks as well as the more established staff members.

Safe recruitment procedures were followed to ensure that new staff were safe to work with people. One member of staff told us, "I saw the job advertised and completed an application form. After a successful interview I had DBS checks before I started". The Disclosure and Barring Service (DBS) is the national agency that keeps records of criminal convictions. Records that we looked at confirmed this.

Good

Is the service effective?

Our findings

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 or 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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We looked to see how the provider was meeting the MCA.

Staff we spoke with understood the importance of consent and told us how people were encouraged to make their own decisions. Guidance was available to people to support people to make decisions when they required it. We saw that plans and agreements were signed by people to show that they had consented to them. Staff knew what circumstances could mean that people had reduced capacity to decide. However, this was not the case for anyone living at the home and there were no DoLS required.

People were supported by staff who had the skills and experience to do so effectively. One member of staff told us, "The training is quite intensive at the beginning and we are not allowed to work with people until it is completed". Staff told us that the induction programme included training in the therapeutic model as well as other subjects, such as safeguarding, over several days. Records that we reviewed confirmed this. Staff also said that specific training was provided. For example, one member of staff described a session that the team had about a certain diagnosis from a healthcare professional in preparation for supporting someone new. Staff were also enrolled on nationally recognised care qualifications.

The manager told us that staff received clinical support on a regular basis to ensure that they were supported. One member of staff we spoke with said, "The reflective practise that we have with the clinical team is really good. It gives us a safe space as a team to trash things out. We discuss techniques and approaches to ensure that we learn from the best interactions and provide consistent support". Other staff also shared how valuable they found these sessions which took place every one to two months.

Staff also told us that they received regular supervisions and appraisals to support them. One member of staff said, "The managers are very approachable and I feel confident to discuss any issues with them in supervision. They are very person centred; for the people who live here and for the staff".

People were supported to choose their food and drink and were assisted to consider a balanced diet. Meals were planned with people and included specialist diets if required. The kitchen had two cooking facilities so that one could be used to assist people to learn cooking skills to develop their independence if needed.

There were arrangements in place for people to have some of their healthcare needs met through an internal clinical support team. They had regular weekly appointments with one health professional and monthly ones with another to monitor and manage their health. There were local arrangements with other

health professionals to ensure that all of people's health needs were considered. For example, staff told us that people were registered with the local dentist.

Good

Is the service caring?

Our findings

There were caring relationships between people and the staff that supported them. Staff knew people well and talked about them in positive ways. They were proud of their achievements and progress and gave people constant support. People made their own choices about the support they received and planned their time. For example, we saw that people chose to do some things independently and at other times asked for staff support. They had goals in place which included becoming more independent so that they could move on to living on their own in the future. Staff were knowledgeable about this and encouraged people do make their own decisions and manage their own lives as much as possible.

We saw that people's dignity was promoted and they were treated with respect. Each person had their own room and we saw that they could choose to spend time there privately. People were supported to manage and develop important relationships in their lives. For example, arrangements were made with people to see family and to keep in touch by telephone.

Good

Is the service responsive?

Our findings

People were supported to design their care and support and to review it regularly. We saw that there were plans in place which had been developed with people to reach their goals. People were included in mapping their progress towards their goals and we saw that they were future focussed and personalised.

Staff knew people well and understood what their plans were and how to support them. There was a division between therapeutic support and the support which was given by the staff in the home. The residential staff were guided by the plans that had been developed by people with their healthcare workers. One member of staff we spoke with said, "There is definitely enough information in the plans so that we know what to do". They told us that if the plans weren't working or if people were not happy with them they would seek advice from the clinical team.

People were encouraged to participate in activities and to pursue their interests. For example, one person had joined a gym. Staff we spoke with recognised that it was sometimes difficult to motivate people to do daytime activities as they chose to stay up for a lot of the night. One member of staff told us that when they had an occasion, such as a night out to look forward to, that helped to motivate people to plan shopping trips etc. in town around it.

There was a complaints procedure in place and we saw that people were informed of this when they moved into the home. When complaints were received we saw they were investigated and responded to in line with the procedure.

Requires Improvement

Is the service well-led?

Our findings

The systems in place to manage the service were not always effective. The home was located some distance from other services managed by the provider and from the central hub where clinical support was based. The therapeutic model was that clinical advice and therapy was managed from this central team. This meant that the people, staff and managers often had to rely on telephone support. Staff told us that they were given guidance by telephone when they were managing incidents; which included aggression from people who lived at the home. However, we found that this was not always adequate. For example, when staff reported one situation they were told to retreat to a safe place. When we asked staff where the safe place was they gave different responses which demonstrated that a safe place had not been designated. We also saw records from incidents where people expressed frustration that clinical support was not available to them in crisis situations. This meant that the qualified, clinical support was not always available to people when they needed it.

The therapeutic model relied on partnership between the clinical team, residential care teams and responsible local agencies. The manager told us that the relationship with local agencies was not as effective as it was in other locations and that this impacted on how situations were resolved locally. When we spoke with a local agency representative they described the support that they gave and felt that risk to people was not sufficiently considered.

There were further incidents where the safety of staff had not been sufficiently considered. For example, we saw that there were risk assessments which stated that staff should always have the work mobile phone with them, particularly in certain areas of the home. When we spoke with staff about incidents they described how they had responded and it was clear that they did not always have the phone with them. This had not been reviewed or followed up afterwards with staff. Furthermore, staff told us that there were incidents of aggression, both physical and verbal, towards them. For example, staff described racially abusive language. When we spoke with the manager they had not addressed this because they said that the incidents had not been witnessed.

There were systems in place to review and measure the quality of the service. Incidents were analysed and evaluated on a local and national level. However, the provider had not always considered whether the service was as effective as others and what actions should be taken to review the situation. For example, we saw that in the provider's annual report the service had been measured as having a high number of incidents of 'violence and aggression', 'inappropriate behaviour' and 'concerning behaviour'. We did not see any evidence of actions taken to support the service with this. Another indication of the effectiveness of the service was the high staff turnover. We saw in team meeting records that staff morale was low and the manager confirmed. They attributed some of this to dealing with this behaviour instead of being able to embed the therapeutic model.

There was a registered manager in place. They notified us of some important events that occurred in the service which meant we could check appropriate action had been taken. However, because other incidents had not been considered as needing reporting, for example as safeguarding, we were also not always

notified of these in line with our regulations.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk was not managed to ensure that people received safe care and treatment.