Zero Three Care Homes LLP

Rascasse

Inspection report

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20 March 2017

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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 20 March 2017 and was unannounced. The service provides accommodation and care for up to seven male adults with learning disabilities. There were seven people living at the service on the day of our inspection.

The previous inspection of the service was undertaken on 8 February 2016 and the service was rated good overall with requires improvement in Safe. Since that inspection we received information about an incident which indicated potential concerns about the management of risk to people living in the service. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to Safe. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rascasse on our website at www.cqc.org.uk.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who lived in the service looked at ease with staff. They were not able to talk to us about the support they received so we observed how they were supported. We also spoke with some of their relatives about the care and they were positive about the support provided and the kindness of staff.

Staff sought to understand the causes of distressed behaviours in individuals but the risk management plans were not sufficiently clear and practice was inconsistent. We were not assured that risks were anticipated and that the management of the service were taking all necessary steps to minimise risks and protect people.

Investigations into incidents were not sufficiently robust and the provider's responsibilities to be open and objective were not fully understood.

Risks relating to the environment were identified and steps taken to reduce the likelihood of harm. However, we found that these were not always implemented consistently for example, the fire safety plans were compromised by the fact that fire doors were propped open.

Staffing levels were satisfactory and enabled people to have good access the community. Recruitment processes ensured that staff suitability to work with vulnerable people was checked however the systems in place for obtaining references should be strengthened to protect people.

The administration of people's medicines was not consistently safe. There were arrangements in place for the use of as and when required medicines (PRN) but these needed to be strengthened as we found anomalies between what was recorded and prescribed, which meant that people were at risk of being given

the incorrect amount of medicine.

Staff were clear about what was abuse and expressed confidence in the registered manager to report and seek advice appropriately.

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

The service was not consistently safe

The risks associated with the management of distressed behaviours were not consistently well managed which meant that people were at risk. Incidents would benefit from a more in-depth and robust analysis.

The management of environmental risks, such as fire safety, need strengthening.

Medicines were not consistently well managed.

Staffing levels met the needs of people using the service.

Staff knew how to respond to concerns.

Rascasse

Detailed findings

Background to this inspection

This responsive inspection was prompted in part by notification of an incident which indicated potential concerns about the management of risk at the service. This inspection examined the actions that the provider had taken to manage those risks.

The inspection took place on 20 March and was unannounced. The inspection team consisted of two inspectors.

Before we carried out our inspection we reviewed the information we held on the service. This included statutory notifications and safeguarding information that had been sent to us. A notification is information about important events which the provider is required to send us. We also spoke with the local safeguarding authority about their contacts with the service.

The individuals who lived in the service were not able to tell us about the support they received but we observed the interaction between staff and individuals. We spoke with two relatives about their observations of the support their relative received.

We spoke with three care staff, the manager and area manager. We reviewed two care plans, medication records and a staff recruitment file. We also reviewed quality monitoring records and records relating to the maintenance of the service and equipment.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found that risks were not consistently well managed. At this inspection we found continued issues, in that the provider had not taken all possible and necessary steps to mitigate risk and keep people safe from harm as could responsibly be expected. We saw that an incident had occurred when an individual had suddenly ran away from staff when accessing the community with staff. Similar incidents had occurred with this individual and because of our position as a regulator we know similar incidents have happened at other locations registered with this provider. With this incident we could not see that there had been an in-depth analysis of this or previous incidents to identify learning and resolve the anomalies in the accounts provided by staff and members of the community. We were not assured that the provider fully understood their responsibilities under the duty of candour. The duty of candour is a duty on providers to be open and transparent when safety incidents have occurred. We found that the investigation into the incident had not been as objective as it could have been and focused on perceived failings by other organisations or individuals rather than identification of learning across the service.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that when the incident occurred, staff were unable to quickly seek assistance and there were no clear strategies for the management of an incident in a community setting. This had not been objectively reviewed and practically addressed when we inspected and staff had not been provided with a mobile telephone with which they could use to seek assistance. They did not have emergency telephone numbers, identification cards or other systems in place to reassure the public and give out in the event of an untoward incident.

The risk assessment which had been in place had not been promptly reviewed after the incident although during our visit, the manager subsequently placed a revised copy on the individuals records. The service had access to clinical input via the provider's clinical psychologist but we were advised that there had recently been some staff changes and this had impacted on their availability.

We found that the rationale for decision making was not always clear and practice was inconsistent; for example, we saw that there had been incidents where an individual had absconded from the car however they continued to travel in the car with one member of staff on some but not all occasions. Other individuals had been identified as requiring two staff to access the community but we observed individuals going out with one member of staff. Staff told us that they, "felt confident", as they were only going into the local community and "Judged [individuals] mood, although accepted that "Sometimes things go wrong." We were not assured that the service was taking all the necessary steps to anticipate and minimise risks to keep the person safe and the staff that support them or potentially the public should an incident occur.

Environmental risks were not well managed. For example at the last inspection we found that there were a number of door wedges in use throughout the building which could compromise the fire safety systems in the event of a fire. It had been agreed that this would be addressed but we found that these continued to be

in use. We saw that knives and chemicals were available in the kitchen and not locked away, although we noted that individuals generally accessed the kitchen with staff support. We found a bag containing soiled continence aids at the front door and there was no wash hand basin in the laundry for staff to wash their hands after handling soiled items. Staff told us that they undertook household cleaning duties alongside providing care. However we noted debris on the carpet and a strong smell or urine in one bedroom. The cleaning log had last been completed the previous week. Each of these points were compromising the health and safety of people who were living and working in this environment.

These shortfalls in the management of risk and safety constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care and support from staff who knew them well. Relatives spoke positively about the staff team and said that the service benefited from a stable staff team and approachable manager. One family member told us that since being at the service, their relative "Is a different boy". Others had written, staff, "Really go the extra mile," and "The keyworker understands my [relative] and knows how to minimise his challenging behaviour."

Staff told us there were enough staff to keep people safe and the majority of the staff had worked at the service for some time. Staff spoke highly of the manager and told us that they were visible and "listens". They told us that they were supported to access regular training. We observed staff taking regular breaks and supporting each other as they worked alongside the people living in the service. On the day of our visit staff had taken a number of people who lived at the service to Lego land and we saw from a review of the records that people had good access to the community and the staffing levels enabled people to lead full lives.

Recruitment records showed that staff had followed an application process, been interviewed and had their suitability to work with this client group checked with the Disclosure and Barring Service. We saw that references had been obtained but they were not satisfactory as they did not evidence that they had been sent to an individual in a management capacity that had oversight of the individual's previous performance in the workplace. The manager agreed to take action and told us that they would discuss our concerns with the providers Human Resources team.

People's medicines were not consistently safe. There were arrangements in place for the use of as and when required medicines (PRN). However we found an anomaly between what was prescribed and what was recorded on the medication administration chart. We agreed that this would be checked with the individuals GP and the arrangement in place for PRN medication tightened. Medication administration charts were in place and were complete. Staff had received training and their competency in administering medication was checked to make sure they were safe to administer. Regular monthly audits were undertaken which checked people's medicines against the records. Medication was securely stored and temperatures of the fridge and storage were recorded to ensure that that they were within recommended levels. Records were available to evidence that the supplying pharmacy had undertaken a visit and checked medication systems.

Staff had a good understanding of safeguarding issues, and the steps that they should take if a concern was identified. Staff told us that they had undertaken training in safeguarding and expressed confidence in the management of the service to take any concerns seriously. Notifications had been made to CQC, but a recent incident had not been identified as requiring a notification and it was agreed that this would be undertaken without delay. We saw that the provider had a policy on the use of personal mobile telephones at work and observed staff using their phones as they went about their duties. However we were not assured

that the potential risks of abuse associated with camera phones had been fully explored in the workplace and it was agreed that this would be reviewed.

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 People who use services and others were not protected against avoidable harm and other risks associated with the environment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour Investigations into incidents should be open, demonstrate learning and the provider's responsibilities under duty of candour.