Five Rivers Child Care Limited

Wylye House

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

We last inspected Wylye House in January 2014. At that inspection we found the provider to be in breach of Regulation 12. This meant people were not protected from the risk of infection because appropriate guidance had not been followed. The provider wrote to us with an action plan of improvements that would be made. During this inspection we found the provider had taken steps to make the

Wylye House is a care home which provides accommodation and personal care for up to four people with a learning disability who may also have additional complex needs. There were three people living at the home at the time of our inspection. The home is a terraced house situated in a residential area of the city and comprises of accommodation over three floors.

The manager was not registered with the Care Quality Commission. 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.

Summary of findings

People who use the service were unable to tell us directly about their experience of the service, we observed people appeared calm and relaxed during our visit. Relatives told us "I think (my relative) is definitely safe, staff keep in regular contact with me". Systems were in place to protect people from harm and abuse and staff knew how to follow them. Records we reviewed showed staff reported incidents to the manager, we found that we were not notified of these. Services are required as part of their registration to tell us about important events relating to the care they provide using a notification.This meant the appropriate authorities were not always notified of significant events.

People were protected from risks associated with their care because staff followed the appropriate guidance and procedures. People's medicines were administered safely. The service had appropriate systems in place to ensure medicines were stored correctly and securely.

Staff knew the people they were supporting, relatives told us "staff have got to know (my relative) well and they look after him very well". Staff spent time sitting with people and engaging in activities.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are an amendment to the Mental Capacity Act 2005 which allow the use of restraint or restrictions but only if they are in the person's best interest.We observed there was a disempowering approach to supporting people and staff were placing restrictions on people without following the principles of the Mental Capacity Act. There were no Deprivation of Liberty Safeguards (DoLS) applications made for two people living at the home where they were subject to continuous supervision and lacked the option to leave the home without staff supervision.

Staff received appropriate training to understand their role. Staff had completed training to ensure the care and support provided to people was safe. Staff received a comprehensive induction, supervision (one to one meetings with line managers) and training to support them to carry out their roles correctly.

We saw that people's needs were identified and recorded in clear, individual plans. These were developed with input from the person and people who knew them well. Relatives were confident that they could raise concerns or complaints and they would be listened to. A complaint was made by a person who uses the service, this was acknowledged and investigated by the provider.

The provider and manager had systems in place to monitor the quality of the service provided. The service had not kept up to date with current best practice and whilst the visions and values of the organisation were available within the home, the staff we spoke with were unable to tell us about them. The manager informed us at the time of our inspection there were plans in place to close the home in February 2015.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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?

This service was not always safe. Safeguarding incidents were not recognised and reported to the Care Quality Commissions. This meant the appropriate authorities were not always notified of significant events.

Systems were in place to ensure people were protected from abuse. People were supported to take risks and there were plans in place to manage the risks they faced.

The provider had systems in place to ensure that medicines were administered and disposed of safely. All medicines were stored securely.

Requires Improvement

Is the service effective?

This service was not always effective. Staff placed restrictions on people without considering the principles of the Mental Capacity Act. There was no clear evidence the restrictions were in the persons best interest.

People's health care needs were assessed and staff supported people to stay healthy. People were supported to eat and drink enough to meet their needs.

Staff recognised when people's needs were changing and worked with other health and social care professionals to make changes to their care package.

Requires Improvement

Is the service caring?

This service was not always caring. The approach to supporting people was disempowering and not in line with current best practice. This meant that people's rights were not always considered and respected.

Staff knew the people they were supporting well and had developed relationships.

People's relatives spoke positively about staff and the care they received. We observed that staff were caring in their contact with people.

Requires Improvement

Is the service responsive?

This service was responsive. People and their relatives were supported to make their views known about their care and support. People were involved in planning and reviewing their care.

There was a system in place to manage complaints. Relatives told us they knew how to raise any concerns or complaints and were confident that they would be taken seriously.

Good

Summary of findings

Is the service well-led?

The service was not always well led. A registered manager was not in post and at the time of our inspection there were no plans to appoint one. Staff felt well supported by the manager and there were systems in place for them to discuss their practice and report concerns.

Whilst the visions and values of the organisation were available within the home the staff we spoke with were unable to tell us the visions and values of the service.

There was a system in place to regularly assess the quality of the service provided, this included actions where there were identified shortfalls.

Requires Improvement

Wylye House

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.

This inspection took place on 12 December 2014 and was unannounced. We returned on 16 December 2014 to complete the inspection.

The inspection was completed by two inspectors. Before the inspection we reviewed previous inspection reports and information we held about the home including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We also made note of notifications. Notifications are information about specific important events the service is legally required to send to us.

During our inspection we spoke with two staff members, three community professionals, the deputy manager and the manager. We spent time observing the way staff interacted with people who use the service and looked at the records relating to care and decision making for three people. We also looked at records about the management of the service. We spoke with one relative and two community professionals by telephone after the visit.

Requires Improvement

Is the service safe?

Our findings

Providers of health and social care services have to inform us of important events which take place in their service. The records we hold about this service showed us the provider had not notified us of any safeguarding incidents. We observed there had been two seperate incidents involving an altercation between people who use the service resulting in a physical assult where we should have been notified of these events. The manager was not aware of the legal requirement to inform us of these events. This meant we were not able to check that the appropriate action had been taken.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2010).

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. They had access to information and guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. Staff told us they had received safeguarding training and we confirmed this from training records. Staff were aware of different types of abuse people may experience and the action they needed to take if they suspected abuse was happening. One support worker talked about how they would recognise potential signs of abuse through changes in people's behaviour and this would be reported to the manager. They said they and were confident the manager or provider would act on their concerns.

Staff were also aware of the whistle blowing policy and the option to take concerns to agencies outside Wylye House if they felt they were not being dealt with. Staff told us "I wouldn't have a problem reporting concerns" and "I am confident it would be followed up".

One person's relative told us "I think (my relative) is definitely safe, staff keep in regular contact with me".They told us if they had any concerns they were confident they would be followed up by the manager.

Medicines held by the home were securely stored and people were supported to take the medicines they had been prescribed. We saw that a medicines administration record had been completed, which gave details of the medicines people had been supported to take. There had not been any medicine errors but staff were able to explain what they would do should an error occur. A GP would be contacted for advice in the event of a medicine error or if people were refusing

to take their medicine. Training records confirmed staff had received training in the safe management of medicines. A review of people's medicines had taken place annually with the phychiactric doctor to ensure that people continued to receive the correct medical treatment.

Risks to people's safety had been assessed and recorded in care plans. These had been personalised to each individual and covered areas such as providing personal care, people using the stairs, going out alone and fire evacuation. Each assessment had guidance for staff to follow to ensure people remained safe. These were reviewed monthly to ensure the information was still valid and nothing had changed. Staff demonstrated an understanding of these assessments and what they needed to do to keep people safe.

Following concerns raised in our last inspection in January 2014 regarding people not being protected from the risk of infection we found systems were now in place and being followed to minimise the risk. We saw staff had access to appropriate personal protective equipment and were aware of their responsibility to follow guidance. We observed all areas of the home were clean and staff completed regular checks.

People were unable to tell us if they felt there were enough staff available to meet their needs. We observed there were enough staff available to safely meet people's needs and the staffing rota's reflected this. The manager informed us they were trying to increase the staffing levels where a person's needs were changing and they require more support.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are an amendment to the Mental Capacity Act 2005 (MCA) which allow the use of restraint or restrictions but only if they are in the person's best interest. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Staff did not demonstrate a good understanding of the principles of the MCA and how the DoLS worked. During this inspection we found staff were not aware of the procedures to be followed when restrictions are in place. We found people had restrictions placed on them without the involvement of relevant professionals and no evidence of it being in the person's best interest.

We observed a person was restricted from having free access to food and their care plan stated they were not allowed to eat sugar. We asked staff why and were told because it made the person excitable, staff told us "the persons family member will give him sugar and he can be 'high' and won't go to bed until 10.30pm". Staff told us the person would choose to eat sweet food from the fridge if they had access. We requested evidence this decision was supported by health professional advice. Staff were unable to provide this or any evidence this decision had been made in the persons best interest and it was the least restrictive option. We found staff were not following processes to ensure the capacity of people to make decisions had been fully and appropriately considered. This meant people were unable to exercise control over their lives and their rights to make decisions were not respected.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activites) Regulations 2010.

Staff told us they had regular one to one meetings with their manager to receive support, constructive feedback and guidance about their work. Staff said they felt this was an open and two way process. We saw the supervision sessions were recorded and held regularly throughout the year. Records we reviewed for staff supervision meetings identified some areas of improvement in their working practices. Where we observed poor practice during our visit we discussed our concerns with the manager. We found the manager was aware of the concerns about the performance of some staff but these specific concerns were not addressed effectively. This meant staff were not corrected about their negative interaction and people were not treated with respect.

Where improvement objectives had been set actions had been identified as to what would be put in place to address these areas of improvement, such as training or mentoring. We saw that care staff who were new in post had completed a comprehensive induction and a probation period.

Staff told us they received training to give them the skills to meet people's needs including the needs of people with dementia and end of life care. The training records we looked at confirmed this. A relative told us staff were aware of people's needs and were able to meet them.

Staff had regular contact with health professionals to ensure people were able to access specialist advice and treatment as required. The home contacted relevant health professionals, GPs and the psychologist where they had concerns over people's health needs. Records showed people had regular access to healthcare professionals and attended regular appointments with them. A health professional told us staff made referrals where appropriate. Where guidelines had been put in place by a health professional staff were aware of and followed these.

Relatives told us people seemed to enjoy the food. Comments included, "He (their relative) never complains about the food". Staff told us people were involved in planning their menus weekly and they were supported to use pictures to choose meals. We saw that residents meetings included the planning of meals. We observed people being offered food choices at lunchtime and staff told us if people did not want what was on the menu alternatives would be offered. Care plans included people's food likes and dislikes and staff demonstrated knowledge of this.

Requires Improvement

Is the service caring?

Our findings

We observed and saw in records the approach to supporting people was disempowering. We saw records stated a person could only enter the kitchen if a staff member invited them, staff told us the person was not allowed to enter without a staff member due to risk. We asked staff about the level of risk to people and if they considered this to be the least restrictive option. Staff were unable to produce evidence other less restrictive options had been considered such as restricting the items identified as posing a potential risk. There had been no assessement of the person's capacity to support the restriction being in their best interest. This meant people were not empowered to have access to their home and had to obtain permission from staff to enter the kitchen.

We observed staff telling a person to "you know where it goes, now go get out of the kitchen" whilst they were drying dishes. We did not observe a valid reason for them to be asked to leave and they did not appear to be at risk. The person did not leave the area and remained engaged in the task. Later we observed a person asking staff if they were ready to go out, staff responded by saying "no I'm not, I will tell you when I'm ready". A senior staff member was present at these times and did not intervene and correct the staff member. We raised this with the manager who was aware of concerns relating to the member of staff and told us they were being managed. It was unclear in records if this specific concern had been raised directly with the staff member.

During lunchtime we observed staff talking to each other about plans for the afternoon without involving people. This meant people were not included in social conversation at this time and the interactions were limited. We discussed this with the manager who told us this was due to the complex communication needs of the people. We found the reason given by the manager was not appropriate as this demonstrated people were not supported to have opportunities to be involved in decision realting to their care.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2010).

Professionals involved with the service told us the homes approach to supporting adults was out of date. A professional said the approach was "not enabling" and focused on "behaviour modification". They told us that the staff were very caring but that their understanding of current philosophy and practice was outdated. The manager told us they followed procedures to support people that had historically been in place.

Although we were concerned about some communication from staff, we saw staff engage in some positive communication and it was apparent staff cared about people they supported. We spoke with three staff about people's preferences and needs. The staff were knowledgeable about the people they supported, they were able to tell us what people liked and disliked. We observed people had developed relationships with staff. A relative told us they thought their family member was well cared for, they were able to visit at any time and staff had regular contact with them.

Records included information about what is important in people's lives for example, family life, likes and dislikes and important relationships. People's preferences regarding their daily care and support were recorded. Records we looked at identified a person didn't want others entering their bedroom at night and they were being supported by staff to lock their bedroom door. We saw evidence of people being involved in writing and reviewing their care plans. Staff told us they respected people's wishes, an example being when a person did not want to attend the day centre they offered alternative activities.

People's bedrooms were personalised and contained pictures, ornaments and the things each person wanted in their bed room. People could spend time in their room if they did not want to join other people in the communal areas.

Good

Is the service responsive?

Our findings

There was a procedure in place detailing the provider's response to complaints, this included an easy read version for people who use the service. We saw in a person's daily notes they expressed they were not happy, this was raised as a complaint and investigated by the organisation in line with their policy. A relative told us they felt confident any concerns or complaints they raised would be responded to and action would be taken to address their problem. They told us they would raise concerns with staff and they had confidence it would be looked into. Comments included "I haven't had to raise any concerns, but I would speak to the manager and I am confident it would be followed up".

Each person had a care plan which was personal to them. Care plans included information on maintaining people's health, their daily routines and personal care. The care plans set out what their care needs were and people and their relatives were involved in writing them. The plans contained detailed and specific information, including information from health and social care professionals where necessary. People were involved in monthly reviews of their care plans, details of these reviews and any actions were recorded. Where a change in need was identified appropriate referrals were made to health professionals for their input and guidance. The service had information about local advocacy services and had made sure advocacy was available to people.

People had a person centred plan (PCP) that they were involved in creating, plans included details of where people wanted to live in the future and things they wanted to learn. We saw in a person's PCP they wanted to move into the community. Staff told us this person was moving into the community in the new year.

People had detailed plans about the support needed to manage their own behaviour (when they became distressed and challenging towards staff). We saw one plan that was developed with the person who had informed staff of how he would like them to respond when he became anxious. The plans had been regularly reviewed to ensure the information was current and changes had been made where necessary. This gave staff access to information which enabled them to provide care in line with people's individual wishes and preferences.

We saw people had regular access to local community facilities and activities. The daily notes in care plans recorded what activities people enjoyed these included trampolining, riding for the disabled and golf. We observed a person being supported to go bowling, they responded positively when talking about this activity with staff. In one care plan we saw that a person liked going out for walks every day. During our inspection we observed this person being supported to go out walking with staff. Staff told us a person enjoyed visual sensory stimulation, this person had visual sensory equipment in their bedroom and staff told us they were planning on taking them out to see local Christmas lights.

Requires Improvement

Is the service well-led?

Our findings

A manager was appointed for the day to day running of Wylye House, however the manager was not registered with the Care Quality Commission. There had not been a registered manager in post since September 2014. The manager told us they were not going to apply for the position of registered manager and our records demonstated there were no plans to appoint one at the time of our inspection. The manager told us they received their support from a senior manager and a member of the learning and development team. Staff told us they thought the manager was doing a great job and they felt confident approaching them with any concerns.

The manager told us they had regular support and supervision meetings with senior managers they could request these when they were needed. The manager had not been in post very long and said they did not feel they had a formal introduction into the management role. The manager told us they were responsible for managing the home as well as working on shift.

At the time of our inspection we were told the home was closing in February 2015, following our inspection we were informed the decision to close the home had been withdrawn. We were told at the time of inspection by staff and the manager they did not feel part of the organisation. This was due to the plans to close Wylye House. Staff told us it was a tough time, they felt “left behind”. When asked staff were not able to tell us about the vision and values of the service there was no clear evidence the service kept up to date with current best practice. Staff told us they had good support from team colleagues and team meetings were used to raise and discuss ideas. We saw there were regular staff meetings, which were used to keep staff up to date with the imminent changes affecting the home. We saw evidence of senior management attending staff meeting and discussing the plans for the future of the service. A senior manager told us they had identified the need to reframe the service and bring it up to contemporary expectations. They told us a significant amount of work had been done with the team to design how the service could look to reflect this.

The manager told us that questionnaires were sent out six monthly to relatives to obtain feedback, relatives confirmed they had received these. Staff told us they regularly contacted relatives and receive feedback from them.

The provider had a system in place to monitor the quality of the service. These included unannounced audits completed periodically throughout the year by a quality assurance manager to assess the quality of care provided. Reports of the visits were in place. We saw the senior manager assessed incidents, accidents, complaints, training, staff supervision, the environment, the staffing and the care provided to people. In addition, the management team completed observations of practice for care staff. The audits identified actions required for improvements and the outcomes of these actions.

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 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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People who use services were not protected against the risks associated with being safeguarded from abuse because the provider did not respond appropriately and notify us of significant events. Regulation 11 (1) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment There were no processes in place to support people to make best interest decisions in accordance with the Mental Capacity Act 2005. Regulation 18 (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People who use services were not given appropriate information and support in relation to their care. Regulation 17 (1) (b).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.