The Brandon Trust

The Cottage Care Home

Inspection report

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Ratings

Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 20 and 22 January 2015 at which three breaches of legal requirements were found. Accurate records relating to medicines, risk assessments and evacuation plans were not available in some instances. People had decisions made on their behalf that were not fully documented to make sure their changing needs and circumstances were addressed. We had not received some relevant notifications from the service. Services tell us about important events relating to the service they provide using a notification.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this focused inspection on 21 and 23 July 2015 to check they had followed their plan and to confirm they now met legal requirements. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for 'The Cottage Care Home' on our website at www.cqc.org.uk.

The Cottage Care Home provides accommodation and personal care for four adults with a learning disability or an autistic spectrum condition. Both younger and older adults use the service. The four people living at the home had a range of support needs including help with communication, personal care, moving about and support if they became confused or anxious. Staff support was provided at the home at all times and people required the support of one or more staff when away from the home.

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

Summary of findings

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 our focused inspection on 21 and 23 July 2015 we found the provider had followed the action plan which they had told us would be completed by 31 May 2015 and legal requirements had been met. The safety of the service had been improved as risk assessments, evacuation plans and medicines records now reflected the help people needed. People's ability to make decisions was being routinely assessed and decisions made in their best interests as a result were being recorded. Staff understood the limitations of their decision making for others. Notifications of significant events were being shared with us in line with the requirements of the law.

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?

We found that action had been taken to improve the safety of the service. Information about the help people needed with their medicines and how medicines should be administered was accurately recorded. Risk assessments had been completed for relevant issues and showed a balance between keeping the person safe and helping them to take appropriate risks. Evacuation plans had been reviewed but some older copies still needed destroying.

This meant the provider was now meeting legal requirements. While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for safe at the next comprehensive inspection.

Requires improvement

Is the service effective?

We found that action had been taken to improve the effectiveness of the service. Accurate records were kept when people's mental capacity was assessed and decisions were made in their best interests. Staff understood the limitations of their decision making for others.

This meant the provider was now meeting legal requirements. While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for safe at the next comprehensive inspection.

Requires improvement

Is the service well-led?

We found that action had been taken to improve the management of the service. Notifications of significant events were being shared with us in line with the requirements of the law.

This meant the provider was now meeting legal requirements. While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for safe at the next comprehensive inspection.

Requires improvement

The Cottage Care Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of The Cottage Care Home on 21 and 23 July 2015. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 20 and 22 January 2015 had been made. We inspected the service against three of the five questions we ask about services: is the service safe, effective and well-led. This is because the service was not meeting some legal requirements in relation to these questions.

Before our inspection we reviewed the information we held about the home. This included the provider's action plan, which set out the action they would take to meet legal requirements, and notifications submitted by the provider. Providers tell us about important events relating to the service they provide using a notification.

The inspection was completed by one inspector. During the visit we spent time observing the care provided and interactions between staff and people living at the home. We spoke with the registered manager and three staff. We reviewed information recorded in four people's support plans, incident records, quality monitoring documents and records for three members of staff.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of The Cottage Care Home on 20 and 22 January 2015 we found some records held about some people did not fully and accurately reflect their needs. This included records about their medicines, how to support them to leave the building in an emergency and the risks people needed support to manage. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 21 and 23 July 2015 we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 17 described above.

Each person had a detailed medicines care plan that explained the support they needed to administer their medicines. This included a flow chart for each medicine that could be taken when needed (PRN) which specified how and when the medicine should be given. Advice from healthcare professionals was included in the chart along with instructions on when further advice should be sought from a healthcare professional. When a PRN medicine was given a record of the time, dose and effect were made of the back of the medicine administration record (MAR) in line with best practice.

One person had recently been prescribed a PRN medicine that did not have a flow chart in place. Similarly, one person was no longer taking a medicine but a flow chart was still in place and the medicine was still on the person's list of prescribed medicines. All other records now matched the MAR. The registered manager explained that the member of staff who normally maintained the medicines records was not currently in work. They told us they would change the system so medicines records were checked every three months by staff alongside other care records.

A book to record when unneeded medicines were returned to the pharmacy was now in place to make sure an accurate record of the medicines that should be in stock was kept.

Risk assessments were in place for each person that showed the need to keep them safe had been carefully balanced against the need to help them make decisions and take appropriate risks. It was clear how the resulting decisions had been made. Staff had considered the restrictions in place to make sure the least restrictive option had been identified. For example, the bathroom was no longer locked as a special key had been introduced to turn the water off to prevent one person causing a flood.

Each person had a personal evacuation plan in place to guide staff on how to help them out of the building in an emergency. There was also an overall evacuation plan on the staff notice board. These plans had been updated in May 2015 but we also found older versions that contained different information in the fire folder. The main differences were information about encouraging the person to leave and what to do if the person refused. The registered manager told us she would ensure all copies were current and in line with safe practice. Staff we spoke with told us how they would safely evacuate people.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection of The Cottage Care Home on 20 and 22 January 2015 we found people's rights under the Mental Capacity Act 2005 (MCA) were not being fully met. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Some mental capacity assessments and best interest decisions had been completed by staff for decisions they were not qualified to make. Making these decisions indicated staff did not fully understand their responsibilities under the MCA although they had received training. MCA assessments and best interest decisions had not been documented for some relevant decisions. Some mental capacity assessments and best interest decisions had not been reviewed within the timescales specific by the provider.

At our focused inspection on 21 and 23 July 2015 we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 11 described above.

We reviewed the MCA assessments that had been completed for four people and found assessments had been completed for appropriate decisions. Any restrictions identified in the person's support plan or risk assessments were supported by a corresponding mental capacity assessment and a decision in their best interests if necessary. Staff told us assessments would be completed for one-off events, such as a significant purchase, as needed. The best interest decisions that had been made by staff all fell within their remit and no medical decisions had been made inappropriately by staff. Staff understood the limitations of their decision making for others.

MCA assessments and best interest decisions were being reviewed every three months in line with company procedures. Changes had been made as people's needs and circumstances changed. For example, staff had started leaving one person's drawers unlocked to see if they could cope without throwing items out of the window. Progress was being recorded regarding this new approach.

The registered manager told us staff received MCA training as part of the local authority online adult safeguarding training. However, this course only contained a brief mention of the MCA. After the inspection, the registered manager informed us that all but two staff had since completed specific MCA training offered by the local authority. The action plan following our last inspection stated the MCA would be discussed at team meetings. The registered manager told us this was not yet happening. The quality of support plans and MCA assessments was reviewed as part of the provider's quality monitoring audits.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection of The Cottage Care Home on 20 and 22 January 2015 we found the registered person had not notified the Commission without delay when Deprivation of Liberty Safeguards authorisations were approved by the local authority. They had also not notified us following a relevant incident involving a person using the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

At our focused inspection on 21 and 23 July 2015 we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 18 described above.

A retrospective notification has been sent to the Commission for each person for whom an authorisation to deprive them of their liberty was in place from the local authority. The registered manager was now aware of the requirement to submit a notification when further authorisations were received. A note had been made in the staff communication book to remind staff to inform the registered manager when an authorisation was received back to allow a notification to be submitted to the Commission.

We checked the record of incidents that had occurred since our last inspection and all relevant occurrences had been shared with us as a notification. This allowed us to monitor the way incidents were managed by the service. A senior member of staff had contacted us when they were unsure if a notification was required. This showed staff were acting in a transparent way and understood the need to submit notifications to the Commission.

All incidents were recorded using an electronic template. A summary sheet was now in place that listed each incident and identified whether a notification to the Commissioner had been submitted. Not all of the staff we spoke with fully understood the criteria for submitting a notification but this was not a problem as all incidents were reviewed by the registered manager to check if notifications had been submitted when needed.