Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Otterhayes

Salston, Ottery St Mary, EX11 1RH

Tel: 01404816300

Date of Inspection: 28 June 2013

Date of Publication: August 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Supporting workers	✗ Action needed
Notification of other incidents	✓ Met this standard

Details about this location

Registered Provider	Otterhayes Trust Limited
Registered Manager	Mrs. Carolyn Allen
Overview of the service	Otterhayes provides residential accommodation for up to six people who require personal care. They are not registered to provide nursing care. They are also registered to provide personal care to people who live in supported housing. The Otterhayes Trust is a registered charity.
Type of service	Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care Personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 28 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff and took advice from our specialist advisors.

What people told us and what we found

Otterhayes provides residential and supported accommodation for people with learning disabilities. We brought our planned inspection forward because we received information from the local authority safeguarding team about two incidents between two people living in the residential home. A safeguarding meeting took place a few days before this inspection to consider the safety of people living in the home and any actions that may be necessary to reduce the risk of recurrence. The people involved in the incident did not appear to have suffered any lasting harm.

On the day of this inspection the registered manager was away on holiday. Two acting managers were managing the home in their absence. A further incident had occurred just before we arrived. A member of staff had diffused the incident without the need to use physical intervention. We looked at the actions taken by the home to reduce the risk of further incidents. We found that two care plans did not provide sufficient information or instructions to staff about the things that may cause people to become upset or angry, how to prevent this happening or what to do if it occurred. Therefore behaviour that could be challenging for staff and distressing for people living at the home was not well managed and adequate steps were not taken to minimise challenging behaviour?

We looked at the support and training given to the staff team specifically around conflict management, restraint and safeguarding people from abuse. Some staff had worked in the home for many years and had received training in the past. For newer staff the level of training in these topics was low. The acting managers told us they were planning to provide further training in the near future. Records showed that formal supervision sessions for staff had recently been introduced. Staff told us there were informal support systems in the home. We did not see records of staff handover sessions during our inspection. The provider told us after the inspection these records were kept on the home's computer system.

The provider had failed to notify the Commission without delay about two incidents that occurred in the home. Since the safeguarding meeting the home has notified the

Commission promptly when further incidents have occurred. This showed they are now aware of their legal duty to notify the Commission about matters affecting the service.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 30 August 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People were supported in promoting their independence and community involvement. We looked at the way the home supported people to lead active and fulfilling lives. We spoke with four people who lived in Otterhayes. We heard about the things they enjoyed doing and how the staff helped them achieve this. Two people told us they liked to stay at home and spend time together. We saw them sitting in a quiet lounge watching television. They told us they were very happy.

We spoke with two staff who told us they respected people's right to refuse to join in organised activities. They told us about the range of regular organised activities available on the Otterhayes site, and also in the local area. For example, on the morning of our visit some people participated in a group art session. We also saw some people working in the grounds carrying out gardening and animal care. In the afternoon of our visit one person told us they were going to do horse riding. Staff told us how they encouraged people to participate in various activities, such as cooking, even though they may initially refuse.

People expressed their views and were involved in making decisions about their care and treatment. People told us about plans for future holidays and parties. We heard how they had been consulted about holidays and activities. We looked at their care plans and saw evidence they had been consulted about their care needs.

During our visit we saw a member of staff sitting with a person to help them send an e mail to a relative. The member of staff was encouraging and helped the person to talk about their daily life and things that mattered to them. The member of staff was respectful and treated the person in a dignified manner.

However, we also observed an interaction between a person living in the home and a member of staff. A person asked a member of staff if they could watch a DVD. The member of staff insisted they "Say please" before allowing them to watch the DVD. This showed the person may not always be treated as an adult or encouraged to make

decisions about the things they wanted to do without having to ask permission. We spoke with the acting managers about the support and guidance that had been given to staff about how to treat people as adults. They told us the home had always emphasised the importance of good manners. The providers may wish to note there was a potential risk that staff may use power inappropriately to control people's behaviour rather than offering people support and guidance.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs and protected their rights. The home had not ensured that all staff had the skills, guidance or information necessary to keep people safe.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. This inspection was brought forward because we had heard about two incidents that had occurred between two people living in the home. The home had also recently notified the Commission about an incident involving a third person. When we arrived at the home we heard that another incident had occurred that morning. We looked at the support and information given to staff to help them reduce the risk of similar incidents occurring again. These incidents were related to managing behaviours that could be challenging for staff.

We looked at three care plan files. We saw that one person had received support from a health care specialist a few years earlier. The health care specialist had helped the home draw up detailed guidance for staff. This helped them understand the person and the things that may upset them. It also helped them analyse the reasons why the person became angry or acted in a way the staff may find challenging. We saw there were clear instructions about the range of actions staff could take to support the person to prevent them becoming angry or upset, for example by suggesting they do an alternative activity they enjoy. The guidance also explained the actions staff should take to calm the person down after any incidents of aggression.

The person's care plan contained a range of documents that explained to staff the importance of treating the person as an adult. The person's care needs had been reviewed in February 2013 and the guidance remained unchanged. This meant that staff had sufficient up to date information about the person's health and personal care needs to enable them to provide consistent and effective care and support to this person.

We also looked at the care plans of two people who had recently been involved in two incidents of aggression. We saw that there was some information in one care plan about the risk of aggressive behaviour towards other people. The care plan provided information to help staff recognise potential signs of anger or upset and various approaches the staff

could take to help calm the person, for example by suggesting an alternative activity they enjoy. The care plan did not explain the actions staff should take to calm the person down after any incidents of aggression.

We looked at the third care plan. We saw that there was brief information to staff about things that may upset the person, and the risk of aggressive behaviour. The care plan had not been reviewed following recent incidents. There was insufficient guidance to staff to help them understand the things that may cause the person to become upset or angry. There was no information about approaches the staff could take to help the person calm down, either to prevent an incident occurring, or to deal with any incidents safely. The lack of detailed guidance in two of the care plans we looked at meant the home had not put in place adequate arrangements in place to deal with foreseeable emergencies and minimise challenging behaviours.

There were no records of any analysis following the recent incidents. We could not see any evidence to show how they had considered any further actions that may be necessary to keep people safe. There were no formal arrangements in place to provide one to one staffing for one person although the acting manager told us that staff were usually in close proximity to the person when they were in the communal areas of the home. This showed that people's needs had not been fully assessed or reviewed as required. Staff had not been given sufficient information about people's care and treatment needs.

The home had not contacted care managers, the local safeguarding team, families or advocates, or the Commission promptly following the first two incidents of aggression. A whistle blower contacted the local safeguarding team to alert them of the incidents. They said they had been given insufficient training and guidance to enable them to deal with serious incidents effectively. A safeguarding meeting took place a few days before this inspection took place. An action plan was drawn up to ensure people's needs were reviewed promptly and measures were agreed to reduce the risk of further incidents occurring.

During this inspection we spoke with two members of staff who told us they had lots of informal opportunities to discuss incidents and consider the reason why they may have occurred. They told us there were good support systems between the staff team and the management team. They said the management team were always available whenever needed.

The acting managers showed us guidance drawn up by the local authority on restraint. They told us this had been given to staff. We spoke with them about other sources of up to date information and guidance by organisations specialising in care of people with learning disabilities. This showed that the home had taken some actions to provide staff with training and information on current good practice methods of de-escalation procedures. However, the home had not actively sought relevant research and guidance to help them review their practice in line with current good practice methods.

We spoke with the acting managers who told us they had contacted the care managers for the two people who had recently been involved in incidents. They had requested the care managers visit the home to carry out reviews of each person's needs, including funding arrangements as soon as possible. The acting managers also told us they had recently been concerned about one person's health and had sought advice and treatment from their GP. We discussed other potential resources they could request further support or therapy, for example counselling therapy. The acting managers told us they would consider this.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

People were cared for by staff who were not fully supported or trained to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Staff had not received sufficient appropriate professional development. We spoke with the acting managers about the skills, training and experience of the staff team. They told us that many of the staff had worked in the home for a number of years and knew the people living there well. We discussed the possibility that newer members of staff may not have the training or skills to deal with difficult situations effectively or confidently. We heard that the staff team had received a varied level of training. Two staff were due to attend a conflict management course in July 2013. The home had a training matrix but we were told this had not been updated recently and therefore the records did not show all training the staff team had received in the last year. We were told a new training matrix was about to be drawn up. This meant systems for reviewing the future training needs of the staff team or to plan future training sessions were not fully effective at the time of this inspection, although we were assured an improved system will put in place in the near future.

The acting managers were in the process of obtaining relevant diplomas in health and social care at level 5. This is the level of training relevant for the management of a team of staff in health and social care settings.

Since the last inspection the level of formal one to one supervision of staff had improved. We saw records of recent supervision sessions. These were planned to take place every two months. This meant that staff had regular opportunities to discuss their training needs and for management to discuss competency levels.

Two members of staff we spoke with told us there was good communication and support between managers and staff. They told us they had plenty of opportunity to discuss work related issues. However, there were no formal or recorded handover sessions between each shift. This meant there was a risk that some staff may not be made aware of important information about people's changing health or personal care needs at the start of their shift.

Notification of other incidents ✓ Met this standard

The service must tell us about important events that affect people's wellbeing, health and safety

Our judgement

The provider was meeting this standard.

The provider has recently introduced systems to notify the Commission without delay of incidents which occur while services are being provided to people.

Reasons for our judgement

The local authority safeguarding team told the Commission they had received information of concern about two incidents that had occurred at Otterhayes. It was alleged that a person living in the home may have attacked another person on two occasions.

A safeguarding meeting took place and it was established that the incidents had occurred. Two acting managers attended the meeting in the registered' manager's absence. They confirmed they had failed to notify the Commission about the incidents. Following the safeguarding meeting the home had notified the Commission about two further incidents. This showed that the home was now aware of their legal requirement to notify the Commission without delay of any serious incidents that may affect the health or wellbeing of people who use the service.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People did not always experience care, treatment and support that met their needs and protected their rights. The home had not ensured that all staff had the skills, guidance or information necessary to keep people safe.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: People were cared for by staff who were not fully supported or trained to deliver care and treatment safely and to an appropriate standard.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 30 August 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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