Phew
Care Home Service

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Type of inspection:
Unannounced

Completed on:
19 July 2019

Service provided by:
Phew (Scotland)

Service provider number:
SP2003000240

Service no:
CS2003001225

About the service

Phew is a residential service located in the centre of Motherwell. It offers short breaks to adults and children with disabilities. Phew has up to 14 places. People using the service are accommodated in single bedrooms with en-suite facilities.

The provider is Phew (Scotland). Phew's mission statement says it 'offers quality accessible planned and crisis services to all eligible people with a disability, their families and carers.' This service registered with the Care Inspectorate on 1 April 2011.

What people told us

We spoke with six people who were using the service during this inspection. Some people were able to tell us their views, other people were not able to tell us verbally what they thought of the service. We observed their interactions with staff and other people using the service, and could see that people were relaxed and comfortable in the service, and seemed at ease with staff. People told us they liked coming to the service, and planned to come back because they enjoyed it. One person told us the beds were "comfy", another person told us they liked being able to go up to the shops with staff.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	3 - Adequate
How good is our leadership?	2 - Weak
How good is our staffing?	2 - Weak
How good is our setting?	4 - Good
How well is our care and support planned?	2 - Weak

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 3 - Adequate

Overall, we saw that people were treated by staff in a warm and friendly way. We saw that when people required to be given assistance with elements of personal care, this was carried out discreetly and with respect to the person.

However, we noted one instance where a person using the service was given an article to wear that was not appropriate for their age/gender and we felt this was demeaning to them. When we spoke with staff about this

they could not see what was wrong with this and said the person liked wearing the item. We suggested that some further work needed to be done by staff and the service in order to source a more appropriate replacement to properly reflect dignified practice.

The service offered a range of experiences and activities to people during their stay, based around their preferences and needs. We saw and heard from people who used the service that they enjoyed it, looked forward to their visits and planned to come back.
However, from our observations we saw that there was a lot of time spent in lounges, with not much activity or guided stimulation for people. Some items that were available for use in the games room were for very young children/babies, and whilst we could see that these may offer activity and stimulation to some, we thought there could be more age appropriate items sourced that would offer similar or better activity for people.

Some staff appeared unaware or even disinterested in planning activity with people using the service. When we asked staff several times over the course of the inspection about what was planned by way of activity we were frequently told "don't know/see what happens." We did not see that activity was being led by any staff in order to ensure that people got something worthwhile out of their visit.

We saw that care plan information needed to be more informative in order to help direct and plan peoples' visits to help them to get the most out of their stay. For example information held by the manager around how to engage one person in activities was not in their care plan. This led us to question how this person was able to be properly supported to engage in activity during their stay.

The service should consider developing an activity champion role to drive forward some energy/improvement across the service in respect of the activity on offer to people.

People were supported with physical health needs such as dietary needs and medication whilst in the service. Information from other agencies involved in people's care was evident within some people's care plans to support a continuation of care. However we noted that this information was not referred to within the service's own paperwork meaning staff may not have accessed or read it.

Meals were provided and kitchen staff were aware of dietary needs, requirements and preferences and we saw this was well organised and effective.

Medication management and administration needs to be improved in order to fully capture how well people are being supported with their medication during their stay. The management team have developed an audit tool, this needs to be extended to include consideration around the use of as required medication, its efficacy and any trends in administration (for example sedatory meds at night-time). This will help to inform guests' carers and relatives in respect of any health issues that need to be followed up. The medication recording sheet needs to be developed to enable full recording of efficacy of as required medication.

How good is our leadership? 2 - Weak

There were some systems in place to monitor aspects of service delivery such as medication audit, senior monthly reporting system, overview of SSSC registration of staff. We found that these had been implemented fairly recently and had not yet been fully effective in leading improvement across the service. We gave some advice as to how these tools could be further developed, to make them more robust and effective. We were concerned that there was a lack of consistency in how service delivery was being monitored, and there was a lack of clarity regarding roles and responsibilities. We have made a requirement around this. This was a recommendation at the last inspection and has not been met. See requirement 1.

The team leader management team were being suppressed and prevented from taking forward improvements, that were needed in this service because of the overall, lack of capacity to improve. The capacity of this service to improve had not changed despite structural improvements, by way of the creation of the team leader posts which should have strengthened the capacity. This is in part due to the use of team leaders to provide direct support and care and a lack of effective delegation and delineation of duties. There was very little evidence of improvement work, planning, prioritising, delegation and monitoring and reviewing of how the service was performing.

The service should have its own development/improvement plan and this should be reviewed regularly, in order to push forward progress. There was no evidence of this. We have made a requirement around this. See requirement 2.

Requirements

1. The provider must ensure it carries out regular, comprehensive quality assurance audits of all key areas of service provision which should include, but not be limited to, the quality of care documentation, analyses of falls, accidents and incidents to ensure appropriate actions are taken to improve care and reduce risk.

This is in order to comply with Scottish Statutory Instruments 2011/210 3 Principles, which state that "A provider of a care service shall provide the service in a manner which promotes quality and safety and respects the independence of service users, and affords them choice in the way in which the service is provided to them".

This is to ensure management and leadership is consistent with the Health and Social Care Standards which state "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19), and, my care and support is provided in a planned and safe way, including if there is an emergency or unexpected event (HSCS 4.14).

Timescale: three months from receipt of this report.

2. The provider must develop, implement, monitor and review its own service improvement plan. This plan should:

- Set out the main areas of day to day service provision,
- Provide an assessment of performance of each area (informed by, but not limited to, audits, service user feedback and inspection activity),
- Identify what improvements are needed and how these should be met,
- Include detail as to who is responsible for seeing through these improvements, and timescales for completion or review of progress.

This document should be a live record of progress and performance within the service, so that it is regularly referred to and updated.

This is in order to comply with Scottish statutory Instruments 2011/210 3 Principles, which state that "A provider of a care service shall provide the service in a manner which promotes quality and safety and respects the independence of service users, and affords them choice in the way in which the service is provided to them".

This is to ensure management and leadership is consistent with the Health and Social Care Standards 4.19 which state "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes".

Timescale: two months from receipt of this report

How good is our staff team? 2 - Weak

Staffing levels were calculated based on the IORNS dependency assessment tool however, this was not fully in use and needs further development in order to better meet the needs of this service. The management team were working out staffing levels based on their knowledge of who was coming into the service and what their level of need would be and using IORNS tool to support this calculation. This meant that the process was time-consuming and not fully transparent. There needs to be some further work done around developing this, to make it more transparent and maximise the outcomes for people using the service. We will monitor progress at the next inspection.

From our observations, we concluded that there was improvement needed in respect of the culture within the staff team. Whilst we saw that staff supported each other fairly well in respect of meeting peoples' needs where they needed two staff to assist them, and in observing and responding to people to ensure their wellbeing and safety, there were other important issues about how staff worked with each other and the management team that need to be addressed.

We reviewed staff supervisions and spoke with staff. We found that newer staff members displayed more motivation and enthusiasm about their roles than longer serving staff. Staff felt morale amongst the team to be low. The management team had introduced some approaches to improve the level of staff morale and were open to further suggestions. There was a culture and attitude amongst some of the staff team that was very resistant to change, and indicated a lack of awareness about their responsibilities as social service workers. It is crucial that staff realise they have a professional obligation as registered social service workers, to work in a way that is respectful, meet relevant standards of practice and work in a lawful, safe and effective way. We could see that there was work needed to support staff to develop reflective practice skills and be open to constructive feedback.

The whole staff team have a responsibility to promote and support a positive culture within the service. This is in order to ensure that they are treating people who use the service for respite and holidays, and each other, with the level of dignity and respect that is expected of a social service worker.

We expressed our concerns around the expectation that team leaders should be covering care shifts for three out of five of their shifts per week. From reviewing rotas we could see that there were frequently changes to this and team leaders were being put on to cover additional shifts. We could not understand the logic in this as it appeared to be expensive cover and did not provide team leaders with the amount of time they needed in order to be effective in their roles. Additionally, we heard how staff contracts were generally for specific amounts of hours, yet there had been a culture where staff refused to work certain shifts within these contracted hours, because those shifts were different to what they usually worked. Again, this highlighted issues amongst the attitude of staff to work to meet the needs of the service, and the importance of the management team conveying a consistent message to staff in regards to their contractual obligations. We have a made a requirement in relation to these issues. See requirement 1.

Requirements

1. The provider must ensure that the staff team work in a way that is respectful and ensures that the needs and quality of experience of people using the service are given priority. This should include, but not be limited to, ensuring:

- There is a staff team that is motivated, enthusiastic and engaging with the service and people who use it,
- There is a respectful culture amongst staff and management and where there are issues of conflict there are systems in place to resolve these in an effective and timely manner,
- There is a staff rota in place that clearly shows the skills mix of the staff on shift by way of staff job titles,
- There is a culture of reflective practice, willingness to learn and adapt to new ways of working with appropriate supports in place for staff, including training and guidance.

This is in order to comply with Scottish Statutory Instrument 2011/210 3 Principles, which state that: A provider of a care service shall provide the service in a manner which promotes quality and safety and respects the independence of service users, and affords them choice in the way in which the service is provided to them.

This is to ensure the quality of staffing is in accordance with the Health and Social Care Standards 3.14 which states "I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes".

Timescale: To be actioned immediately on receipt of this report.

How good is our setting? 4 - Good

We saw that people could move around within the service although there were keypads to control access in different parts of the building, in order to reduce risks to people using the service. Access to the garden was free, when we visited, and we saw that people were supported to get out and get fresh air, go to the games room, use the dining area or go out on the bus for activities.

We spoke with the management team in regards to some of the toys that were available for people to use. We could see that some of these were designed for infants or small children and suggested some work was needed to source other items, that would offer stimulation or relaxation and be more suited to the age group of people using the service.

People we spoke to, told us they liked their rooms and slept well when they came to the service. The service had access to assistive technology such as, epilepsy monitors to promote peoples' privacy and maximise safety.

The service had made some improvements to décor in dining area, by way of a wall mural depicting places of interest that people who used the service enjoyed visiting, which made it meaningful to them. Also, we heard that the service now had a more accessible sling for the hydro pool, which meant that more people could use the pool than were able to previously.

We did not see the kitchen areas off lounges being used much by the people who were in the service, when we visited and thought this could be more of a focus. We were assured by the management team that certain people do make good use of these areas, by getting involved in baking activities etc when they are staying in the service.

There were some areas of water damage that had happened as a result of a plumbing issue, and we spoke to the handyman who informed us he had purchased the materials needed and the repairs would be underway imminently. We will look to see that this has been addressed at the next inspection.

How well is our care and support planned? 2 - Weak

There was some evidence that people's needs were reviewed prior to each visit, by way of a telephone call to the person's main carer, and that some care reviews had taken place with carers and relatives in attendance. There had been a previous area for improvement in relation to ensuring that people had at least an annual review of their care needs and wishes, and whilst we saw some progress in this area, not everyone had yet had a review, therefore we have repeated this area for improvement. The service needs to ensure, that review documents state who was in attendance at reviews as well as who was invited and did not attend.

Of the care plans, we sampled we found contradictory information, out of date information, and poor quality information in relation to the management of challenging behaviour. The management team had delivered some training to key workers around care planning however, this had not been followed up with any auditing or further guidance or support, meaning that active care plans for people with high risk behaviours and needs were not sufficient to safely meet people's needs.

We found examples where a care plan had not been updated for someone, following incidents of aggression and others where they had been updated with poor quality information, that did not usefully inform staff practice. We did see an example, where the service had made use of information from the person's main care provider, but this had not been referred to within their own care plan. This needs to be referred to in order to direct staff to read it.

There were examples of risk assessments that were adequate however, we also found some that indicated risks posed to and by people using the service were not being fully assessed and management strategies of these were not robust enough. We concluded that in order for the management team to effectively ensure the quality of care plans within the service they need to carry out a full audit of all care plan documentation, including risk assessments and management of challenging behaviour strategies, to ensure these are robust, clear for staff to follow and ensure peoples' safety and wellbeing. We have made a requirement in relation to this. See requirement 1.

Requirements

1. In order to ensure that people receive care and support that is right for them, meets their needs and wishes and ensures their own and others' safety, the provider must ensure that care plans are appropriately completed, reviewed and updated to reflect people's current needs.

In order to do this, there needs to be a full audit of all care plans for people using this service, with an action plan attached to each care plan that demonstrates what action is needed in order to bring the care plan up to the required standard, timescales for completion, who is responsible for completion and a signing off section to inform that the necessary actions have been taken. Where possible key workers should be involved in this process in order to engage them in it and offer them a learning opportunity.

This is in order to comply with Scottish Statutory Instruments 2011/210 5 Personal Plans, which state "a provider must, after consultation with each service user and, where it appears to the provider to be appropriate, any representative of the service user, within 28 days of the date on which the service user first received the service,

prepare a written plan ("the personal plan") which sets out how the service user's health, welfare and safety needs are to be met".

This is in accordance with the Health and Social Care Standards 1.15 "My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices," 1.19 "My care and support meets my needs and is right for me" and 1.24 "Any treatment or intervention that I experience is safe and effective".

Timescale: To be completed within one month from receipt of this report.

Areas for improvement

1. The provider should ensure each person who stays at Phew, has at least an annual formal review of their care and support needs and wants. The person, their carers and all professionals concerned should be invited with absences and apologies minuted.
This is to ensure the care and support is consistent with Health and Social Care Standards which state I am fully involved in assessing my emotional, psychological, social and physical needs at an early stage, regularly and when my needs change (HSCS 1.12).

This recommendation was made at a previous inspection and whilst we saw some progress with this not every person who used the service had yet had a review of their care and support needs.

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

The provider should ensure each person who stays at Phew has at least an annual formal review of their care and support needs and wants. The person, their carers and all professionals concerned should be invited with absences and apologies minuted.

This is to ensure the care and support is consistent with Health and Social Care Standards which state I am fully involved in assessing my emotional, psychological, social and physical needs at an early stage, regularly and when my needs change (HSCS 1.12).

This area for improvement was made on 20 August 2018.

Action taken since then

We saw that there had been some improvement in this area, with a more robust system for highlighting when reviews were due. However, there were still a number of outstanding reviews therefore the recommendation is not met and is repeated. We will follow-up on this at the next inspection.

Previous area for improvement 2

The provider should ensure that its care planning and risk assessment documentation is comprehensively completed and reflect the personalised needs of each person the service supports.

This is to ensure the care and support is consistent with Health and Social Care Standards which state my personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices (HSCS 1.15).

This area for improvement was made on 20 August 2018.

Action taken since then

Some information had been updated however, of three files sampled we found contradictory information, out of date information, and poor quality information in relation to the management of challenging behaviour. The management team had delivered some training to key workers around care planning however this had not been followed up with any auditing or further guidance or support, meaning that active care plans for people with high risk behaviours and needs were not sufficient to safely meet people's needs.

This recommendation is not met and we have made a requirement around this. See requirement 1 under Key Question 5 How well is our care and support planned.

Previous area for improvement 3

The provider should ensure that all recommendations and actions relating to any environmental assessments, maintenance reports or certifications are recorded completed and signed off within appropriate timescales.

This is to ensure the environment is consistent with Health and Social Care Standards which state my environment is safe and secure (HSCS 5.17), and, I experience an environment that is well looked after, tidy and well maintained premises, furnishings and equipment (HSCS 5.22).

This area for improvement was made on 20 August 2018.

Action taken since then

We noted that on-going maintenance of the environment was happening, with some evidence of records to keep track of actions needed and completed. We spoke with the management team and maintenance worker in relation to water damage to ceilings that we saw, and heard what the action plan was for this. We were pleased to see some improvements to the dining area by way of a wall mural, which provided a much brighter and more interesting dining space. We heard that the service had purchased a new sling to enable more people to access the hydro pool than had previously been able to do this.

This recommendation is met and we will continue to monitor progress in this area.

Previous area for improvement 4

The provider should utilise a dependency, or equivalent tool to ensure staffing levels are sufficient to meet people's needs and provide for good outcomes.

This is to ensure staffing is consistent with The Health and Social Care Standards which state my needs are being met by the right number of people (HSCS 3.15), and, people have time to support and care for me and to speak with me (HSCS 3.16).

This area for improvement was made on 20 August 2018.

Action taken since then

The dependency assessment was in place and was being used to calculate needs retrospectively and therefore inform future staffing level planning. However, the tool being used was not adapted to the service, and limitations as to its usefulness were evident in relation to the changing nature of the client group on a week to week or sometimes even shorter basis. The provider should look to resource a more suited dependency tool and use this to inform staffing levels. We also raised concerns that the team leaders were often on shift providing direct support, which was not an effective use of resources. We were assured by the chair of the board that this would be looked at.

This recommendation is met and we will continue to monitor progress in this area.

Previous area for improvement 5

The provider should ensure it carries out regular, comprehensive quality assurance audits of all key areas of service provision which should include, but not be limited to, the quality of care documentation, analyses of falls, accidents and incidents to ensure appropriate actions are taken to improve care and reduce risk.

This is to ensure management and leadership is consistent with the Health and Social Care Standards which state I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes (HSCS 4.19), and, my care and support is provided in a planned and safe way, including if there is an emergency or unexpected event (HSCS 4.14).

This area for improvement was made on 20 August 2018.

Action taken since then

There was insufficient progress in this area. Whilst we did see that some tools had been developed including a senior monthly reporting tool and some audit tools, the usefulness of these was limited and their completion was inconsistent. This meant that we found concerning issues within care plan documents and the management of risks. This recommendation is not met and we have made a requirement around this. See requirement 1 under key question 2 How good is our leadership .

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	3 - Adequate
1.1 People experience compassion, dignity and respect	3 - Adequate
1.2 People get the most out of life	3 - Adequate

1.3 People's health benefits from their care and support	3 - Adequate

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement is led well	2 - Weak

How good is our staff team?	2 - Weak
3.3 Staffing levels and mix meet people's needs, with staff working well together	2 - Weak

How good is our setting?	4 - Good
4.2 The setting promotes and enables people's independence	4 - Good

How well is our care and support planned?	2 - Weak
5.1 Assessment and care planning reflects people's planning needs and wishes	2 - Weak

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