Carlton House Care Limited

92 Carlton Road

Inspection report

92 Carlton Road
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 6 and 7 September 2018. We gave the service 48 hours' notice that we were coming as it is a small home supporting people with a learning disability, autism and mental health issues. This was the first inspection of 92 Carlton Road since they were registered with the Care Quality Commission (CQC) in August 2017.

92 Carlton Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home accommodates up to six people over three floors. Each person has their own living space, including en-suite shower. Communal kitchenettes are on each floor to make drinks and snacks, with the main kitchen and dining room located on the basement level.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At the time of our inspection the manager had been in post for three months and was in the process of registering with the CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Clear risk assessments and guidance was in place for staff to follow to support people with their complex needs. Positive behavioural support plans were detailed and provided strategies and distraction techniques for each person. Any physical intervention techniques that could be used were specified in the positive behavioural support plans. These were reviewed each month or following an incident.

The manager had provided additional training for staff in the recording of incidents to increase their level of detail. These were seen to now included a full description of the incident and any distraction techniques or physical intervention used by staff.

All incidents were reviewed by the manager to identify any patterns in the incidents. De-brief meetings were held with the staff involved to review the incident and discuss what, if anything, could be done differently in future to reduce the risk of further incidents occurring.

Newly recruited staff were trained in physical intervention before starting a week of shadow shifts to get to know the people they would be supporting. Staff training in a range of courses was seen to be up to date.

Courses were tailored to meet the individual needs of the people living at the home.

Staff were knowledgeable about people's needs and how to support them to minimise their anxiety levels. Staff told us they enjoyed working at the service and felt well supported by the manager, deputy manager and senior care worker. Regular supervisions and team meetings were held.

A new grade of level 2 care worker had been introduced to provide more leadership on each shift. The level 2 care workers completed a monthly key worker report, summarising the person's daily records, incidents, goals and ensuring all health appointments were planned. The deputy manager or senior care worker now worked at weekends to provide additional support for the staff team.

Observations of practice had been introduced for the care team to ensure they were following the agreed support plans.

Each person had a communication passport in place which provided information about how people communicated their feelings and needs both verbally and through body language. People were assisted to communicate through picture cards and Makaton signs. 'Easy read' symbols were used to try to involve people in their care plans.

Medicines were managed safely at 92 Carlton Road. Clear protocols were in place for the use of medicines that were not administered regularly.

There were sufficient staff on duty to meet people's assessed needs. A recruitment system was in place to ensure staff were suitable for working with vulnerable people.

People were supported to maintain their independence where possible and were encouraged to complete any tasks they could do for themselves.

People's health, nutritional and dietary needs were being met by the service. Other professionals, for example learning disability team and psychiatry services were involved in supporting people and the service where needed.

The service was meeting the principles of the Mental Capacity Act (2005). Capacity assessments and best interest decision meetings were seen in people's care files.

Relatives told us they were involved in discussing their relatives care plans and were kept up to date by the staff team about any changes in their relatives' wellbeing. The service sought the views of people, their relatives, staff members and professionals involved with the service through annual surveys. The results we saw were positive and a report was written highlighting any areas for the manager to respond to.

Each person had an activity planner in place with what they were doing each day. The manager recognised that activities, both within the home and in the local community, needed to be increased.

A quality assurance system was in place at the service. The manager and deputy manager completed checks for medicines, finances, the environment and health and safety. The provider's quality manager completed nine different audits per year. The manager completed a monthly report giving an overview of the service.

People's wishes at the end of their life and in the event of their death were recorded in advanced care plans.

A complaints policy was in place. Complaints had been investigated and responded to appropriately.

People's cultural and religious needs were being met by the service.

The home was visibly clean with no malodours. Equipment was maintained in line with national guidelines. The manager planned to personalise people's rooms with pictures of their choice and re-decorate their living space in colours of their choice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risk assessments and positive behaviour support plans were in place. Staff had clear guidance to reduce the identified risks and manage people's anxieties.

The recording of incidents had improved, with more detail now being included in the incident reports. Staff were debriefed following an incident to learn any lessons about how support may need to change to reduce the risk of further incidents.

People received their medicines as prescribed. Protocols were in place for when medicines prescribed as 'when required' should be administered.

Is the service effective?

Good

The service was effective.

Staff received the training and support through supervisions and team meetings to effectively undertake their role. All staff were trained in physical intervention techniques.

The service was working within the principles of the Mental Capacity Act (2005).

People were supported to meet their nutritional needs and maintain their health.

The manager planned to support people to personalise their own living areas more.

Is the service caring?

Good

The service was caring.

Staff had developed positive relationships with people and knew their needs well.

Individual communication passports, pictures and Makaton signs were in place to assist people to communicate, verbally

and non-verbally.

People were encouraged to complete the tasks they were able to do themselves to maintain their independence.

Is the service responsive?

Good

The service was responsive.

Care plans were in place which gave detailed guidance for staff in how they should support people to meet their assessed needs.

Each person had an activity planner in place. The manager recognised the need to increase the activities people participated in, both within the service and in their local community.

The service had a complaints procedure in place. All complaints received had been responded to appropriately.

Is the service well-led?

Good

The service was well-led.

A quality assurance system was in place, including audits by the provider's quality manager.

Staff said they enjoyed working at the service and felt the management team were supportive and approachable. The deputy manager or senior care worker now worked at weekends, increasing the support for the staff team.

Feedback was obtained from residents, relatives, professionals and staff through surveys. Reports had been written to summarise the feedback received.

92 Carlton Road

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 6 and 7 September 2018. We gave the service 48 hours' notice of the inspection visit because it is a small home supporting people with learning disabilities, autism and mental health issues, who can display behaviour which can be described as challenging. We wanted to give the home time to inform and support people before our visit. One inspector completed the inspection.

Before our inspection the provider completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. We looked at the statutory notifications the home had sent us. A statutory notification is information about important events, which the provider is required to send to us by law.

We contacted the local authority safeguarding and commissioning teams. Details of their feedback is included within the main body of this report. We also contacted Manchester Healthwatch who did not have any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with one person who used the service and observed people and staff interactions as five people living at the service could not verbally communicate with us. We also spoke with one relative, four members of care staff, the manager, deputy manager, quality manager and service director.

Following the inspection, we also contacted two specialist professionals involved with the service and two members of the night care staff team.

We looked at records relating to the management of the service such as the staffing rotas, policies, incident and accident records, four staff recruitment files and training records, two care files, meeting minutes and auditing systems.

Good

Is the service safe?

Our findings

The risks people may face had been identified, for example with personal care, community activities, use of the kitchen and the environment. Clear guidance was in place for staff to mitigate these risks. For example, one person was at risk of self-harm and detailed information about the person's environment was provided to reduce the opportunity for them to do this. The risk assessments were reviewed each month or following an incident.

The people living at the service had complex needs and may have behaviour described as challenging. Each person had a positive behaviour support plan in place. This had been written with input from the professionals from the learning disability and mental health teams. The plans included a description of the person's interactions and behaviour when they were calm (at baseline), possible triggers for their anxiety and the signs that they were becoming agitated. Information was provided on how staff should support and distract the person to try to reduce their anxiety. There was a description of behaviours the person may have when they were agitated and how staff should support and re-assure them. There was also a description of the physical interventions that could be used by members of staff, if necessary, to keep the person and staff safe. All staff were trained in the use of physical intervention through a course called CITRUS.

The service monitored all incidents and accidents through 'ABO' forms (for less serious issues where there was no injury or harm to people or staff) and accident and incident forms. These were reviewed by the manager and deputy manager. Debrief meetings were held with staff to discuss what happened and if there was anything that could be done differently in future. The accidents and incidents were also analysed for any patterns, for example time of day and the support strategies agreed to try to reduce people's anxieties at these times.

Feedback we received from the local authority commissioning team was that the accident and incident forms had not always included sufficient detail and staff did not always acknowledge their responsibility to fully complete all records. The manger had completed training with the staff team on completing records and the importance of having clear and accurate records. A guidance sheet on how to complete the incident forms had been provided for staff to follow. Staff told us, "We include a lot more detail now, including a body map. Before it was more of a summary but now it's every detail from start to finish."

The shift leader now signed each accident and incident form when it had been completed by the staff members involved to ensure all the relevant details had been recorded before the staff members finished their shift. Record keeping was now part of every staff supervision and team meeting to ensure staff were fully aware of the requirements to fully record all incidents.

The recent accident and incident forms included clear details of the incident, the lead up to the incident, the person's behaviour, distraction techniques used, any physical intervention techniques used and what happened after the incident. Body maps were used to indicate if the person had injured themselves. This meant the service had responded to the findings of the local authority and the manager had supported the staff team to improve their record keeping.

Staff we spoke with were aware of the safeguarding procedures at the home. They understood how to report any safeguarding concerns and confirmed they had received safeguarding training. They told us they would report any concerns to the management team.

The provider had clear personnel policies and procedures in place. These had been followed with investigations completed and disciplinary action taken where deemed necessary.

People living at 92 Carlton Road required support to manage their finances. Records were kept of all monies and the balances checked daily. This safeguarded people from financial abuse. Where people had their own bank accounts bank statements were received. The manager told us they would begin checking the statements against the money records to ensure that all withdrawals had been accounted for.

Medicines were safely managed. The medicines administration records we saw had been fully completed with two staff signing that the medicines had been taken and daily stock checks were made of all boxed tablets. Clear protocols were in place for when medicines that were prescribed to be administered when required should be given.

Staff who administered medicines completed an annual refresher training, including a competency check and an observation by the manager or deputy manager. A monthly medicines audit was completed and any discrepancies found investigated.

Staff were safely recruited. All pre-employment checks were made before the new staff member started work, including two references and a Disclosure and Barring Service (DBS) check.

There were sufficient staff on duty to meet people's assessed needs. Where people's needs had changed we saw that the service had worked with the Clinical Commissioning Group (CCG) and increased the staff support during the day.

The home was visibly clean throughout, with no malodours present. The manager had met with staff to re-iterate the need for all cleaning tasks to be completed. Personal protective equipment (PPE) was available for staff when supporting people with personal care tasks.

We saw evidence that equipment was maintained and serviced in line with national guidelines and the manufacturer's instructions. Weekly checks were made on the fire alarm and monthly checks for the emergency lighting system and call bells. Legionella water checks were completed each month.

Personal emergency evacuation plans were in place for each person. These detailed the support a person would need in the event of having to leave the building in an emergency. Regular fire drills had been completed. Contact information and guidance was seen for staff to deal with any emergency situations such as a gas or water leak.

Good

Is the service effective?

Our findings

Staff we spoke with said they felt well supported by the manager and deputy manager. The new manager held supervisions every two months; although prior to their appointment we saw supervisions had not always been completed to this schedule. Staff meetings were held every month and de-brief meetings were now completed following incidents to discuss any changes that could be made to reduce the likelihood of further incidents and keep people and staff safe. Staff said these were open discussions about the service and the needs of the people living at 92 Carlton Road.

Staff told us they were given enough information to meet people's needs. A handover was held between each shift change to update the staff coming on shift of any changes in people's health and wellbeing.

Staff had completed an induction and training relevant to their role. All staff completed the CITRUS physical intervention training before doing shadow shifts with experienced staff. Staff told us they spent a week reading people's care files, policies and procedures and working alongside colleagues to get to know people and their routines. Following this they were part of the rota. New staff we spoke with said they were confident when they started supporting people and that there were always other staff close by if they needed any assistance or advice.

New staff completed an induction work book which met the standards of the care certificate which is a nationally recognised set of principles that all care staff should follow in their working lives.

On line courses were used for training including infection control, food hygiene, first aid, safeguarding, mental capacity, mental health and nutrition. Taught courses were also held with relevant professionals for epilepsy awareness and diabetes so the course content could be personalised to the people living at the service. The manager told us they had requested training in mental health through the community learning disability team. We also discussed ligature training as one person was assessed as at risk of using different objects as a ligature. A ligature knife was kept on site in case this occurred. We were told that this would be arranged.

The manager had introduced observations of practice for staff supporting people to ensure the staff were following the care plan guidance and were clear why the support was structured the way it was. For example, observations had been completed for staff supporting one person to safely make a cup of tea. The manager told us they planned to undertake more observations of practice in the future, which would ensure staff were supporting people in the agreed way.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The service was meeting the principles of the MCA. Capacity assessments and best interest decision meetings were seen in people's care files. Applications for DoLS had been made where it had been assessed that people lacked capacity to consent to their care and treatment. The registered manager used a matrix to track when DoLS had been applied for, when it had been granted and when it needed to be renewed.

People were supported to maintain their health. Each person was registered with a local GP and referrals were also made to other health professionals, for example, psychiatry and speech and language team (SALT) as required. People were supported to attend hospital appointments. Oral health care plans were in place and optician appointments had been arranged.

Each person had a hospital passport in place. This provided key information about a person's needs for hospital staff in the event the person needed to be admitted to hospital.

Clear epilepsy care plans were in place which provided information about a person's seizure, action staff should take in the event of the person having a seizure and when any rescue medication should be used.

People's nutritional needs were being met by the service. A weekly menu was agreed for the main evening meals. People were supported to make their own choices of meals. Guidance was provided to meet people's dietary needs, for example healthy eating information and guidance for a diabetic diet. The speech and language team (SALT) had provided guidance for people to reduce the risk of choking. For example, clear instructions had been written for one person who needed a soft, moist diet with food cut into small pieces.

Each person had their own living space and en-suite shower facilities. Doors had key fob locks for safety reasons. Some people had personalised their rooms with help from their families, however other living areas were not personalised. We noted that due to some people's anxiety their rooms needed to not contain too many items as this caused overstimulation for them.

The manager was aware of this and had requested for people's living areas to be decorated in colours of their choice. Staff had also been asked to identify how people's rooms could be more personalised, for example pictures of things they liked. We will check progress on this at our next inspection.

Good

Is the service caring?

Our findings

Our observations showed staff had formed positive relationships with the people living at 92 Carlton Road. The relative we spoke with told us their relative enjoyed living at the service and looked forward to returning to the home whenever they had visited the family home. They said, "The staff are brilliant; they have lots of patience and are so calm."

Each person had a communication passport which detailed how the person communicated and explained how a person would show what they wanted through their behaviour or actions, for example that they were happy, bored, wanted to go out or wanted to be on their own.

The communication passports and care plans also provided details of people's interests, likes and dislikes and what they enjoyed talking about. This meant staff had the information to be able to positively engage with people about topics they were interested in. Staff knew people's likes, dislikes and interests. For example, one staff member told us, "[Name] likes football so I chat to them about this to distract them."

Some people living at the service used Makaton signs as part of their communication. Makaton uses signs and symbols to support verbal communication. The staff team had done some training in Makaton which meant they were able to communicate better with people.

One person also used the Picture Exchange Communication System (PECS). This is a series of cards with pictures and symbols. The person points to the cards to communicate what they want to.

Staff could describe people's support needs and how they gave them choices in their day to day lives. For example, showing people a choice of food or clothes so they could indicate which they wanted.

Staff spoke with people in a respectful way. Staff were aware how to maintain people's privacy and dignity when providing support. One staff member told us, "I always explain what I'm going to do before I give any support so people know what is happening."

People were encouraged to complete the tasks they were able to themselves. One person told us they had helped make their evening meal the night before our visit. Care plans clearly identified where people were able to do things independently. Staff could tell us how they prompted and encouraged people where possible. The relative told us their relative was now doing far more things for themselves than they had done when living at the family home.

Equality and diversity training was part of the training all staff had completed. People's preferences for their support staff was recorded, for example if they wanted male or female staff to support with personal care.

Care plans included information about people's religious observance where appropriate. The service had also supported one person to discuss their sexuality and had identified external agencies that may be able to provide further support in this area.

Where appropriate independent advocates were used to ensure decisions made were in people's best interests.

People's confidential information was securely stored in the office at the home. The computers used by staff to complete their training were password protected.

Good

Is the service responsive?

Our findings

Person centred care plans were detailed and provided staff with clear guidance on how to support people. This included people's daily routines and step by step information about how to safely involve people in daily tasks such as making hot drinks.

The staff we spoke with were able to describe people's support needs. The person we spoke with said the staff team knew them well and they enjoyed going out and cooking with members of staff.

Individual daily outcomes had been identified for each person. There were up to 40 outcomes per day including attending to personal care, involved in meal preparation, having the meal from the menu planner, going out and completing their own laundry. Whether the outcomes were completed or not was input to a database and plotted on a graph so trends could be seen. The manager used this information to discuss with the person and staff areas where changes could be made.

Each person had a designated staff member as their key worker. The key worker met with the person each month to talk about their support, things they enjoyed and areas they were not happy about. The keyworker also wrote a monthly report which gave an overview of the month, including the persons health, any professionals' visits, family contact and activities they had taken part in.

The care plans were reviewed each month or following an incident or accident. Relatives told us they were kept informed of any changes in their relative's care plans or health.

Multi-disciplinary meetings were arranged when required to review a person's needs and support. A range of specialists were involved, for example community learning disability team, mental health team, social worker and the specialist support team.

The care plans included easy read symbols and photographs. This enabled people to be involved in their care plans and be more able to understand what had been written and meant the service was meeting the requirements of the accessible information standard.

The service used sensor mats where there was an assessed need. These alerted staff through the call bell system if a person got up and may need support. This allowed the staff to be close by, but not in, people's living area, thereby giving them privacy.

Each person had an activity planner in place which outlined possible activities the person may want to take part in each day. We saw people going out in the local area during our inspection. Clear care plans were in place for staff to follow when supporting people in the community to reduce the chance of incidents occurring. We saw a new care plan had been introduced following an incident in a shop. This had been discussed with the staff team and they had all been asked to read and sign that they understood the new guidelines.

The manager was keen to promote activities, both within the home and the local community and acknowledged that this area needed further work. The people living at the home sometimes needed to be encouraged to participate in activities and there were some days when their anxiety would mean they could not go out into the community. The staff team also needed to constantly promote meaningful activities within the home. We will check how this has progressed at our next inspection.

Each person's wishes for the end of their lives was recorded. This included any wishes for after their death and who should be involved in planning their funeral.

A complaints policy was in place. All complaints received had been investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

The new manager had been in post for three months and had started the process to register with the Care Quality Commission (CQC). They were supported by a deputy manager. Senior care worker and level two care staff posts had been introduced at the home in May 2018. These staff had applied for these positions internally and organised the shifts and staff team on a daily basis. The level 2 care staff completed monthly key worker reports for each person. these summarised what the person had done in the last month, any incidents and patterns of behaviour, goals and achievements. They also ensured all health appointments were up to date and liaised with the person's family.

The senior or deputy manager had changed their shift patterns two months ago so that one of them now worked at weekends to provide additional support for the staff team.

A quality assurance system was in place at 92 Carlton Road. This included weekly and monthly audits for medicines, people's money, bedrooms, mattress checks and health and safety. The manager compiled a monthly overview report of the service for the service director. This reported the staffing hours deployed, an overview of the accident and incident records, reviews of people's care plans undertaken and the management audits and checks completed. Any actions required from these reviews and audits were recorded along with the progress to date.

The manger and deputy manager also reviewed all incident and accident forms and de-briefed the staff involved to discuss what had happened and whether anything could have been done differently to reduce the likelihood of further incidents. The relevant care plans and risk assessments were then reviewed and staff informed of the changes. For example, the care plan for one person had been changed after an incident in a local shop. The staff knew about the updated care plan and how this could avoid similar incidents in future.

Staff told us they enjoyed working at the service and felt well supported by the management team. Following a series of allegations made by one person against staff the providers disciplinary processes were followed. Following an investigation, the staff had returned to work. Staff told us this had unsettled the staff team as they had been concerned that allegations could be made against them. One said, "[Manager] called to check I was okay. I've felt supported by [Manager] since I came back and there have been no problems." Back to work supervision meetings had been held with all the staff who had been suspended to update them on changes since they had last supported people. This included information on the new requirements for more detailed incident reports to be completed.

The provider had created a quality manager role from April 2018, which had strengthened the provider's oversight of their services. The quality manager completed nine audits per year at 92 Carlton Road. Each one concentrated on a different area, covering the five domains used by the CQC, the environment, finance, medication and support plans. A night audit was also done every quarter to give an overview of the waking night shifts. An action plan was written for following each audit which was reported on in the manager's monthly overview report. We saw actions that had been identified had been completed or were in progress.

The quality manager told us, "I check the progress on the actions at my next audit; they tend to have been completed here (at 92 Carlton Road)."

The service sought the views of the staff team, residents and relatives to inform improvements in the service. The quality manager co-ordinated the annual staff, professionals, residents and family surveys. The residents and relatives survey had been completed in March 2018. A report of the responses had been written which identified any areas the manager needed to follow up. The responses were positive, with a relative stating that their relative was safe, the staff were polite and they were kept informed by the staff about their relative. The staff survey had not been completed for 2018 at the time of our inspection.

A staff forum had also been established where staff representatives from each of the provider's services could meet to discuss common issues across the services. Regular staff meetings were held. Staff said these were open meetings where they could raise any ideas or concerns they had.

The provider planned to introduce an electronic care planning system. The manager had completed a pilot care plan for one person at a different home. The system would enable staff to access people's care plans and record the support provided via hand held tablet devices. The agreed outcomes (support) for each person would be displayed on the hand held devices to prompt staff as to what was required. This could be monitored by the management team. Monitoring charts and staff daily tasks, for example cleaning could also be completed through the electronic system. The manager told us this would improve the monitoring of the service, the support provided and reduce the time staff needed to complete the required paperwork.

The manger was clear that they wanted the people living at 92 Carlton Road to be more active, both in the house and in their local community. They were working with the staff team to introduce new activities and ensure all staff encouraged people to participate in things as much as they wanted and were able to.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the CQC. We checked the records at the service and found that all incidents had been recorded, investigated and reported appropriately.