Care Quality Commission

Care Expertise Ltd

Spring Lake

Inspection report

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

Overall summary

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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

Spring Lake is a care home that is registered to accommodate up to 11 people who have learning disabilities and require support with personal care. At the time of our visit, the service was providing care for 10 people.

This was an unannounced inspection. The service was last inspected in October 2013, and was found to be meeting regulations relating to consent to care and support, care and welfare of people who use services, staffing, medicines management and assessing and monitoring the quality of service provision.

Summary of findings

The service had a registered manager in post. A registered manager is a person who has registered with CQC to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Staff understood people's needs and we saw that care was provided with kindness and compassion. People's relatives told us staff were kind and caring, which we observed during this visit. We saw staff treated people with respect and dignity.

All staff had undertaken the required training and where necessary refresher training had been booked to keep their skills up to date and to ensure that the care provided was safe and effective to meet people's needs.

The registered manager and staff considered families as a valuable source of information, with a role to play in care decisions. We saw from people's care records that families were involved in people's care. However, in a few cases the service had failed to respond to the needs of some people.

The manager and deputy manager demonstrated an understanding of their role and responsibilities, and staff told us they felt well supported. There were systems in place to monitor the safety and quality of the service provided. The manager encouraged feedback from families and other stakeholders, which they used to make improvements to the service.

Staff understood how to safeguard people they supported. Managers and staff received training on safeguarding adults, the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA).

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff we spoke with knew how to keep people safe. All staff had received training in safeguarding, which ensured they could recognise abuse and knew what action to take when responding to allegations or incidents of abuse.

Appropriate checks had been undertaken before staff commenced work with the service. This helped to ensure staff were safe to work with people who used the service.

The provider had effective systems to manage risks to people without restricting their activities. The service was meeting the requirements of the MCA code of practice and DoLS.

Is the service effective?

Good

People received individualised care that met their needs. Staff had received appropriate training to ensure they had the skills and knowledge to care for people.

People had plans of care, which addressed their needs. Where needed, risk assessments had been completed and regularly reviewed. People were supported to attend health and medical appointments. Each person who used the service had a Health Action Plan to help the staff meet their health needs.

Is the service caring?

Good

The service was caring. Staff were pleasant and polite to people. They treated people with dignity and respect. The service explored and implemented a range of methods to support people to express their views.

People's families and representatives were involved and largely their views were respected and acted on. Staff knew and responded to each person's religious and cultural needs.

Is the service responsive?

Requires Improvement

The service was not always responsive. Whilst the service was responsive to the needs of most people, the service had not responded to the needs of other people receiving care.

People were asked about their views of the service through participation in satisfaction surveys, parent and advocate meetings and review meetings.

Overall, professionals involved in people's care gave us positive feedback about the service. Relatives informed us that they could talk to the manager or care staff about any concerns or complaints they may have.

Summary of findings

Is the service well-led?

Good

The service was well-led. Relatives of people receiving care, professionals and staff informed us that the registered manager was approachable and were satisfied with the management of the home. The service had a clear vision, which promoted values such as rights, independence, choice and inclusion.

Where a concern had been raised, the manager had responded and contacted the person concerned.

Spring Lake

Detailed findings

Background to this inspection

We inspected the service on 7 July 2014.

The inspection team consisted of an inspector and an expert-by-experience. An expert-by- experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we held about the service, including a Provider Information Return (PIR).This 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.

During the inspection visit we spoke with six staff members and three members of the provider's management team. We were not able to speak with people using the service because they had complex needs and were not able to share their experiences of using the service with us. We gathered evidence of people's experiences of the service by reviewing their care records, observing care and talking to their relatives. We looked at five care records of people receiving care and seven staff records which included recruitment information.

Following our visit we spoke with relatives and representatives of five people receiving care. We also received feedback from healthcare professionals, including GPs, psychiatrists, dieticians, psychologists and district nurses. This was in addition to comments we received from commissioners.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

Relatives of people who used the service reported that people were safe from abuse and harm. Their comments included, “Care is safe. I have had no reason not to think so” and “I feel [my relative] is safe. When [my relative] comes home, they quickly want to go back.” Professionals were also complimentary, stating, “The overall quality of the service is good.”

The service had a policy for the prevention of abuse and safeguarding of adults. All staff had received training in safeguarding, which ensured they could recognise abuse and knew what action to take when responding to allegations or incidents of abuse. We spoke with five staff and they stated they would report allegations of abuse to their manager in the first instance and were also aware of when to use the whistleblowing procedure. Whistleblowing is when a worker reports suspected wrongdoing at work to a public body such as the police or a regulatory commission. They told us they could report allegations to the local authority safeguarding team and the CQC if management staff had taken no action in response to relevant information.

Where there were risks associated with people’s support, these were appropriately assessed, and measures were put in place to ensure people’s safety. The service employed ‘positive behaviour approaches’ to manage behaviours which challenged the service and their associated risks. Positive behaviour approaches are methods that aim to reduce challenging behaviour and improve quality of life through teaching an individual new skills and adjusting the environment to promote positive behaviour changes. People using the service were referred to appropriate community learning disability teams for behavioural assessments. Depending on the function of the behaviour, we observed a range of strategies being used to support people. This included strategies that targeted improving communication, facilitating supporting positive relationships or enabling engagement in meaningful activities.

The service had also undertaken environmental risk assessments to identify hazards that could cause harm to people using the service. For example, electrical cupboards were kept locked, and chemicals were locked in the designated cupboard. The service had a fire safety risk assessment and an evacuation plan for staff, and people who used the service. Fire alarm and doors were checked once every week and fire drills were completed once every month. Most staff had completed health and safety training. Guidelines were in place for people at risk of scalding due to exposure to hot water and hot surfaces and those at risk of leaving the premise alone. Information about risk was shared in staff meetings, review meetings and staff handovers. We observed staff were aware of risks to people.

The registered manager and staff were knowledgeable regarding the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). They knew if people were unable to make decisions for themselves that a ‘best interests’ decision would need to be made for them. We observed where restriction of people’s liberty was considered necessary to manage risk, the service ensured this was in the person’s best interest, proportionate to the risk of harm and was the least restrictive alternative. For example, the registered manager told us people were at risk of scalding if they were exposed to hot water or hot surfaces. This is because people using the service had complex needs, which limited their ability to react appropriately or in a timely manner to prevent injury.

The provider locked the kitchen door to stop people entering the kitchen without a member of staff accompanying them during busy times. People could enter the kitchen at other times such as during the morning or other less busy times with support from staff. For example, breakfast times were considered less busy and we saw that people were supported to prepare breakfast by staff in the kitchen. We checked to see if locking the kitchen door at selected times was lawful. CQC is required by law to monitor the operation of the DoLS. DoLS provides a process of determining whether individuals who were deprived of their liberty were being lawfully deprived. We saw evidence the service had sought standard authorisation from respective authorities, which concluded the restrictions were lawful and proportionate.

The service employed safer recruitment practices. The manager explained this minimised risk of harm to people receiving care. Appropriate checks had been undertaken before staff commenced work with the service. We looked at seven staff personnel records and saw that each contained a list of checks, including at least two references, criminal record checks, proof of identity and address, along

Good

Is the service safe?

with documents confirming the right of staff to work in the United Kingdom (UK). The provider's policy required that these checks were undertaken prior to staff commencing work.

There were enough staff available to ensure people were safe. The registered manager told us they did not employ agency staff because people using the service in an environment that promoted continuity and consistency. The registered manager told us bank staff were always on standby if there were any emergencies. We saw that one to one or two to one support was provided when this was required.

Good

Is the service effective?

Our findings

We received positive feedback from relatives and professionals involved in people's care. One relative told us, "My relative is well cared for here. I have peace of mind knowing my relative is in good hands." Equally, we received positive comments from professionals involved in people's care, including, "I have carried out reviews on a regular basis and the outcomes are positive. I find the staff very positive and accommodating to people's needs. We have in fact been able to reduce some of the one to one hours." This feedback was consistent with comments we received from all the other professionals we contacted for their views about the service.

All staff had undertaken relevant training and where necessary refresher training had been booked to keep their skills up to date. Examples of training covered included, communication for adults with learning disabilities, mental capacity, British Sign Language (BSL), autism awareness, epilepsy, diabetes awareness and basic Makaton. Some staff had completed national vocational qualifications (NVQ) in health and social care such as NVQ 3.

We observed a few examples where staff demonstrated relevant skills, including the use of communication tailored to individual needs, managing behaviours which challenged the service and managing risks relevant to people they supported with epilepsy and diabetes. All staff had received induction to understand their role and become familiar with the physical environment, the culture and procedures of the organisation. One health professional told us staff were very knowledgeable and dedicated. The health professional stated staff knew the patients' individual needs and how to keep them calm. Relatives were also complimentary about the competence of staff. One relative said, "Staff are very knowledgeable. They have training in autism and Asperger's. I did not have any understanding but I now know a lot through staff."

Staff were appropriately supported in their roles by the registered manager through regular supervision, meetings and annual appraisals. We looked at the personnel records of seven staff and we saw records of regular formal staff supervision and appraisals had been kept. Regular staff meetings had been organised and the minutes were available. These showed staff had been provided with guidance regarding the care of people and they had been updated regarding the management of the home.

People were supported to access healthcare services and receive on going healthcare support. Each person had a Health Action Plan (HAP). HAPs held information about each individual's health needs, the professionals who were involved to support those needs, hospital and other relevant appointments. The HAPs covered a range of services that the person needed. These included dentistry, eye care, speech therapy, recent investigations and medicines taken. The service also took preventative action to keep people in good health by ensuring they received 'annual health checks'. Appropriate referrals had been made to other health care services, including eye care, dentistry, psychiatry, neurology, nutrition, and speech, language and swallowing disorders.

When people visited hospitals or other providers of health, they carried 'hospital passports' with them. A hospital passport is used in the event of a hospital admission to ensure hospitals have relevant information on people's needs and preference, especially when people cannot speak for themselves. This helped to ensure a smooth transition between services if a person was admitted to hospital.

People's plans of care included an assessment of their eating and drinking needs. Where needed, risk assessments had been completed and regularly reviewed. For example, people at risk of losing weight were weighed monthly and where necessary referrals were made to dieticians or appropriate healthcare professionals. The same was true of people at risk of choking. We saw in one person's records that they had a plan for staff to support them to eat developed by a speech and language therapist (SALT). At this inspection we observed people having lunch and we saw they were supported appropriately.

Good

Is the service caring?

Our findings

Relatives spoke positively about the attitude of staff who they described as 'pleasant' and 'polite'. One relative told us "My relative is treated very well. Staff are very caring and kind." Another relative said, "The care has been good. My relative is well treated." We saw staff attending to people and offering them drinks. Staff sat with people and interacted with them at intervals. We saw staff talking to people in a gentle and respectful manner.

We observed people were dressed appropriately and appeared well cared for. We saw the interactions between staff and people were caring and respectful. People freely walked about without hindrance. Staff understood people's preferences and needs. We spoke with five staff, who had relevant knowledge regarding people's routines, behavioural strategies and their likes and dislikes, which reflected the information included in people's care records.

Relatives spoken with said staff were 'respectful'. A representative of a person receiving care told us, "Staff do knock before entering the service users' bedrooms." We observed staff were always courteous to people. They always bent down to people's eye level or sat next to them during conversations or when assisting with meals. Staff always closed doors when supporting people with personal care. Staff induction covered 'promoting dignity in care in everyday work'. We also noted 'dignity and care' was a recurring theme in all staff meetings and was subject to monthly audits.

The registered manager explained the service had explored a range of methods in order to meet people's communication needs. For example, the 'objects of reference' technique was used to facilitate choice in some cases; sets of objects were used systematically as a means of communication. For example, people were able to choose their preference for morning breakfast by choosing between different containers of cereal. In other cases, gestures or Makaton sign language were used. There were a lot of posters and images around the home to help people to communicate with the staff

People and their relatives were appropriately supported to make decisions about their care. A representative of one person told us, "I am very involved in all aspects of [my relative's] life; hospital appointments, church/social activities, holidays, liaising with day centre and social worker." We observed information was presented to people in ways they could understand; each tailored to their varying needs. Pictures, drawings and symbols were used to support text in order to encourage people to exercise control and choice as they did not need to rely on staff or others to speak for them. HAPs and hospital passports and other tools relevant to people's care were written in accessible and personalised formats, and from the person's point of view, with statements such as, "Things you must know about me", "Things that are important to me" and "My likes and dislikes." We saw this ensured staff were able to understand and respond to the needs of people.

Through person-centred planning, staff understood the need of involving people's relatives or representatives, including relevant professionals in assessments, care planning and reviews. Families and people's representatives were seen as valuable sources of information about the person, with a role to play in care decisions. We saw from people's care records that families and people's representatives were involved in their care. The service had sought the assistance of families, advocates and relevant professionals to support decisions about health care when people did not have the capacity to do so.

Most staff understood and responded to people's religious and cultural needs. People's care records contained documented evidence that arrangements had been made to ensure that their religious and cultural needs were responded to. These included any specific requirements in relation to food and religious observances. For example, we saw people were offered culturally-appropriate meals and were supported to attend local places of worship of their choice. A relative told us, "My relative is respected. My relative is allowed time to pray in privacy. The food offered reflects my relative's needs." Care records showed that people's capacity had been assessed in regards to making specific decisions about their daily lifestyles. For example, decisions about their nutrition, personal care, and medical interventions. People's relatives told us that staff listened to them.

Requires Improvement

Is the service responsive?

Our findings

A relative told us, "The service is responsive. I have made comments before, which have been taken on board." Although we found this to be largely true, the service had failed to respond to the needs of some people. The representative of the person had made two requests; not to serve a halal meal and for the menu to reflect food preference of this person. During this visit we observed this person was being served a halal meal. This was explained to us as having happened because supporting this person's request would have entailed preparation of three meals instead of two. Equally, the menu plan had not been adapted to reflect this person's food preferences. This showed this person's preferences and cultural needs for food were not being met. In another example, a professional raised concerns that behavioural guidelines of another person receiving care were not being implemented effectively. This may have put the person at risk of inconsistent care or not receiving the care and support they needed.

Before people moved to the home, a pre-assessment of their needs was undertaken by the registered manager to determine if the service was suitable to meet their health and social needs. This involved visiting the person to carry out an assessment. Relatives or important others were also invited to participate.

The pre-assessment information was used to develop support plans, which we saw was focused on the person. The support plans, including HAPs and hospital passports focused on what was important to the person; their goals and what support they needed. The registered manager referred a support plan as a 'live' document because it was subject to regular reviews and tailored to changes in needs, choices and preferences of the person. Support plans were regularly reviewed for their effectiveness and kept up to date in recognition of the changing needs of the person using the service. We saw examples of changes to people's care and support in light of their changing needs. For example, in one case one to one support had been reduced owing to improvements in the person's support needs. In another example, frequency of reviews had been reduced due to improvements in the health of a person using the service.

The service was structured around the concepts of TEACCH and PROACT SCIPr. TEACCH is an evidence-based programme for individuals of all ages and skill levels with autism spectrum disorders. It focuses on the person with autism to develop strategies of intervention that centres on the person's skills, interests and needs. For example, as part of TEACCH approach, we observed a picture exchange communication system (PECS) was used as an intervention to improve communication in people with language and communication needs. People were taught to give a picture of a desired item in exchange for the chosen item; a picture of an apple for an apple. We saw this was effective in ensuring people were able to express choice and independence. PROACT SCIPr is a whole approach to working with people with learning disabilities. It aims to support staff to identify triggers and recognise early behavioural indicators, so that non-physical interventions can be used to prevent a crisis from occurring.

The service routinely sought feedback from people who used the service and their relatives, and we saw that this was acted upon. People participated in satisfaction surveys, parent and advocate meetings and review meetings. Feedback from service users was a recurring theme in staff meetings. Where people had raised concerns, this was recorded along with an action plan. In one instance, travel training had been organised for an individual who liked outdoor activities. This showed the service had appropriate systems to support people's views and took appropriate action to ensure their views were responded to.

Relatives informed us that they could talk to the manager or care staff about any concerns or complaints they had. They stated that the manager and staff were responsive and pleasant. The home had a complaints policy and procedure, which was available on display. The policy was available in many formats so that it was accessible to people. Staff we spoke with were aware of action to take when a complaint was received. They stated that they would report it to the manager and record it in the complaints book.

Good

Is the service well-led?

Our findings

There was a registered manager in post. Relatives described the manager as, "excellent" and "caring". Staff we spoke with were knowledgeable regarding their roles and responsibilities and the needs of people who used the service. They were content with management support who they felt able to approach with any concerns, knowing this would be acted on.

Staff were aware of the organisation's vision and values. They told us their role was to promote the rights, independence and choice of people. We observed these values were reflected in practice through implementation of such programmes as TEACCH and PRACT SCIPr. TEACCH and SCIPr focused on the person receiving support and ensured any plan of support was developed around this person's skills, interests and needs. We observed that staff went about their work calmly and people co-operated well with them. They had a good understanding of the needs of people and how to care for them. The manager had taken appropriate action in one instance we had indicated these values were not evident.

The provider conducted a number of meetings and surveys to gather feedback from people and their relatives. The results of a recent satisfaction survey indicated that some people and relatives were satisfied with the services provided and had described aspects of the service as "very good." The service had taken action to improve laundry services and food choices in response to our feedback.

There was a quality monitoring system in place. A senior compliance officer from the provider visited the service once every month. The service was assessed for compliance on nutrition, involvement, team meetings, choice, activities, complaints and health and safety, among other areas. Evidence from the audits showed where gaps were identified, this always led to improvements. The audit assigned ratings on a three tier scale of gold, silver and bronze; gold indicating compliance with all standards. In months where silver and bronze were assigned, the service had taken steps to make improvements. For example, the manager had ensured repairs to furniture and relevant parts of the building were completed in response to quality monitoring.

The provider worked in partnership with other services. A GP practice that supported people who used the service commented on the good relationship they had with the provider. They told us that staff were very proactive and always communicated when there were problems, queries or changes. A professional from a local community learning disability team told us, the provider provided appropriate information to support relevant reviews. The provider was commended for implementing recommendations from health professionals who were involved in the care of people.

The provider had links with other national bodies which represent the needs of people with learning disabilities such as the British Institute for Learning Disabilities (BILD), Epilepsy Society and National Autistic Society (NAS). The service subscribed to relevant publications for training purposes. Relevant topics from such publications had been discussed as evidenced from minutes of staff meeting. These included dyspraxia, a condition which affects gross and fine motor skills, health checks and diabetes type 1 and type 2 medications; all relevant to some people receiving care.

The provider participated in a number of schemes aimed at improving the quality of service and staff development. The service contributed to Skills for Care's National Minimum Dataset for Social Care, (NMDS-SC), Social Care Commitment and South West London Workforce Development Network, Skills for Care (LWDN-SC). Cited benefits included access to information sharing with other local providers, access to staff training, and other workforce development initiatives.