The Regard Partnership Limited

Adrian Lodge

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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 15 March 2016 and was unannounced. At our previous inspection in May 2014, we found the provider was meeting the regulations in relation to all the outcomes we inspected.

Adrian Lodge provides accommodation and residential care for 10 people living with mental health issues. At the time of our inspection the home was providing support to 10 people. The home had a registered manager in post. 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.

There were systems in place to protect people from abuse, staff had received appropriate support and training which enabled them to identify the possibility of abuse and take appropriate actions to report and escalate concerns. Risks were assessed and managed appropriately through the use of detailed risk assessments.

There were systems in place to monitor the safety of the environment and equipment used within the home minimising risks to people. There were arrangements in place to deal with emergencies.

There were safe staff recruitment practices in place and appropriate recruitment checks were conducted before staff started work ensuring people were supported by staff that were suitable for their role. There was enough staff on duty to meet the needs of the people living at the home.

Medicines were managed, stored and administered safely by trained and competent staff.

There were processes in place to ensure new staff were trained appropriately and staff received regular training, supervision and annual appraisals. Staff gained consent for the support they offered people. The registered manager and staff were able to demonstrate their understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards legislation.

People were supported to maintain good health and had access to a range of health and social care professionals when required. People's nutritional needs and preferences were met.

Staff had a good understanding of the needs of the people and how they liked to be supported. Staff spoke with and treated people in a respectful and caring manner and interactions between people, their relatives and staff were relaxed and friendly. Staff respected people's privacy and dignity. People and their relatives told us they were made welcome in the home.

People received care and treatment in accordance with their identified needs and wishes. Care plans documented information about people's personal history, choices and preferences and preferred activities.

There was information on how to make a complaint was on display on the notice board for people living at the home. People knew how to complain and felt that when they did that their concern was taken seriously.

People and their relatives felt that the atmosphere in the home was open, friendly and welcoming and that the registered manager and staff were approachable.

There were systems and processes in place to monitor and evaluate the quality of the service provided. The management of the home's records were maintained to a good standard. The records that we inspected were clear and easily accessible for staff to use.

The service had a positive culture that promoted independence and was responsive to peoples changing needs.

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.

Regular assessments and staff knowledge reduced the risks to people.

Medicines were stored and administered safely.

There were enough staff to keep people safe.

Is the service effective?

Good

The service was effective.

Staff had the skills, training and knowledge to offer effective support to people.

Staff members understood the implications of the Mental Capacity Act 2005 and sought consent from people prior to care or treatment.

Staff liaised with community based health care professionals to make sure people's care and treatment needs were met.

Is the service caring?

Good

The service is caring.

People were treated with dignity and respect.

People were supported by compassionate, kind and positive staff.

Staff were aware of people's individual needs, backgrounds and personalities.

Is the service responsive?

Good

The service was responsive.

People's care plans contained an appropriate level of detail to enable staff to understand their needs.

People's care plans were reviewed as their needs changed.

The provider had a system in place for handling and responding to complaints.

Is the service well-led?

Good

The service was well led.

The service had a registered manager in post.

The atmosphere in the home was open friendly and welcoming. The registered manager and staff were approachable.

Regular audits were carried out to identify any areas for improvement.

Adrian Lodge

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 15 March 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection, the provider completed 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. We reviewed this and also the information available to us about the home, such as the notifications they sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with four people using the service and two members of staff, as well as the registered manager and the provider's locality manager. We also spoke to one relation of a person living at the home. We observed interactions between people and staff around the service. We looked at records for three people using the service, including care plans, medicine administration records, health care records and risk assessments. We also looked at records in relation to the running of the home which included three staff files containing training and induction records and recruitment information as well as audits, surveys and minutes of meetings.

Good

Is the service safe?

Our findings

People using the service told us they felt safe. One person said, "I'm safe here, I like the lock on my bedroom door." Another person told us, "Staff make sure that I am safe."

Staff received training in safeguarding and understood how to keep people using the service safe. One member of staff said, "We do everything we possibly can to keep people safe. If I thought that someone vulnerable was being taken advantage of, I would go straight to [registered manager]." Staff were able to tell us who they would contact if they felt people were at risk of harm and could describe the whistleblowing policy which was in place to help staff report suspected abuse anonymously. A member of staff we spoke with told us, "I would go to the local authority safeguarding team if I had any whistleblowing concerns."

We saw that information to help people raise concerns was displayed in the home. Local authority safeguarding team contact details were displayed. The registered manager told us that they organised a quiz at house meetings so that people can update their knowledge and be aware of their rights. This included how to keep safe and local safeguarding procedures, fire safety and infection control. Information was displayed identifying 'who could help you if you are concerned', which listed contact details for the registered manager, the locality manager, and the Care Quality Commission, (CQC).

Risk assessments were detailed and contained enough information to help staff to support people to keep safe, and were incorporated into people's care plans. We saw that for one person, risk assessments had been co-written with their community mental health nurse. This had created a vulnerability risk analysis that reflected that the person's level of support needs could fluctuate depending on their current state of health. This meant that the person was supported to take risks to retain their independence, whilst any known hazards were minimised to prevent harm. Each person living at the home had a risk profile regarding their behaviour that was reviewed by the registered manager and locality manager every three months.

There was a policy in place for dealing with accidents and incidents which included the information needed so that any issues affecting people's safety would be investigated and reported to the relevant authorities where necessary. We saw that accidents were logged locally, then submitted to the provider's central database where the incident was reviewed by the locality manager. This meant that the provider had oversight of any incidents that occurred and could ensure that these were being managed appropriately.

During our visit we saw records of health and safety audits that were completed monthly to assess the safety of the environment and premises, and identify any areas where there might have been a risk to people's safety. A weekly health and safety checklist was completed, which included water temperature checks and fire detection equipment. Fire evacuation drills were completed every month and fire prevention doors checked every night. The registered manager told us that the providers' health and safety manager visited every three months. This meant that the service and provider had a proactive approach to monitoring and assessing risks within the environment.

People told us that there were enough staff to keep them safe. One person said, "There are staff when I need

them." The registered manager told us that the provider had three services in the locality that shared a bank of staff that could be called upon, and that if required they or the deputy manager would provide direct support. We reviewed rotas for the past two months and found that there was always enough staff available to meet people's needs, we saw that working times included 15 minutes of handover time at the beginning and end of each shift to ensure key information was shared. This meant that people were supported by the right amount of staff to enable them to access the community or live as independently as possible in the home safely. For example, we observed people being supported to cook meals in the kitchen with staff who helped with dangerous items such as knives or pans of hot water when required.

Staff were recruited safely to work in the service. We looked at records relating to three members of staff. Files contained references from former employers, health questionnaires and completed application forms. Interviews assessed the person's skills and experience to ensure they were of appropriate character to undertake the role. Staff had completed Disclosure and Barring Service (police check) checks on file and these were renewed every three years to ensure that staff remained suitable to work with people who lived at the home.

People's medicines were managed and administered safely. Information relating to people's medicines and the reasons they were administered were included within people's care plans. This included details of medicines prescribed on an 'as and when' basis, which were prescribed for specific reasons and therefore were administered under certain circumstances. We saw that one person managed their own medicines and was provided with a lockable safe in their bedroom to store this in. The other people living in the home had their medicines stored in a designated room, which also had the facilities so that people could take their medicines in private.

Each person living in the home had their medicines stored in trays that had their photograph on so that they could be identified as the right person to staff who were not familiar with them. One person told us, "Staff manage my medicines for me, but each month I go and collect them from the pharmacy." This meant that people's individual needs and wishes were taken in to account whilst ensuring people were kept safe.

We saw records of daily checks of medicine records and that medication administration records (MAR) were completed appropriately with no gaps in recording. The registered manager also undertook a monthly audit of medicines and records, and the supplying pharmacist had completed an audit in December 2015 and found that there were no issues. The home's procedure for the administration of medicines was located at the front of the file containing the MAR charts as well as blank copies of the homes medication administration error reporting forms. We saw that one medicine presented a risk to anyone other than the person taking it handling it without protective gloves. This was clearly identified as such, and a protocol had been put in place so that the person taking it removed the medicine from the packet themselves.

Good

Is the service effective?

Our findings

We looked at the homes training and supervision matrix and saw that all staff completed mandatory training in fire safety, safeguarding, health and safety, infection control and first aid. The home had also identified other training essential to the role, which included record keeping, diet and nutrition, administration of medicines, de-escalation techniques, conflict resolution and understanding mental health. All staff completed a comprehensive induction process which included shadowing experienced members of staff and spending time talking to people living at the home as well as reading people's care plans. The registered manager told us that all staff had completed or were working towards the Level 3 diploma in health and social care.

The registered manager told us that staff and people who used the service could access the provider's positive behaviour support service. This service provided training to staff in de-escalation techniques and direct support to people living at the home in self-help techniques for managing behaviour. The registered manager told us that recent direct input from this service had resulted in a person living at the home being able to proactively manage periods of anxiety and saw that this led to a reduction in behaviour that challenges others.

Staff we spoke with felt that they had the training and skills they needed to meet people's needs and were supported to refresh their training. Staff told us that they were confident that the skills they had gained enabled them to support people manage their behaviour if required.

Staff received regular supervisions with the registered manager. These alternated between a 1:1 session and a group session. One member of staff told us, "[Registered Manager] always asks us what training and development we think we need in supervision and does her best to get this for us." Each member of staff also received an annual appraisal of their performance. Staff told us that they felt well supported by the registered manager.

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 are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff demonstrated a good understanding of the MCA and DoLS. They told us that all of the people living in the home had capacity to make decisions about their own care and treatment, other than where people needed support to manage their medicines. We saw that people who needed their medicines managed for them, had a MCA assessment completed or had consented to medicines being

managed on their behalf. At the time of our visit, no one living at the home required a DoLS application to be made. We saw records that showed us that staff had completed training sessions and a quiz on the MCA as part of their development. The home's staff induction programme also covered an introduction to the MCA and DoLS.

People had signed their care plans to indicate that they gave consent to receiving care from the service. One person told us, "I have seen my care plan, I have my own copy of it in my room. I was asked if I agreed with what's in it, and asked to sign it, but I didn't have to if I was unhappy with it."

Where individual agreements were in place that might have required consent, we saw that these had been discussed with people and that all agreements were signed by the person. For example, where one person needed support with the management of their finances, they had been asked to sign to state that they were happy with this arrangement, and that it would be reviewed periodically.

People's dietary needs were met by the service. One person told us, "The food is brilliant, too good, you can eat wherever you like, staff do my cooking and I join in when I want too. They are trying to help me learn cooking skills for living in the community." We observed a person living at the home making a meal, they told us, "I enjoy cooking, I cook for other people every other day, staff help me with the preparation, I tell them what to do." We saw that people could choose to eat on their own or as part of a group, and that mealtimes were flexible to fit around people's daily activities. Fresh fruit was available around the home, and people using the service were able to access the kitchen to make hot or cold drinks. We observed that one person with limited mobility was regularly offered drinks by staff as they were unable to prepare drinks for themselves. We looked at menu forms for the service and found that people ate a varied and balanced range of foods and had enough to eat and drink throughout the day.

The service had identified when people were due for healthcare appointments and kept records of the outcomes of each appointment. Each person living at the home had 'personal daily outcomes' of what they wished to achieve in order to stay healthy. This included on going monitoring and support to ensure people stayed healthy which was discussed during key worker meetings. We saw from records that people's healthcare needs were discussed with them during the meetings, and people received support and encouragement to maintain or improve their health. A person visiting their relative at the service told us, "They [relative] like living here, I can see that his health is improving since moving here."

Good

Is the service caring?

Our findings

People were positive about the care and support they received living at the home. One person told us, "This is the most relaxed I have been in my life, staff will do everything they can to help, lovely they are." They also said, "The staff are the most polite I have had supporting me, they are very gentle towards you." Another person told us, "Staff are great here, they help me with any concerns I have, I like it because it's peaceful and calming, staff respect me, I was involved in writing my care plan." A relative who was visiting the service told us, "I can see that (relative) is really happy here."

All the people we spoke with told us they knew and understood what was in their care plans and had been involved in the planning and review of their care. One person said, "Staff wrote my care plan for me, I wouldn't want to write it, but I agree with what they wrote."

The nature of the service was to allow people to live as independently as possible, the registered manager told us, "People are independent, staffing is for promoting and prompting independence."

We observed interactions between staff and people and found that these were positive and respectful, people living at the home appeared comfortable talking to staff and we saw that people were regularly engaged in relaxed conversation. Staff were able to tell us about people's backgrounds and what was important to them, such as hobbies and preferred activities.

People had monthly key worker sessions if they wanted them. They were able to set their own agenda for the meeting, and discuss what was important for them. The records we looked at showed that one person had said that they felt cold in the building at times We saw that this issue was discussed at a group meeting and linked to feedback from a recent survey. As a result of this the thermostat temperature in the home was adjusted, and a notice displayed with the title, 'You asked, so we did…' informing people that the issue had been addressed and action taken.

People were treated with dignity and respect. One person told us, "I am a religious person, in places I have lived before, nobody has respected this, they do respect your religion here." People told us that they liked having their own key to their bedroom, as well as a front and back door key as it gave them the privacy they wanted. We saw that the home had a charter of people's rights. This included statements that people were free to choose what time they got up or went to bed, that people would be treated with dignity and respect, and that the home would ensure that people's privacy would be maintained. This document also detailed that people could expect confidentiality at all times, and how the service would strive to ensure this. The home provided people with details about how their post would be kept secure, and how to access support to discuss the content of their post.

We saw staff gave people time and space to do the things that they wanted and to make their own choices. Some people preferred to spend time in their own rooms and this was respected, we observed that staff always knocked on people's doors and waited for the door to be answered. Information about people that we looked at was kept confidential and secure.

House meetings took place every other week, this had been a recent change in response to people's feedback when the meeting had previously taken place on a weekly basis. Attendance was voluntary and around half the people at the home attended. The registered manager attended these meetings by invitation, as did the locality manager. Feedback from these meetings were incorporated into the homes development plan.

We saw that records at the home were up to date, relevant and personalised. Daily notes were respectfully and professionally written. We observed the team handover from the morning to the afternoon and evening team. The registered manager ensured that any discussions about a person living at the home were conducted with privacy and dignity, referring people to the daily notes to read sensitive details rather than discussing them openly in a group.

Good

Is the service responsive?

Our findings

People we spoke with felt that the staff had the skills and knowledge required to provide them with the support they needed. One person told us, "My goal is working towards moving back to my home community when I am well enough, staff have been helping me to do this and know how to support me."

We saw that one person had told their key worker that they wanted to increase the amount of times they took a shower as a target for improving their self-help skills, but found that the shower was difficult to access. As a result of this, the home had arranged for their bathroom to be adapted to make the shower more accessible.

Details of people's likes and dislikes were included and ways in which they could be encouraged to develop and maintain their hobbies. For example, one person told us that they enjoyed metal detecting, particularly when they could do this with their relation. Staff told us that they helped the person arrange times and dates to meet their relation, and how the person could get there using public transport. Another person told us that it was important that they get to the gym at least twice a week, and that staff had helped them in organising this. The registered manager told us one person enjoyed making models, but because they did not have finances to purchase the materials, they used some of the homes activity budget to purchase them so that they could continue to do this.

The records we reviewed contained comprehensive information about the person. Each person had a pen portrait completed which highlighted their preferences, their background and what was important to them. People told us that they could contribute to the content of their care plan if they wished, and some people had their own copies. We saw that care plans identified people's abilities in a section titled 'what I am good at' as well as detailing their support needs. Care plans had been signed by staff to say that they had read and understood them. When we spoke with staff about people's care plans, they were able to tell us what was in them and that they were informed when the plan had been updated. We observed that staff supported people in accordance with what information was detailed in their care plan. Where people had a local authority care plan, this was referenced in the homes care plan so that information was consistent.

People living in the home had details of their support network identified in the care plan. People had signed to say that they agreed that they were happy with this network and had been given a copy of the contact details. People told us that they were given their own copy of notes taken at reviews or meetings.

There was a complaints policy in place that listed ways in which people could complain. These details were also displayed on the door of the office in the home and included details of how to complain to the provider, the local authority and the Care Quality Commission. One person told us, "If you want to complain, knock on the office door and they will give you a complaint form." Another person told us, "I would talk to [registered manager] if I was not happy about anything, but I have never had to complain." The registered manager told us that people were able to raise complaints as a group if they wished to, and that usually these were discussed at house meetings. They also told us that formal complaints were acknowledged on the day of receiving them, and that every complainant received written feedback. We saw examples of these in the

homes records. Complaints were logged electronically on receipt, and all complaints were reviewed and required 'sign off' from the locality manager. People told us that they could have consultations with the locality manager who visited the home at least every two weeks.

Good

Is the service well-led?

Our findings

People we spoke with were positive about the registered manager. One person told us, "They are very approachable, they are very kind." A member of staff we spoke with told us, "I am well supported by [registered manager], people who live here are very comfortable around her." Staff told us that they had confidence in the management and leadership of the home and that the manager operated, "An open door policy." We observed that the registered manager had a good relationship with the people living at the home who responded to them very positively. People and staff told us that the home always felt welcoming and had a friendly atmosphere, they said that they felt relaxed living at the home.

The registered manager told us it was essential that proper planning went into ensuring that any new people moving into the home could fit in to the existing quiet culture of the home. We saw that the manager had strong relationships with people who lived at the home and spent time talking to people as they came and went during our visit. The registered manager was able to describe to us how learning and feedback from people living at the service was fed into the services development plan.

The registered manager provided us with documents that had been developed to measure the services performance against the CQC's five key questions when these were introduced in 2014. They told us that this was to enable them to ensure that the home was able to meet the new regulations that came in to force and to identify and address and areas for development.

Quality assurance systems were in place to monitor the quality of care and support that people received. The registered manager completed a monthly quality check of the home that was returned to the provider. The locality manager then completed a follow up check of actions identified and a spot check of areas deemed to be compliant. The provider's quality manager completed an audit of the home on a quarterly basis, and during this reviewed competed actions.

Surveys were sent to people on a quarterly basis, themes from surveys were shared with people at house meetings, and actions arising from these also displayed on noticed boards in the home. The registered manager told us that themes arising from surveys and audits were shared with colleagues at regional meetings where appropriate so that organisational learning could take place.

The registered manager said that they had regular team meetings every month, at which keyworkers updated the rest of the team of any changes to people's needs. We saw minutes from the last three team meetings, we could see that these were well attended, and saw that the agenda covered standing items, for example safeguarding and health and safety.

The registered manager and team leader told us that they had regular training and development sessions along with other managers working for the same provider and that the organisation promoted a strong ethos of high standards. The registered manager told us that she had regular communication with the locality manager.

The home had a whistle blowing policy, staff told us that they knew how to whistle blow and that they had received training in the importance of this. Staff records detailed how this was discussed, and that staff were told that they could contact the Care Quality Commission if they needed to.