Swanton Care & Community (Autism North) Limited

Murton Grange

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

Overall summary

This inspection took place on 16 and 17 November 2015 and was unannounced. This meant the staff and provider did not know we would be visiting.

Murton Grange provides care and accommodation for up to 10 people with a learning disability, autistic spectrum disorder, and associated complex needs. On the day of our inspection there were seven people using the service.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Murton Grange was last inspected by CQC on 2 September 2013 and was compliant.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Summary of findings

Accidents and incidents were recorded and investigated, and analysis was carried out to identify any trends.

People were protected against the risks associated with the unsafe use and management of medicines.

Staff received regular training and any gaps in refresher training had been identified and planned.

Staff received regular supervisions and appraisals. Appraisals that hadn't taken place during 2015 were planned.

The home was clean, spacious and suitable for the people who used the service.

People were protected from the risk of poor nutrition.

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).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider was working within the principles of the MCA.

Family members, were complimentary about the standard of care at Murton Grange.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records showed that people's needs were assessed before they moved into Murton Grange and support plans were written in a person centred way.

We saw that the home had a full programme of activities in place for people who used the service.

The provider had an effective complaints procedure in place. People who used the service, and family members, knew how to make a complaint.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

The service had links with the community and other organisations.

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?
The service was safe.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were recorded and investigated, and analysis was carried out to identify any trends.

People were protected against the risks associated with the unsafe use and management of medicines.

Good

Is the service effective?
The service was effective.

Staff received regular training and any gaps in refresher training had been identified and planned.

Staff received regular supervisions and appraisals. Appraisals that hadn't taken place during 2015 were planned.

People were protected from the risk of poor nutrition.

The provider was working within the principles of the MCA.

Good

Is the service caring?
The service was caring.

Staff treated people with dignity and respect and talked with people in a polite and respectful manner.

People were encouraged to be independent and care for themselves where possible.

People had been involved in writing their care plans and their wishes were taken into consideration.

Good

Is the service responsive?
The service was responsive.

Care records showed that people's needs were assessed before they moved into Murton Grange and support plans were written in a person centred way.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints procedure in place. People who used the service, and family members, knew how to make a complaint.

Good

Is the service well-led?
The service was well led.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Good

Summary of findings

Staff told us the registered manager was approachable and they felt supported in their role.

The service had links with the community and other organisations.

Murton Grange

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 16 and 17 November 2015 and was unannounced. This meant the staff and provider did not know we would be visiting. One Adult Social Care inspector took part in this inspection.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. No concerns were raised by any of these professionals.

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.

During our inspection we spoke with one person who used the service and three family members. We also spoke with the registered manager, deputy manager and three care staff.

We looked at the personal care or treatment records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Good

Is the service safe?

Our findings

Family members we spoke with told us they thought their relatives were safe at Murton Grange. They told us, “Of course he’s safe”, “There have never been any safety issues” and “Yes, definitely. We don’t have any issues”.

We looked at the recruitment records for three members of staff and saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We discussed staffing with the registered manager and looked at the roster. We saw there were between eight and 10 staff, including senior staff, on duty during the day and three on night shift. The registered manager told us staff absences and vacancies were usually covered by their own staff however they also had the option of using staff from other homes belonging to the provider. The registered manager told us agency staff were not used at Murton Grange. We observed sufficient numbers of staff on duty and staff we spoke with did not raise any concerns about staffing levels.

We saw that entry to the premises was via a locked door and all visitors were required to sign in. The home had three floors and was set in its own grounds. We saw window restrictors were fitted on the windows of the rooms we looked in and the home was clean and suitable for the people who used the service.

We saw hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014.

Equipment was in place to meet people’s needs and we saw evidence that where required equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. Risks to people’s safety in the event of a fire had been identified and managed, for example, fire extinguisher checks were up to date and there had been a recent fire inspection of the service.

We saw Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service and included the person’s name, room number, mobility, method of evacuation and number of staff required.

This meant that checks were carried out to ensure that people who used the service were in a safe environment.

Each person who used the service had a ‘Keeping safe’ booklet, which was in an easy to read format and described abuse and how to get help if they believed they were a victim of abuse or bullying.

We saw accident and incident records, which included details of the accident or incident, where and when it took place and who was involved. Details of what action had been taken following an accident or incident was recorded and we saw for one incident, where a person had a seizure, the ambulance was called and the person’s GP was contacted. It was documented that the ambulance crew and GP were happy with the actions taken by staff and were happy for the person to remain at Murton Grange. We saw all accidents and incidents were recorded on the provider’s electronic system. Analysis was carried out by the provider to identify any trends or issues and emails sent to the home if anything required following up.

We saw a ‘Crisis plan’ for one of the people who used the service. This described low and high risk behaviours, what staff should look out for and how they should deal with the behaviour. This described known triggers, potential behaviours if things escalated and staff responses, for example, verbal redirection and a change of stimulus. Staff we spoke with were aware of this plan and actions they should take.

We saw risk plans were in place for people’s finances, safety and self harm. Each risk plan had a risk category, details of

Good

Is the service safe?

the risk and a risk management plan. For example, a risk for safety was the use of restraint. We saw the risk management plan included instructions for staff to follow and to update documentation.

We looked at safeguarding records, which included details of local authority strategy meetings and saw that CQC had been notified of all the incidents. We saw a safeguarding audit had been carried out in October 2015, which had identified that although all staff had been trained in NAPPI (non abusive psychological and physical intervention), some staff had not received their annual referesher training as per the provider's policy. We discussed this with the registered manager who told us the refresher training was planned and that four new members of staff had recently completed their training.

We looked at the management of medicines and saw medicines were stored in a locked cabinet in a locked medicines room. We saw when medicines were taken from the medicines room, two members of staff were in attendance and the administration record was signed by both members of staff. We saw a record was maintained of staff signatures and initals. We saw relevant staff had undertaken medicines awareness and administration training.

We saw daily medicines checks were carried out however due to a discrepancy identified in October 2015, checks were increased to twice daily and carried out by day and night team leaders. These checked whether two signatures were on each record, stock balances, cleanliness, temperatures and controlled drugs. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We saw controlled drugs were stored in a separate locked cabinet. We saw temperature records were up to date and within recommended ranges.

We looked at the 'Medication administration' file and saw a separate section for each person who used the service. For each person who used the service there was an up to date photograph and a record of personal details, including any allergies. There was also a 'My hospital pack' for each person stored in the medicines room and this included a list of medicines the person was taking and important things to know about the person in case of an admission to hospital.

We saw a 'Midazolam handover record', which documented the date and time midazolam was administered, the amount administered, the amount in stock and whether it had been signed out of the building, for example, when a person went to stay with family members. Midazolam is used as a sedative. We saw all the records were signed by two members of staff.

This meant appropriate arrangements were in place for the administration and storage of medicines.

Good

Is the service effective?

Our findings

People who lived at Murton Grange received effective care and support. Family members told us, "They are working very hard to look after him and keep him occupied", "Staff are excellent", "They have some very good staff" and "There are a lot of staff there we rate very highly".

We looked at staff supervision and appraisal records. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. We checked staff files and saw staff had received regular supervisions and had a supervision contract however we saw not all the staff appraisals were up to date. We discussed this with the registered manager and saw the appraisal planner, which showed that appraisals were planned for December for the staff who had not yet received an appraisal in 2015. The registered manager told us a new system had been put in place where all staff now had a named supervisor. This had been delegated to senior staff at Murton Grange.

We looked at training records and saw the training matrix was completed monthly and sent to the provider. Although the majority of the training was up to date, we identified some gaps on the training matrix and discussed these with the registered manager. The registered manager explained that staff had received the training, and we saw records to confirm this, however some of the training had not been refreshed in line with the provider's policy. We saw a copy of the staff training plan on the office wall, which included training in November 2015 for safeguarding, health and safety, first aid, food safety and fire awareness. This meant that training needs had been identified and planned for.

We saw learning and development traing needs analysis had been carried out in October 2015, which identified what training was required for staff to be able to support each person who used the service.

We saw all staff received an induction when starting work at Murton Grange. This included an introduction to the home, the provider's policies and procedures and information on staff roles and responsibilities. The registered manager told us all new staff were now being enrolled on the Care Certificate. The purpose of the Care Certificate is to provide clear evidence to employers and people who receive care and support that the health or social care support worker has been assessed against a specific set of standards and has demonstrated they have the skills, knowledge and behaviours to ensure that they provide compassionate and high quality care and support.

Care records showed that people at risk of under nutrition or eating disorders had been identified and risk plans had been put in place. For example, one person who used the service had dysphagia. We saw the Speech and Language Therapy team (SALT) had been consulted and special measures had been put in place to support the person, such as using specialist eating equipment, cutting food into manageable sized pieces and gravy or sauces used to soften food. We saw this risk plan had been regularly reviewed and was up to date.

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).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We discussed DoLS with the registered manager and saw records of applications for DoLS to the local authority had been made and saw records of communication with the local authority to follow up on applications. This meant the provider was following the requirements in the DoLS.

We saw mental capacity assessments had been completed for people and best interest decisions made for their care and treatment, which documented the people involved in making the decisions such as staff, health professionals and family members. We saw best interest decisions in place for dental services, financial wellbeing, seatbelts, restraint and taking prescribed medicines. We also saw staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Good

Is the service effective?

We saw people who used the service had access to healthcare services and received ongoing healthcare support. Records contained evidence of visits from, and appointments with, external specialists including GPs, speech and language therapists and dentists.

We looked around the home and saw the layout of the building provided adequate space for people to mobilise safely. Each bedroom was large and had en-suite facilities, which were suitable for the people who lived there. Bedrooms were individually decorated and furnished with people's own furniture and personal items.

Good

Is the service caring?

Our findings

Family members we spoke with were complimentary about the standard of care at Murton Grange. They told us, “He seems quite happy”, “We don’t have any problems with the standard of care”, “His health and everything else is well looked after” and “They really do care”.

People we saw were well presented and looked comfortable with staff. We saw staff talking to people in a polite and respectful manner and staff interacted with people at every opportunity. We observed one person who used the service going for a haircut. We saw a member of staff stroke the person’s hair and talk to them in a calm manner.

People’s privacy and dignity was respected and we saw staff knocking and waiting for an answer before entering people’s rooms. We saw staff were given instructions regarding one person who used the service. These were, “Staff to knock on [Name’s] door and wait for [Name] to answer, not walk in. Knock again after a few minutes and if still no response say “May need to come in for safety reasons” to check he is ok.”

We asked family members whether staff respected the dignity and privacy of people who used the service. They told us, “Oh yes, definitely” and “Yes, as much as they can”.

We saw people were assisted by staff in a patient and friendly way. We saw and heard how people had a good rapport with staff. One person who used the service had odd socks on. Staff asked why and the person said, “I need to.” The staff member asked whether the person wanted to change their socks and they said “No.” The staff member said, “Ok, you like being difficult” and they both laughed.

Staff knew how to support people and understood people’s individual needs. All the staff on duty we spoke with were able to describe the individual needs of people who used the service and how they wanted and needed to be supported.

We looked at care records and saw that support plans were in place and included daily living skills, healthcare needs, hobbies and interests, mobility, night time support and nutrition and hydration. These records contained evidence that people had been involved and their wishes were taken into consideration, for example, we saw personal preferences included people’s dietary likes such as, “I like spicy, strong, flavoured foods” and “I enjoy crunchy foods”.

We saw people were supported to be independent, for example, doing their own laundry and setting and clearing the table. One person’s daily living skills support plan described how they liked to go shopping and “Load up the conveyer belt with goods,” The support plan also stated, “I like cooking with one member of staff. I do not mind if it is male or female.” Where people needed a little support with tasks, staff used hand over hand support for some tasks such as preparing breakfast or pouring out drinks. Hand over hand is where a member of staff places their hand on the person’s and helps them complete a task. A staff member told us how some of the people who used the service were being given more responsibility for tasks in the house, for example, domestic work and carrying out health and safety checks. The person showed us their workbook, which included details of the tasks and checks they carried out.

We saw night time support plans showed people had a choice of what they did and what time they went to bed. For example, one person liked to have a bath on a night time before having supper and liked to have their bedroom light turned off at 10.15pm however “Sometimes I will just take myself off to bed and indicate to staff this is what I am doing.” This meant that staff supported people to be independent, people were allowed to make choices and were encouraged to care for themselves where possible.

Good

Is the service responsive?

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated. Family members told us, "I feel they listen to what I say", "They keep his day full as best they can", "They [Staff] take it upon themselves to come up with new ideas" and "They tell you honestly what is going on. We get three calls per week. If there's anything at all in between, like doctor's appointments or incidents, they let us know".

Murton Grange was trialling an electronic care records system called Caresys and was in the process of updating all the care records for people who used the service on the electronic system. We saw admission details were recorded, as well as important personal information such as ethnicity, nationality, religious beliefs, food allergies, medical allergies, dietary likes and dislikes, and height and weight.

We saw daily records were up to date and included information on night time support, nutrition and hydration, personal care, emotional wellbeing, hobbies and interests, communication and daily living skills. The records contained comprehensive information on what the person had done that day, the personal care carried out and what the person had eaten or had to drink. The records also included details of conversations with family members, for example, "Rang [Family member] tonight with an update on how [Name] had been over the last couple of days."

Each person who used the service was set goals to achieve. These included trying new activities, promoting greater independence with shopping, domestic tasks, personal care and travelling on public transport.

We saw care records included risk plans, for example, road safety, epilepsy, safety and seizures and dysphagia and eating. Each risk plan described the risk to the person and described what action staff were to take.

We saw care records were regularly reviewed and were up to date.

Each person had an activity planner, which included an activity timetable. We saw for one person activities included bicycle and go-kart activities, pub visits, cookery, sensory play, swimming, memory books and the cinema.

Daily living skills records provided evidence that people were involved in planning their own activities and activities were person centred. For example, "I enjoy going to the park and play on the slides as well as on the swings", "I like to spend time in my room alone" and "One of my friends sometimes comes with me on the trampoline". A staff member told us that one person liked music and it had been arranged for them and another person who used the service to attend a drop in music session for people with learning disabilities.

We saw one of the people who used the service come back from a swimming session. They told us, "It was mint." The person asked the registered manager whether he could change the time of his swimming session so they could attend when the slides were open. The registered manager told them they would change the person's calendar so they could attend. We discussed activities with staff, who told us there was always plenty to do and that people went out every day to various activies including swimming, discos and the cinema.

This meant the provider had a full programme of activities in place for people who used the service.

Each person had a copy of an easy to read complaints booklet in their care records. This explained what people can complain about and how to make a complaint. We looked at the 'Concerns, complaints and compliments' file and saw no formal complaints had been received. Family members we spoke with told us they did not have any complaints but were aware of how to make a complaint if required. This meant the provider had an effective complaints process in place.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

The service had a positive culture that was person-centred, open and inclusive. Staff we spoke with felt supported by the manager and told us they were comfortable raising any concerns. Family members we spoke with told us, "We have been really happy from the beginning" and "I speak with the manager regularly. She often answers the phone but passes me on to someone who deals with [Name] more". One family member told us they thought management were "A little invisible" however said, "I don't really need to speak to management, the staff know what they are doing".

We saw staff were regularly consulted and kept up to date with information about the home and the provider. We saw a staff meetings calendar on the office wall, which included meetings every month during 2015. We looked at records of staff meetings and saw agenda items included staff responsibilities and specific duties, training and appraisals.

The service had links with the community and other organisations. These included Gateway Wheelers, which is a service that enables people with disabilities to enjoy cycling and creates opportunities for personal development, a disco for people with learning disabilities, swimming and leisure facilities, and local pubs and shops.

We looked at what the provider did to check the quality of the service and to seek people's views about it. We looked at the audit file, which included details of the provider's quality visits, the most recent on 9 September 2015, which was an out of hours visit. This included an audit of the CQC five quality standards and provided an overview of the service based on the observation and questioning of staff, review of documentation and observations of the general environment. We saw that following this out of hours visit, the provider had sent a letter to a member of staff praising their attitude and knowledge during the visit.

We also saw the provider was holding a home manager's meeting at Murton Grange during our visit.

We saw copies of the 'Governance and quality report', which was completed on a monthly basis and submitted to the provider. We looked at a copy of the report from October 2015, which had been completed by the deputy manager. This report was broken down into four sections; stay safe, enjoy and achieve, contribute to my own wellbeing and be part of my chosen community. Records, activities, complaints and incidents were all reviewed by the deputy manager as part of this report.

We saw a copy of the 'Manager's self audit' from November 2015. This looked at the engagement between staff and people who used the service and included observations of interractions and identified any development needs. We also saw the registered manager had delegated responsibility to senior staff for carrying out some checks around the home. These included health and safety, medicines, money, fire, kitchen, activities and night shift cleaning.

Other audits carried out by staff at the home included documentation audits, domestic audits and bedroom audits.

We discussed with the registered manager whether any meetings took place at the home between staff and people who used the service. The registered manager told us they had tried these in the past but they had not been successful due to the individual needs of people who used the service. Instead, they held individual meetings with people to see if they were happy, what they would like to do or buy for the house. These meetings were documented in the daily notes.

We saw a copy of the 'Family and friends survey' from 2015. We saw nine surveys had been sent out and three received. The survey asked questions regarding family members' visits to the home, staff communication, the environment, staffing levels and whether the service meets needs. We saw the majority of responses to the questions were positive. Family members we spoke with told us they had received questionnaires.

This meant that the provider gathered information about the quality of their service from a variety of sources.