Salutem LD BidCo IV Limited

Meade Close

Inspection report

1-2 Meade Close
Urmston
Manchester
Lancashire
M41 5BL

Tel: 01617468313
Website: www.salutemhealthcareltd.com

Date of inspection visit:
01 February 2019

Date of publication:
08 March 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 1 February 2019. We announced the inspection as Meade Close is a small home and we wanted to ensure the registered manager was available.

This was the first inspection since Meade Close was bought by Ambito Care (which is part of the Salutem Group) in April 2018. The staff team at Meade Close, including the registered manager and team leaders, remained the same. The area managers also transferred to the new company. The home, under its previous ownership (Scope), was inspected in June 2016 and was rated as Good in all domains.

Staff members and the registered manager said there had been no change in the support provided for the people living at Meade Close following the change in ownership.

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

Meade Close comprises two separate fully adapted bungalows. Each bungalow could accommodate up to four people with a severe learning disability, some of whom also had physical needs. The staff team work across both bungalows.

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

Meade Close had a registered manager in post. They were supported by two team leaders. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Clear person-centred risk assessments and care plans were in place providing guidance for staff so they could meet people's assessed needs.

People had little (one word) or no verbal communication. Information was available for staff to interpret what people's facial expressions or body language was trying to communicate. From our observations it was clear staff knew the people and their needs well. People seemed relaxed and comfortable with the members of staff. We observed people being treated with dignity and respect during our inspection.

Staff enjoyed working at the service and had the training and support to meet people's needs. Staff had

completed specific training, such as Percutaneous endoscopic gastrostomy (PEG) feeding, the use of suction machines, moving and handling and epilepsy where required.

People received their medication as prescribed. The registered manager said they would introduce records of when thickeners were added to drinks to reduce the risk of choking and have clear protocols for when medicines should be administered that were not routinely given.

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

The service was working within the principles of the Mental Capacity Act. Capacity assessments, best interest decisions and deprivation of liberty safeguard applications were all completed as required.

Staff gave people choices where possible and involved them in the day to day tasks of the home. This ensured people were engaged by staff throughout the day. Each person had an activity planner in place with what they were doing each day. These were personalised for each person. Two relatives said that they thought more activities should be arranged for people living at the service. The registered manager was working with the staff team to plan and record activities, both within the house and when they went out.

People's health, nutritional and dietary needs were being met by the service. Other professionals, for example physiotherapists and speech and the language team (SALT), were involved in supporting people and the service where needed.

The service had been pro-active in arranging a change in one person's PEG feed regime which had meant they had not had any further hospital admissions since this change.

A quality assurance system was in place, with weekly and monthly checks being made for the care plans, people's finances, medicines, mattresses and the environment.

We saw evidence that best interest decisions had been made with one person's family and other professionals to agree on the support they needed at the end of their life.

A complaints policy was in place, although no formal complaints had been made. Relatives and professionals told us that the communication with the service was good and the service was transparent and effective.

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

The home was visibly clean with no malodours. Equipment was maintained in line with national guidelines. People's rooms were personalised with photographs and pictures of their choice. The registered manager planned for the communal areas to be re-decorated, following some leaks of water through the sky-lights.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risk assessments were in place giving staff clear guidance to manage and reduce the identified risks.

People received their medicines as prescribed. The recording of when thickeners were used and clear guidance for when medicines prescribed as when needed were to be introduced.

Staff were safely recruited.

Is the service effective?

Good

The service was effective.

Staff received the training and support through supervisions and team meetings to effectively undertake their role.

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

People were supported to meet their nutritional needs. The service was pro-active in supporting people with their health needs.

Is the service caring?

Good

The service was caring.

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

Individual communication passports were in place providing information about what people's non-verbal communication, such as facial expression, may mean.

People were encouraged to be engaged with staff in tasks around the home.

Is the service responsive?

Good

The service was responsive.

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

Each person had a personal activity planner in place. More emphasis was being placed on activities and engaging people. Some relatives thought more activities were needed.

The service communicated effectively with relatives and professionals and were described as being open and transparent. No formal complaints had been received.

Is the service well-led?

Good

The service was well-led.

A quality assurance system was in place.

Staff said they enjoyed working at the service and felt the management team were supportive and approachable. A member of the management team worked each day, including weekends providing support for the staff team.

Positive feedback had been obtained from relatives, professionals and staff through surveys. A report had been written to summarise the feedback from staff for the area manager.

Meade Close

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 1 February 2019 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and we needed to be sure that they would be in. The inspection was completed by one inspector.

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

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

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

During the inspection we observed people and staff interactions as people living at the service could not verbally communicate with us. We spent time with people in communal areas of the home and observed people's facial expressions when we engaged with them. We spoke with three members of care staff, two team leaders, the registered manager and area manager.

Following the inspection, we also contacted four relatives and two social workers from the community learning disability team.

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

Good

Is the service safe?

Our findings

The risks people may face had been identified and guidelines written for staff to follow to manage these risks. Where appropriate guidelines had been written by external professionals, for example individual moving and handling guidelines had been written by the physiotherapist.

Staff were knowledgeable about people's needs and the support people required to keep them safe. The local authority commissioner and the community learning disability team (CLDT) told us they had no concerns about the safety of the people living at Meade Close.

Staff explained the procedures in place for reporting any incidents or accidents. They said they would report any concerns they had to the registered manager or team leaders and were confident that they would address any issues raised. The registered manager discussed how they had internally reported and looked into five potential issues during the last 12 months and liaised with commissioners and other parties so that they had been resolved. A social worker from the CLDT commented, "Any issues or cause for concerns are reported and discussed in a timeframe that we would expect from a provider" and "We have a transparent and effective working relationship with the service."

People living at Meade Close required support to manage their finances. Records were kept of all monies and the balances checked daily. One team leader audited all monies and bank statements each month. This safeguarded people from financial abuse.

Any incidents were recorded on a central computer system, which the group quality manager would review with the registered manager. The provider also had a central safeguarding team to follow up if any safeguarding issues were raised.

A new computer based recording system was being introduced so all information about an incident could be directly put into the database so managers could access and review what had happened and the action taken following the incident.

The home had consistent staffing levels across the two bungalows. Agency staff weren't used, with the staff team covering where required. The team leaders and registered manager were in addition to the support staff rota and so were able to cover if required, for example short notice sickness. The service was in the process of recruiting more bank staff who could cover for any staff annual leave. Previous bank staff had become part of the regular staff team when a vacancy had arisen. The register manager or a team leader were on call outside of their shifts.

One staff member we spoke with said, "We usually get cover. If we don't whoever is on call will come in. [Team leader name] will work a shift if required" and another said, "We're sometimes left a bit short but it's got better now. Sometimes [team leader name] will step in and we help each other across the two bungalows."

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

People received their medicines as prescribed. Each person had a medicines cabinet in their own bedroom. Staff told us they found this helpful as each person's medicines were kept separate. Medicine administration records (MARs) had been fully completed.

Where people were prescribed medicines that were not routinely required (PRN), for example for pain relief, staff were able to describe how they would know that the person required the medicine, for example through people's facial expression or sounds they made. However; there were no written protocols in place to ensure staff followed a consistent approach.

Some people were prescribed thickeners to be added to their drinks to reduce the risk of choking. Staff knew how much thickener to add to people's drinks however they did not record when they had done so.

We discussed this with the registered manager who said they would implement a record for thickeners and guidelines for when PRN medicines should be administered.

Staff who administered medicines had completed training, including a competency check and an observation by the team leaders. A monthly medicines audit was completed and any discrepancies found investigated.

The home was visibly clean throughout, with no malodours present. Personal protective equipment (PPE) was available for staff when supporting people with personal care tasks.

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

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

Good

Is the service effective?

Our findings

Staff received the training and support they needed to carry out their role and meet people's identified needs. Specific training had been completed where required, for example Percutaneous endoscopic gastrostomy (PEG) feeding, the use of suction machines, moving and handling and epilepsy.

The provider had introduced on line training to supplement the taught courses. One member of staff said, "I feel that I've got enough training, if I'm unsure about anything I just ask."

New staff had an induction period, where they shadowed experienced staff to get to know people and their needs. Staff that were new to working in care were enrolled onto the care certificate, which is a nationally recognised set of principles that all care staff should follow in their working lives.

Staff had regular 1:1 supervision meetings with one of the team leaders. Staff were positive about these meetings saying, "They make sure I'm on top of everything and if there is any help or support I need" and "They're useful. We speak about my progression and gives me something to focus on."

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

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

The service was meeting the principles of the MCA. Capacity assessments and best interest decision meetings were seen in people's care files. Applications for DoLS had been made where it had been assessed that people lacked capacity to consent to their care and treatment. The registered manager and team leaders explained how best interest meetings had been held in regard to people's finances, healthcare and their ongoing care and support.

People's nutritional needs were being met by the service. Clear guidelines were in place detailing the support people needed with their nutritional needs, including the PEG feed regimes to be followed. The speech and language team (SALT) had written guidelines for people who were at risk of choking, including the consistency of the food and the position people needed to be in to reduce the risk of aspiration. One relative said, "The staff are really good with [name], especially with eating as she has dysphagia (swallowing difficulties)."

On person had different support needs for eating depending on whether they were having a 'good' or 'bad' day with their coughing. Staff could explain how they recognised if it was a bad day and what they then had

to do to support this person with their food.

One person required their food to be pureed. The service bought pre-pureed meals from a reputable supplier to meet this need.

People were supported to maintain their health. Each person was registered with a local GP and referrals were also made to other health professionals, for example, physiotherapy and speech and language team (SALT) as required. People were supported to attend hospital appointments.

Each person had a hospital passport in place, although not all had been dated. This provided key information about a person's needs for hospital staff in the event the person needed to be admitted to hospital.

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

The service had been pro-active when one person had repeated hospital admissions. The registered manager and staff team identified the possible cause and had liaised with the medical professionals to change the PEG feed regime. The person had not needed a hospital admission since this change had been made.

Some people living at the service used wheelchairs. Care plans were in place to support them with pressure area care. No one living at the service had any skin viability issues at the time of our inspection. We saw there had been some concerns for one person who had worn a support around their waist which seemed to cause them discomfort and resulted in them having red skin. The registered manager had sought medical advice and the person's needs had been re-assessed by a physiotherapist. The result was that the support around the waist was no longer used, which had reduced the risk of the person having issues with their skin.

The two bungalows were fully adapted to meet the physical needs of the people living there. Each bungalow had an adaptive bath and shower trolley. Rooms had built in track hoists. The registered manager told us some redecoration of the communal areas was planned as water had leaked in through the sky-lights.

Good

Is the service caring?

Our findings

Our observations showed staff had formed positive relationships with the people living at Meade Close. Staff knew people and their needs well and could describe their individual needs and support.

We spent time with people in the communal areas of the bungalows and people looked relaxed and content with the staff team. One person was able to respond with a thumbs up and a smile when we asked if they liked living at Meade Close.

People living at the service had little (single word) or no verbal communication. We observed staff interacting with people throughout our inspection and engaging them in what they were doing, for example making the breakfast. Staff gave people day to day choices in a way that people could be involved, for example one person was able to indicate yes when they wanted something. We heard a member of staff go through different options for breakfast with this person and made them the option they had indicated they wanted.

Each person had a communication passport and information about what their facial expressions or noise they made could mean. Staff explained how they knew what people wanted and how sometimes this needed to be a process of elimination to establish what this was.

Care plans included details about people's family, what was important to them, the things they liked to do and any preferences they may have. For example, one person preferred female staff to support them.

Staff spoke with people in a respectful way. Staff were aware how to maintain people's privacy and dignity when providing support and supported people discretely when they may need personal care.

There was equality of opportunity at Meade Close and people were treated equally regardless of their age, gender, disability, religion/belief or race. People's protected characteristics (such as age, gender, religion and disabilities) were established from the outset and appropriate support measures were in place. The service had celebrated the Chinese New Year to meet the cultural needs of one person living at Meade Close.

Staff explained how they encouraged people to be involved, as much as they were able, in the day to day routines of the service. For example, people were present in the kitchen engaging with staff when they were preparing meals or helped carry their clothes form the laundry. One member of staff said, "[Name] will walk with you and put the towels on the rack. It gives her some independence. I picked this up from the other staff when I started."

The registered manager told us they had emphasised this philosophy of engaging people in the day to day activities with the staff team. The daily logs and activity sheets showed that people were regularly encouraged to take part by staff in these day to day tasks.

One relative said, "[name] speaks better than they did at home; he's found some independence."

People's rooms had been personalised with photographs and ornaments that people and their family had chosen. Most families were involved in their relatives care and support and were able to visit whenever they wanted to. One person did not have much contact with their family. The service had made a referral to the Trafford Centre for Independent Living, which provides advocacy services. An advocate is an independent person who ensures any decisions taken on a person's behalf are in their best interests.

Good

Is the service responsive?

Our findings

Care plans were person-centred and gave guidance for staff on how to meet people's identified needs. This included people's daily routines and the support they needed, for example with personal care, sleeping and the activities they liked to do.

These were reviewed each month by one of the team leaders and then by the registered manager at least every quarter. Review meetings were held with families and other professionals. Minutes of these showed that where families had raised any questions actions had been put in place to address these.

When new people were due to move to the service their needs were assessed to ensure the service was able to support them. A transition plan was also put in place. Prior to one person moving to the service we saw records of home visits made to the family home to discuss and assess the person's needs. The person made a series of visits to Meade Close so they knew the staff and other people living at the service before they moved in. Members of staff had also visited the family home to observe the person's morning routine, including how the person was supported with their hoist. This enabled the staff to get to know the person, the support they needed and how they communicated before they moved in.

Each person had two designated staff members as their key worker. Each month they reviewed what the person had done and if there were any concerns. A team leader also reviewed if there had been any changes in their needs and any medical appointments they had attended.

Each person had a personalised weekly activities planner in place. People's needs in this area varied greatly as there was a range in ages for the people living at Meade Close. The activity planner reflected this and some people went out to the cinema or local football matches, whilst others would be supported to local shops and cafes or art and craft activities in the house. Where it was part of a person's plan they attended college or a day centre.

However, feedback from two of the relatives we spoke with was that there were not enough activities available for people to be involved in. One said, "They (the service) could do more to keep [name] busy; they're in the house a lot" and another told us, "The activities are more ad-hoc now than they used to be."

People were supported to go on a holiday of their choice, although one relative said their relative had not gone on holiday last year. One person was due to go to Blackpool for a few days and had visited Llandudno last year. We were told external entertainers also visited Meade Close, and people's families were invited on these occasions.

We discussed this with the registered manager who was aware that more emphasis was needed for activities. The registered manager was promoting in house activities as well as going out, for example reading with people. As mentioned previously in this report, staff also encouraged people to be engaged in day to day tasks in their home, for example putting towels away or being with staff when meals were being prepared so they could smell the food cooking. This helped maintain people's skills as well as staff engaging

with people throughout the day.

A social worker from the community learning disability team had also discussed with the registered manager about the planning and recording of activities both within and outside of the house.

We saw the service provided some information, for example the complaints policy, in an easy read format so that the information was more accessible to people with a learning disability.

The registered manager told us the service had not received any complaints since being registered with the new provider. A complaints policy was in place and any complaints received would be logged on the central computer system and the group quality manager would review them with the registered manager.

Relatives told us they were kept up to date with any changes at the service and they were able to raise any issues they may have directly with the staff team. These were addressed and so there had been no need for any formal complaints to be made.

No one living at Meade Close was being supported at the end of their life at the time of our inspection. We did speak, with their prior permission, with the relative of a person who had recently passed away. They were very complimentary about the care and support their relative had received at the end of their life. They said, "The staff were amazing; they did everything they could to make [name] comfortable. They couldn't have looked after [name] any better."

Other medical professionals had been involved in the person's support as required. The relative told us, "We were involved in every aspect of [name's] treatment. We went to every best interest decision with the consultants."

Good

Is the service well-led?

Our findings

The registered manager was supported by two team leaders. At least one of the management team was on duty each day.

A quality assurance system was in place at the service. This included weekly and monthly audits for medicines, people's money, mattress checks, daily logs and activity sheets.

The team leaders told us they completed observations of staff practice, for example medicines administration, engaging with people and hygiene. Staff said they were not always aware of when these were taking place. The team leaders would then discuss any observations with the staff members during their supervisions.

The staff we spoke with enjoyed working at the service and felt well supported by the management team and their colleagues. One said, "The staff are like one big family; they are all really supportive and very friendly. It's really nice to work with a close team" and "I could speak with any one (of the management team)."

Regular staff meetings were held and staff told us these were open meetings where they could contribute and raise any ideas or concerns they had.

The service sought the views of the staff team, relatives and professionals by using six-monthly surveys to inform improvements in the service. The responses we saw were positive. One professional had commented, "There is good communication, the service is transparent and effective" and a family member commented, "The care provided has always been beyond our expectations, we are always kept up to date with information. There is a great team who work well together."

A report had been written after the staff survey to highlight the issues identified by the staff team to the provider's area and senior managers. Areas identified by staff had also been discussed in team meetings.

The service worked with the local authority and commissioners. A meeting had been arranged with the local authority and families to discuss how people's money was being managed. The registered manager was keen to ensure that people's finances were safeguarded, well managed and used appropriately.

The registered manager met with the commissioners every six months. One commissioner told us, "We have a good relationship with the provider and the registered manager and have not had any recent concerns with the provision."

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). The registered manager knew what had to be notified and had made appropriate notifications when required.