Leonard Cheshire Disability

James Burns House - Care Home Physical Disabilities

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

About the service:
James Burns House is a residential care home that was providing personal care to 19 adults with physical disabilities at the time of our inspection.

People's experience of using this service:
People told us they felt safe and there were enough staff to meet their needs. Staff understood their role in recognising and reporting any safeguarding concerns or poor practice. People were involved in how their risks were managed. Actions taken to minimise avoidable harm were the least restrictive respecting people's freedoms and choices.

People had their medicines administered by trained staff who understood the actions needed should an error occur. Infection control processes were in place which protected people from avoidable infections. People had access to healthcare both for planned and emergency events.

Staff had received an induction and had on-going support and training that enabled them to carry out their roles effectively. Care plans were person centred, clear to follow, reviewed regularly and reflected people's needs and diversity. People had communication plans that were effective in enabling them to be involved in choices and decisions about their care. People's eating and drinking needs were understood and met. Meals were well balanced and provided people with hot and cold options at each mealtime.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People described the staff as caring. Relationships between people and the staff team were friendly, kind and caring. People described how staff had been emotionally supportive and helped them overcome anxiety and regain confidence.

Staff spoke positively about their roles in supporting people, teamwork and communication. People, families and the staff team had opportunities to share views and feedback through meetings and quality assurance processes. A complaints process was in place that people felt able to use and records showed us concerns were investigated in line with the complaints policy. The leadership promoted an open culture and when things went wrong they were honest and transparent.

Rating at the last inspection:
At our last inspection we rated the home Good (published 10/11/2016).

Why we inspected:
This was a planned inspection based on the previous rating.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective
Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.
Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.
Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well led.
Details are in our Well Led findings below.

James Burns House - Care Home Physical Disabilities

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection began on the 4 June 2019 and was unannounced. It continued on the 5 June 2019 and was announced. The inspection team consisted of one adult social care inspector.

Service and service type:
James Burns House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.'

What we did:
Before the inspection we looked at notifications we had received about the service. A notification is how providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider had completed a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the

service and made the judgements in this report.

During our inspection we spoke with four people who used the service. We spoke with the registered manager, three team leaders, four support workers, the chef and administrator. We reviewed four people's care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice. After our inspection we spoke with a district nurse who had experience of the service.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse
• People described the care as safe and told us they felt confident in reporting any poor practice. Information had been shared with people and visitors to the home about how to report suspected abuse which included contact details of external safeguarding agencies.
• Staff had been trained to recognise signs of suspected abuse and understood their role in responding and reporting concerns.
• People were protected from discrimination as staff had completed training in equality and diversity and we observed staff respecting people's lifestyle choices.

Assessing risk, safety monitoring and management
• Assessments had been completed to determine risks to people such as falls, skin damage, malnutrition and choking. People had been involved in making informed decisions about how their risks were managed and these had been respected by the staff team.
• Staff understood the actions they needed to take to reduce risks to people. For example, some people were at risk of falls and had their beds set at a very low level with a crash mattress alongside the bed. Other people were at risk of malnutrition and had food supplements to provide them with extra calories. Where people were at risk of skin damage they had specialist air mattresses on their beds which staff were using correctly.
• Assessments were reviewed monthly and any changes shared with the staff team through daily handovers, changes to care and support plans and a communication log book.
• When health specialists had been involved in risk assessments such as safe swallowing plans or wound care their instructions had been understood and followed by the care staff team.
• People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.
• A schedule for equipment to be serviced such as boilers, passenger lifts and hoists was in place. We checked records for the lifting equipment and this was up to date.

Staffing and recruitment
• People were supported by staff that had been recruited safely. This had included obtaining and verifying references and completing criminal record checks to ensure suitability for working with vulnerable people.
• Staffing levels and skill mix met people's needs. The registered manager carried out a monthly call bell audit to ensure people were receiving prompt care when needed. They explained how the information had been used to ensure staffing levels were meeting people's needs. The staff rota ensured staff skills matched people's needs. The registered manager gave examples, such as if a person required a feeding tube into their stomach, they ensured each shift had somebody trained in the procedure.

Using medicines safely

• People had their medicines ordered, stored and administered by staff trained in the safe administration of medicines and who had regular competency checks. Medicine administration charts included a photograph of people and any known allergies. Medicines were stored securely in locked cabinets in people's rooms with additional storage provided in a clinical room.

• Protocols were in place for medicines prescribed for as and when required ensuring they were administered safely.

• Staff understood the procedure for reporting medicine errors and records showed us these had been followed.

• When people were prescribed topical creams body maps had been completed which provided clear guidance for care staff on correct application.

Preventing and controlling infection

• People were protected from avoidable risks of infection as staff had completed infection control training. We observed the home and equipment was clean and in good order. Staff had access to appropriate personal protection equipment such as gloves and aprons.

• Handwashing guidance was displayed around the building for visitor's information.

Learning lessons when things go wrong

• Accidents and incidents were reviewed by the management team and analysed so that actions could be taken where necessary, trends could be identified, and learning could be facilitated. One person had experienced several falls. The registered manager explained, "(Name) would frequently kick their shoes off and just be in socks. We organised some non-slip socks and reduced the number of falls".

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People and, when appropriate, their families and health and social care professionals with knowledge of the person had been involved in pre- admission assessments. Information gathered included details of a person's care needs and lifestyle, spiritual and cultural choices. Where equipment had been identified as being needed, such as an air mattress, these were in place at the time of admission.
• Assessments had been completed in line with current legislation, standards and good practice guidance and used to create people's initial person-centred care and support plans.

Staff support: induction, training, skills and experience
• Staff had completed an induction and had on-going training and support that enabled them to carry out their roles effectively. Induction for some staff included the Care Certificate. The Care Certificate is a national induction for people working in health and social care who do not already have relevant training.
• The registered manager had created a clinical risk register. This reflected the specialist needs of people and was linked to the training provided to the staff team. Examples included stoma and catheter care and epilepsy.
• Staff felt supported in their roles and received regular supervision and an annual appraisal. Opportunities for professional development included diplomas in health and social care.

Supporting people to eat and drink enough to maintain a balanced diet
• People had their eating and drinking needs understood and met. This included allergies, textured diets and people's likes and dislikes. We observed people being offered a variety of well-balanced meal choices. Main meals were provided from a central kitchen and snacks and drinks were available to people in kitchenettes in the communal areas.
• People spoke positively about the food. Food focus meetings were held with people. One person told us "We tell (chef) what they're cooking good and what we didn't enjoy, and he takes it on board; he makes a great moussaka".
• We observed people using specialist drinking beakers and rimmed plates to enable their independence.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Records showed us that staff had worked with other health teams to enable consistent, effective care. Examples included working with epilepsy nurse specialists and the community mental health team. We spoke with a district nurse who told us, "Staff are responsive to change and would know to telephone the GP if concerned, such as if somebody perhaps had an infection. Quick on skin integrity".
• People had access to a range of healthcare services including chiropodists, opticians, dentists and

audiologists for both planned and emergency situations.
• When people transferred to another service, for example a hospital admission, information was shared. This included details of a person's medical history, important contact details, how the person was able to communicate and the medicine administration record. The medication record only included medicines administered by James Burns' staff. This meant that medicines administered by the district nurse, such as insulin for diabetes, was not included. We discussed this with the registered manager who agreed to add this to the transfer form to ensure a person's full medicine administration details were shared.

Adapting service, design, decoration to meet people's needs
• People had access to both private spaces, an area to meet and socialise and an enclosed accessible garden. Specialist bathing and showering facilities were available for people when needed. All areas of the home were able to accommodate people who used wheelchairs. Kitchenettes had been installed that were compatible for use with people in wheelchairs.
• People's personal space was reflective of their individual interests and lifestyles.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• People were having their rights upheld as the service was working within the principles of the MCA. We observed staff seeking consent from people and offering choices before providing any interventions. When people declined an intervention, we saw this was respected.
• Deprivation of Liberty Safeguards had been applied for where a person who needed to live in the home to be cared for safely, did not have the mental capacity to consent to this. The registered manager had clear records about when applications had been made and whether these had been authorised, any conditions and expiry date. At the time of our inspection a new authorised application had been received with conditions that were being reviewed alongside the persons care plan.
• When people had been assessed as lacking capacity to make a decision records showed us best interest decisions had been made on their behalf. Input had included family, other professionals and the staff team. Best interest decisions were decision specific and the least restrictive option.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
• People spoke positively about the care they received. One person told us, "The staff are brilliant, great fun, they cheer me up". Another said, "Carers are superb; they don't mind what they do for you". They went on to tell us how staff support had helped reduce their anxiety and increase their confidence.
• We observed relationships between people and the staff team that were relaxed, kind and friendly. Staff supported and respected people's individual lifestyle choices. One person explained, "(Name) helps me dye my hair".

Supporting people to express their views and be involved in making decisions about their care
• People felt involved in decisions about their day to day care. One person told us, "I know what I need, and it's definitely respected".
• Pictures and easy read information had been used to aid some people's understanding and ability to make choices and decisions.
• We observed respectful interactions between staff and people. Staff explained their actions to people, giving people time and listening to what they had to say.
• People had access to an advocate when they needed somebody independent to support them with decision making.

Respecting and promoting people's privacy, dignity and independence
• People consistently told us staff were thoughtful and respected their privacy and dignity. One person told us, "They (staff) keep me covered in case somebody comes to the door". We observed people having their privacy, dignity and independence respected throughout our inspection.
• Staff had a positive attitude to supporting and enabling people to maximise their independence. This had including sourcing technology and other aids to assist people.
• Confidential data was accessed by electronic passwords or stored in a secure place ensuring people's right to confidentiality was protected.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People had care plans which reflected their personal care needs and choices, were understood by staff and reviewed regularly with people and their families. Care plans had been created in an easy read format.
• The service met the requirements of the Accessible Information Standard (AIS). This is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People's communication needs were assessed and detailed in their care plans. This documented the person's preferred method of communication, any impairments that could affect communication, and guided staff on the best ways to communicate with them.
• Each person had a communication passport that provided details of their communication skills and needs. Staff were knowledgeable about how people communicated their needs and choices. A support worker explained, "(Name) communication is very limited. Can say yes and no and uses facial expressions. Can point at things but mainly facial expressions".
• Care plans reflected people's diversity and included information about how a person's cultural and spiritual needs were met.
• People had opportunities to be involved with activities tailored specifically to their interests. Examples included walks along the river, coffee and lunches out in the local community, shopping, attending church, completing jigsaws, arts and craft work and accessing education. When people wished not to join in activities this had been respected.

Improving care quality in response to complaints or concerns
• People were aware of the complaints process and felt if they raised a concern appropriate actions would be taken. The complaints policy had been produced in an easy read format. People were reminded of the complaint's procedure at resident meetings.
• The registered manager kept a log of any complaints or concerns raised, how they had been investigated, actions taken, the outcome and any lessons learnt to share with staff.

End of life care and support
• People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements.
• Care files contained the appropriate paperwork when people had made decisions on whether they would or would not want resuscitation to be attempted.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Good: The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• People and the staff team spoke positively about the management of the home. Communication processes were effective at keeping staff up to date ensuring consistent and effective practices. A support worker told us, "Communication is very good amongst the team. Anything comes up we constantly check everybody is up to speed. The communication book is read every day, we also have a board with messages and shift handovers".
• The culture of the home was open and transparent. The registered manager understood the requirements of the duty of candour. This is their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm. Records showed us they fulfilled these obligations, where necessary, through contact with families and people.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• The manager had a good understanding of their responsibilities for sharing information with CQC. The service had made statutory notifications to us as required and our records told us this was done in a timely manner. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.
• Staff had a clear understanding of their roles and responsibilities and understood the limits of their decision making. A support worker told us, "It all works well. They (staff) have different skill sets so you know who to go to for particular things".
• Quality assurance processes effectively captured service delivery, identified areas requiring improvement and provided opportunities for learning. People, their families and the staff team had opportunities to feedback comments through meetings and quality assurance surveys.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People, their families and staff had opportunities for developing the service and sharing information and learning through regular meetings and social events. Meeting topics had included the possible impact of Brexit, pro's and cons of staff uniforms and health and safety.

Working in partnership with others

• The staff team worked with other organisations and professionals to ensure people's care and support was in line with best practice guidance. This included national organisations linked with clinical and social care practice such as Skills for Care.