Royal Mencap Society

Southernwood

Inspection report

148 Plantation Road
Amersham
Buckinghamshire
HP6 6JG

Tel: 01494721607
Website: www.mencap.org.uk

Date of inspection visit:
06 February 2017
07 February 2017

Date of publication:
18 May 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Southernwood residential home is situated in the residential area of Amersham and provides accommodation for up to six people from the age of 18 to 64 with a learning disability.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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.

Medicines were not always managed effectively in accordance with best practice guidelines. Stock levels of medicines were not accurate and did not reflect what medicines had been booked into the service. Prescribed medicines did not always correspond to what medicines were being administered.

We have made a recommendation regarding the management of medicines.

The quality team of the provider completed checks on the service; we saw these had been completed. However, none of these checks had identified the issues relating to stock levels of medicines noted during the inspection.

Recruitment files we saw showed that there were robust recruitment systems in place. Sufficient numbers of staff were available to meet the needs of the people at the service. All of the people living at the home had been assessed as needing one to one care in order to safely meet their needs.We were aware the provider was in consultation with the relevant authorities to request additional funding to meet increased needs.

Risks to people were appropriately assessed and recorded in care records. Each risk encouraged people's independence and focused on what people could safely do for themselves.

Staff understood the different types of abuse and what signs to look for. Staff told us they would not hesitate to report any concerns they had.

Relatives we spoke with told us they felt their family member was safe living in the home.
Staff were trained in a range of subjects relevant to the needs of people using the service. New staff completed an induction programme and shadowed experienced staff before being assessed as competent. Staff were supported by having regular supervisions and appraisals. Staff told us they felt supported.

Mental Capacity assessments were carried out and recorded. DoLS applications had been submitted in accordance with good practice.

Arrangements were not in place to ensure the service was clean and hygienic to ensure that people were protected from acquired infections. Premises and equipment was not kept clean and cleaning was not

completed in line with current legislation and guidance. Staff told us they were expected to carry out cleaning duties of the home. However, due to people's high level of care needs this was not always possible. A cleaning schedule was not in place to show areas that had been cleaned or were in need of cleaning.

We have made a recommendation in relation to implementing a cleaning schedule to show areas that had been cleaned or were in need of cleaning.

The registered manager told us that open communication with families was encouraged at all levels. They said that they see families on a regular basis when they visit.

Staff had been trained to ensure that people received their food and fluids in a safe manner. One person was unable to have food orally and we saw a Percutaneous Endoscopic Gastrostomy (PEG) tube was in place in order for sufficient nutrients to be given. Staff had been trained in administering food via a PEG tube. People living at the service were not able to demonstrate a preference for a particular meal or drink, but staff told us they knew from experience what people preferred and provided food accordingly.

People's day to day health needs were met by the service in collaboration with families and healthcare professionals. Staff supported people at healthcare appointments and used information to update care plans.

We observed staff interacting with people in a kind and caring manner. Staff explained what they were doing and discussed needs and activities. The staff we spoke with were motivated to provide high quality care and understood what was expected of them.

The registered manager knew the people using the service and their staff well. Staff spoke positively about how the service was managed and all said they felt supported by the manager. Notifications relating to people who lived at the service had been submitted to the commission as required. For example, we were notified when a person's hoist had broken down. We saw evidence that the provider had made contact with an engineer to visit the service as soon as possible.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Records relating to stock levels of medication were inaccurate. Some medicine charts did not reflect what medicines were being administered.

The home did not have arrangements for keeping the service clean and hygienic to ensure that people were protected from acquired infections.

Is the service effective?

Good

The service was effective.

Staff were trained and supported to ensure they could meet the needs of the people living at the service.

People were supported with specialist diets

Is the service caring?

Good

The service was caring

Staff interacted with people living at the service with kindness and compassion

People were consulted about their own care and contributed to making decisions based on information provided by staff

Is the service responsive?

Good

The service was responsive

People were encouraged to be as independent as possible.

Staff knew the needs of people and responded with confidence when care or communication was required.

People's rooms were individual to reflect their personalities
Is the service well-led?

Is the service well-led?

Good

The service was well led.

Audits carried out did not identify issues highlighted during our inspection. For example stock levels of medicines and the cleaning of the premises.

Staff were motivated to do their job and enjoyed working at the service.

Southernwood

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 6 and 7 February 2017 and was unannounced. The inspection was conducted by one inspector. We previously inspected the service in November 2014 the service was meeting the requirements of the regulations at that time.

We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used this information to plan how the inspection should be conducted.

The provider had 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 any improvements they plan to make.

Because of communication difficulties we were unable to speak directly to people living at the service, but we spoke to five relatives, five staff and the registered manager. We also spoke with the compliance officer over the phone who works for the service. We inspected four care plans, six Medication Administration Records (MAR). Staff training records and other records relating to the management of the service.

We used a Short Observational Framework for Inspecting (SOFI). This is a tool designed to be used when reviewing services for people who have conditions that mean they cannot reliably give their verbal opinions on the services they receive.

Requires Improvement

Is the service safe?

Our findings

We checked the services procedures for the storage, administration and recording of medicines. Medicines were stored in people's bedrooms in a locked cabinet and staff completed a record of administration. However, we found one person's medicine did not correspond to what staff were administering. For example, the MAR chart instructed the person to have analgesia four times a day. Staff had been administering the medicine when they thought the person was in pain. This was 'as required' rather than on a regular basis. We spoke to staff and the registered manager about this and they told us it was an error by the pharmacy. We requested that correct instructions was confirmed by the GP and the MAR chart amended accordingly. We also noted stock levels of medicines did not correspond to what was documented in the stock control folder. We spoke to the registered manager about this and they said staff do not always document when medicines come into the home and sometimes take medicines out of the stock cupboard without completing the stock control form.

We recommend that the service reviews its procedures for the storage of medicines to ensure they follow the guidance from the National Institute for Health and Care Excellence (NICE) for care homes.

Staff were recruited safely subject to the completion of appropriate checks this included a Disclosure and Barring Service (DBS) check. The DBS enables organisations to make safer recruitment decisions by identifying candidates who may be unsuitable for certain work, especially those that involve working with vulnerable adults.

Staff had completed training in safeguarding. Staff clearly understood the different types of abuse and what signs to look for. One member of staff told us, "I would not hesitate to report anything if I had concerns." Staff we spoke with had a good understanding of the risks associated with people living at the service. One example was a person needed a member of staff to support their head when they were offered fluids to avoid choking. We saw staff carrying out this procedure and the care plan reflected the support the person received.

Relatives we spoke with told us they felt their family member was 'in good hands' and was safe living at the home. Comments included, "Yes most definitely I would safe they are safe" and "We have no need to worry".

Risks to people were appropriately assessed and recorded in care plans. We saw one specific risk assessment relating to a person's epilepsy. The risk was also included in the person's medicine folder which set out clear guidelines of what actions to take in the event of the person having an epileptic seizure. Each risk assessment focused on ensuring people remained as independent as possible while safely managing any risks. The staff we spoke with demonstrated a good understanding of the risks associated with each of the people living at the home and had taken steps to reduce the likelihood of harm.

We discussed staffing levels with the registered manager. We saw that some people required one to one support due to their increased requirements. We were aware that the service was in consultation with commissioners to request additional funding for people's changing needs. We saw that staffing levels were

adequate at the service during our inspection.

Arrangements were not in place to ensure the service was clean and hygienic to ensure that people were protected from acquired infections. The premises was not kept clean and cleaning was not completed in line with current legislation and guidance. We saw the entrance hall, stairs and landing carpets dirty with a layer of dust. The main areas of the home, dining area and lounge, had floors that were sticky and unclean. Staff told us they were expected to carry out cleaning duties of the home. However, due to people's high level of care needs this was not always possible. A cleaning schedule was not in place to show areas that had been cleaned or were in need of cleaning. We spoke with the registered manager about this and they told us, "We all do what we can, but supporting people living here are our priority." This meant people were at risk of acquiring infections relating to poor hygiene practices.

We recommend a cleaning schedule is implemented to ensure the premises are clean and hygienic to ensure people are protected from infections.

Good

Is the service effective?

Our findings

Staff had been recruited and trained to ensure they had the right skills and experience to meet the needs of people living in the home. Staff were trained in a range of subjects which included safeguarding adults, administration of medicines, Mental Capacity Act 2005, moving and handling and fire safety.

New staff were required to complete an induction programme and to shadow experienced staff as part of the induction process. Staff training was planned and recorded on an electronic system that alerted the management when training was due for renewal. We saw that training required by the service had been booked and was up to date. Staff we spoke with told us, "The training they provide is good" and "If I want additional training I know I only have to ask".

Staff were supported by the registered manager through regular supervisions and appraisals. Staff told us they felt supported. Comments included, "The manager is very supportive and approachable" and "Their door is always open, they really care about the staff." Another member of staff told us, "I love it here it's my second home." We saw evidence that regular supervisions were taking place. The registered manager told us they were in conversation with staff throughout the day. We saw conversations taking place with staff regarding people's routine and support needs.

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 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 made in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when it is in their best interests and legally authorised under the MCA. The application procedures for this in care services 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 saw appropriate referrals had been made to the local authority to deprive people of their liberty. We saw records of best interest decisions had taken place with appropriate people to act on behalf of people who lacked capacity.

Staff we spoke with had a good awareness of the MCA and associated legislation.

People living at the service were not always able to demonstrate a preference for a particular meal or drink. However, staff knew from experience what people preferred and provided food accordingly. Some people had specific health conditions which required their nutrition to be prepared and consumed in different ways. For example, one person was fed through a percutaneous endoscopic gastrostomy (PEG) tube. Another person required thickeners to be used in drinks to help them swallow safely. Staff had received training to ensure that people received their food and drink safely. One member of staff told us, "We know

what people like we can tell by behaviours or refusal if they don't like something". During the inspection we saw that people were supported with their meals. For example, one person required two members of staff to assist them with their meal. One member of staff supported the persons head whilst the other member of staff assisted with the food this ensured the safe consumption of their food.

We used Short Observational Framework for Inspecting (SOFI) during our inspection. This is a tool used mainly when reviewing services for people who have conditions that mean they cannot reliably give their verbal opinion on the services they receive. We saw staff supported people in a caring unhurried manner throughout both days of our inspection.

Staff supported people to attend healthcare appointments and information was updated in people's care plans. One member of staff told us, "We organise the appointment with the relevant healthcare professionals and we accompany them". We saw evidence of support from Physiotherapy, Speech and Language Therapist and were aware of visits from a Consultant Psychiatrist.

Good

Is the service caring?

Our findings

Throughout our inspection we saw staff interacting with people in a kind, compassionate and caring manner. One relative we spoke with told us, "I am really pleased with the care; I honestly do not believe (name) would be here today if it wasn't for the care they receive".

Most of the people living at the home had high communication support needs due to profound and multiple disabilities. We observed that one person had sight and hearing loss and the way staff communicated with them was through touch and smell. Staff told us, "We have different smells that the person associates with activities. For example, lavender is associated when staff are about to carry out personal care". Staff we spoke with were able to describe people's needs and preferences in detail. We saw this knowledge was used when they talked to people or provided support.

Staff adapted their communication skills to meet individual needs of people. For example, one person became agitated during the preparation of lunch. We saw staff interact in a way that offered the person distraction whilst waiting for their lunch to arrive. We saw people were offered choice and control over their life and that staff responded to them in a supportive encouraging manner.

Support was provided with flexibility as we saw staff adjusted their practice depending on the response from people. One example was one person was having a foot massage during lunch time and was able to have their meal following the activity. Staff told us "It relaxes them and they eat their food when they are more relaxed".

Privacy and dignity were protected by staff. Staff promoted people's dignity in practical ways. For example, personal care was provided discreetly in bedrooms and bathrooms. Staff told us they always make sure they close curtains and doors when carrying out personal care.

Each of the people living at the service had a family member to ensure they acted on their behalf when required. The registered manager told us they speak to families sometimes on a daily basis. Families were free to visit when they wanted to some had regular specific days they visited and others just visited when they were able.

People had been able to personalise their rooms as they wished. The rooms were individual in the design and layout. Visitors could join people in their rooms or in the communal lounge area.

Staff are able to support people during end of life with support from healthcare professionals. One person had an end of life care plan in place. We saw specific wishes relating to support during end of life care in the person's care plan. For example, people they wanted to see and funeral arrangements

Good

Is the service responsive?

Our findings

Staff involved people living at the service about daily care, but communication difficulties meant that formal reviews of care were limited. However family members told us they had regular reviews about care and support needs. One relative told us, "They keep me informed if anything happens; I had a review sometime last year". Key workers were in place at the service. Support plans were checked each month by the key worker and reviewed every six months or as needs changed. Family members had an important role in the service and strong productive relationships were evident with all families we spoke with. Care plans were regularly reviewed and any changes were noted. One member of staff told us, "As a key worker I can make sure the family are aware of any up and coming events or if there are any changes to the family members support. Support plans showed that individuals were present in any discussions with other professionals. We saw examples of care plans relating to professional support, community activities and important relationships.

Activities were organised on an individual basis and reflected people's personal preferences. One relative told us, "They take [name] to the church lunch they really enjoy that". The people living at the service were supported to follow their interests and to maintain relationships with family members and other people in the local community where appropriate. We saw that the registered manager was taking people to pre-arranged events on the first day of our inspection. There was a regular lunch club that people could attend as well as a day centre. Other activities were specific to individual preferences like swimming and going to a Chocolatier Café. In house activities were also organised, we saw a complimentary therapist during our inspection providing foot massages for people who wanted this.

People's health conditions limited the ability to be fully independent. However, staff encouraged people to be as independent as possible. Needs and preferences were responded to with confidence by staff who knew the people they were supporting well. Communication was improved because staff had information to ways in which non-verbal communication could be achieved in people's care records.

The service had a complaints procedure for people and their families who used the service. This was outlined and given to people when they first joined the service. One relative told us, "I would speak to the manager or staff if I had any complaints". The records we saw indicated no formal complaints had been made in the last 12 months. Families could communicate with staff on visits or by contacting the service by telephone.

We saw evidence of many compliments made to the service from relatives. Families we spoke with were all very positive about the care and support their family member received.

Good

Is the service well-led?

Our findings

The registered manager was a Registered Nurse in Learning Disabilities with over 20 years of experience in managing care homes. We observed the manager was 'hands-on' and spent time each day in discussions with staff and observing practice. They had completed additional training in Mental Capacity, Leadership and Enteral Feeding.

Staff told us they felt well supported. Relatives we spoke with were complimentary about how the service was run. One relative told us, "It's all down to the captain of the ship". Other comments included, "I can't fault the service, we are in constant communication with the manager and it's all good". Many of the staff had worked at the service for many years.

Regular monitoring of staff performance and satisfaction was addressed by the registered manager and any issues were addressed as they arose. The quality team completed regular checks of the service; we saw these had been completed. However, these checks had not identified issues around the stock levels of medication and the cleaning of the premises which we had identified during our inspection. The registered manager confirmed they will review the audit processes to ensure they were more effective in relation to the recording of stock levels of medicines.

Open communication was encourage with families and staff at all levels. Staff told us monthly staff meetings were held where care and support needs of people could be discussed along with any other issues relating to the service.

The organisation had a clear set of visions and values which were communicated in brochures and other materials. These visions and values were linked to organisational strategy and used as an opportunity to assess the quality of care. Staff were able to explain the visions and values of the service and applied them in their practice. The core values of the service reflected people's rights to equality, opportunity and independence. Staff told us, "We have got an established team here". The registered manager told us the core staff team have worked at the service for many years which enables delegation of additional responsibilities.

Staff we spoke with were motivated to provide high quality care and understood what was expected of them. For example, they spoke positively and with enthusiasm about the support and quality of care offered by the organisation. One member of staff who had recently joined the service told us how excited they were about the opportunity they had been given. Another member of staff told us, "We work with lovely families and their compliments and feedback is very much appreciated".

The provider had an extensive set of policies and procedures to guide staff and measure performance. The registered manager was knowledgeable about their role and responsibilities. They spoke with enthusiasm about working for the organisation and said they were supported by senior managers.

The registered manager was aware of the culture of the service. We saw that they knew the people using the service and the staff well. The registered manager understood their responsibilities in relation to their registration. Notifications relating to people who used the service had been submitted to the commission as required. For example, the provider had notified us about a person's hoist breaking down. We saw evidence they had made contact with engineers to visit the service as soon as possible.