Sunderland City Council

Grindon Mews Short Break Centre

Inspection report

Grindon Mews
Nookside Grindon
Sunderland
Tyne And Wear
SR4 8PQ

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25 June 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 22 and 25 June 2018 and was announced. This was to ensure someone would be available to speak with us and show us records.

Grindon Mews Short Break Centre is a respite 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Grindon Mews Short Break Centre accommodates up to six adults with physical and multiple learning disabilities in one purpose built building. At the time of our inspection, the service supported up to 34 people with respite care.

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.

The service had a registered manager in place. A registered manager is a person who has registered with CQC 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.

Grindon Mews Short Break Centre had not previously been inspected by CQC.

Accidents and incidents were appropriately recorded and investigated. Risk assessments were in place for people who used the service and described potential risks and the safeguards in place to mitigate these risks. The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

The premises were clean, spacious and suitable for the people who used the service. Appropriate health and safety checks had been carried out.

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 vetting checks when they employed staff. Staff were supported in their role via appropriate training and regular supervisions.

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 were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care specialists.

Family members were complimentary about the standard of care at Grindon Mews Short Break Service. Staff treated people with dignity and respect and helped to maintain people's independence where possible.

The service was effective at supporting people to move between services and responded to the individual needs of people. Care records showed that people's needs were assessed before they started using the service and support plans were written in a person-centred way. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Activities were arranged for people who used the service based on their likes and interests, and to help meet their social needs. The service had good links with the local community.

People who used the service and family members were aware of how to make a complaint. The provider had an effective quality assurance process in place. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys.

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.

Staffing levels were appropriate 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 appropriately recorded and investigated, risk assessments were in place and staff had been trained in how to protect vulnerable adults.

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

Is the service effective?

Good

The service was effective.

Training was developed and delivered based on specific individual needs, and staff received regular supervisions and appraisals.

The service had an effective referrals process in place and people's needs were assessed before they started using the service.

People were supported with their dietary needs.

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

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted where possible.

People were well presented and staff talked with people in a polite and respectful manner.

People and family members were involved in care planning and

their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

Care records were up to date, regularly reviewed and person-centred.

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

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

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

Grindon Mews Short Break Centre

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.

Inspection site visit activity took place on 22 June 2018. It included a visit to the location to speak with the registered manager and staff; and to review care records and policies and procedures. The inspection was announced. One adult social care inspector carried out the inspection. We also spoke with family members and contacted health and social care professionals on 25 June 2018.

Some of the people who used the service had complex needs which limited their verbal communication. This meant they could not always tell us their views of the service so we carried out observations and spoke with five of their family members. In addition to the registered manager, we also spoke with three members of staff and received feedback from two health and social care professionals. We looked at the care records of three people who used the service and the personnel files for three members of staff.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff.

A Provider Information Return (PIR) was not requested for this service. A PIR 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.

Good

Is the service safe?

Our findings

Family members we spoke with told us they thought their relatives were safe at Grindon Mews Short Break Centre. They told us, "Yes it's safe. It's secure", "He is safe" and "He's definitely safe there." Another family member told us the premises were "absolutely fantastic" and there was "a very high level of cleanliness and hygiene". The premises were secure and electronic tags were used by staff to access the building.

Staff recruitment records showed that appropriate checks had been undertaken before staff began working for the service. 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. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports and birth certificates. Copies of application forms were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained.

We discussed staffing levels with the registered manager. Staffing levels depended on the number of people using the service and their individual needs. The registered manager told us the crossover period between the early and late shifts provided an opportunity for staff development and community activities with the people who used the service. The registered manager told us the service previously used agency staff but all the agency staff used in the past now worked permanently at the service, except one who had applied for a permanent contract. None of the family members we spoke with had any concerns regarding staffing levels.

The premises were clean and people were protected from the risk of acquired infections. Appropriate personal protective equipment (PPE), hand hygiene and liquid soap were in place and available. Monthly infection control audits were carried out and included hand hygiene, PPE, laundry facilities, environment and equipment, waste, disinfectant and cleaning products, food hygiene, outbreak management, and staff training. There were no actions identified on the previous two audits.

Accidents and incidents were appropriately recorded and reviewed by the registered manager. Each record included details of the person who had the incident, details of the incident, whether any injuries occurred and what action was taken. Any lessons learned from accidents and incidents, and complaints were discussed at staff supervisions and meetings.

Risk assessments were completed where appropriate and described potential risks and the safeguards in place. These included health, eating and drinking, allergies, personal care, physical or verbal aggression, falls and new surroundings. People who were at risk of an epileptic seizure, had epilepsy support plans in place. These described the type of epilepsy, the description and frequency of the seizures, what could make seizures more likely and how to manage them. Epilepsy protocol charts were also in place for all the people who required them. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents and incidents from occurring.

A health and safety service audit was carried out every three months. Hot water temperature checks were carried out weekly 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 including hoists, adapted beds and wheelchairs. Where required we saw evidence that 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.

The service had a business continuity plan. This was implemented earlier in the year during the period of bad weather. Meetings were arranged and attended by the management team to discuss the impact and severity of the weather conditions. The registered manager showed us a case study that had been produced following the period of severe weather that stated staff had gone "above and beyond their roles" to ensure service delivery was not affected and people remained safe.

Risks to people's safety in the event of a fire had been identified and managed. For example, a fire risk assessment was in place, fire drills took place regularly and firefighting equipment checks were up to date. The service had an emergency action plan and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We saw a copy of the provider's safeguarding policy, which defined abuse, how to raise an alert, and roles and responsibilities of staff. Staff had signed to say they had read and understood the policy. Safeguarding related incidents were appropriately recorded and CQC was notified of any relevant incidents. The registered manager understood their responsibilities with regard to safeguarding and staff received training in the protection of vulnerable adults. We found the provider understood safeguarding procedures and had followed them.

We looked at the management of medicines and saw people had medication support plans in place. These described the medicines people were taking, what they were for, how they preferred to take their medicines, dosage, any possible side effects and what assistance they required.

Medication risk assessments were in place. These included an agreement form for the person or their representative to sign to say they had been given all the necessary information to support the planning of any assistance with medicines.

Medicines were appropriately stored, staff training was up to date and regular audits were carried out.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. Family members told us, "The staff are fantastic, very efficient", "[Name] has made good connections with the staff now. The girls always let you know about everything" and "The staff are lovely." A health and social care professional told us, "They have the skills there within the staff team" and they [staff] "go above and beyond".

Training was developed and delivered based on specific individual needs. 'Training pathways' were used to identify mandatory and service specific training to take place during and after the staff induction period. Mandatory training is training that the provider deems necessary to support people safely. The provider's mandatory training included safeguarding, emergency first aid, health and safety, fire safety, moving and assisting, food hygiene, personal safety, mental capacity, person centred support planning, infection control, nutrition and hydration, equality and diversity, and safe handling of medicines. The training pathways were also used to identify and source additional specialist and bespoke training to ensure people's specific needs could be met. For example, stoma care, epilepsy and percutaneous endoscopic gastrostomy (PEG) feeding.

New staff completed an induction to the service and all new staff were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Staff received regular supervisions and appraisals. 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.

The service had an effective referrals process in place and people's needs were assessed before they started using the service. A pre-assessment tool was used to capture person-specific details to enable the service to meet people's needs, wishes and outcomes. Introductory visits were carried out and prior to each subsequent visit, a telephone call and exchange of documentation took place with family members.

A verbal handover took place on arrival at the service to ensure all the information was up to date and appropriate checks and assessments had been carried out. For example, health and safety, and equipment checks, and safeguarding and well-being assessments. The admission meeting book was updated with any additional information. A family member told us, "[Registered manager] came out to the house and spoke at length. [Name] had several tea visits to get used to it."

For emergency and complicated referrals to the service, the registered manager produced a chronology to record any significant concerns, events or incidents that had, or continued to have, an impact on the person's wellbeing. These provided evidence of the registered manager's
holistic approach to assessing, planning and delivering care and support in partnership with other professionals. For example, it was identified the bed one person was using at the service was unsuitable for their needs. Staff remained with the person during the night and an alternative bed was sourced the next

day. During the admissions process and as a result of identified issues, the registered manager liaised with a range of services such as the local authority, clinical commissioning group and learning disabilities team. Transport was arranged for the new bed and appropriate assessments were carried out for it's safe use.

The service worked collaboratively with other organisations to support people to move between services. The registered manager showed us a case study that demonstrated how the service had responded to the needs of a person who had been an emergency admission to the centre. The service worked with the person and other professionals, and amended the staff rota to suit the person's individual needs. When a permanent home had been identified for the person, staff from the home worked at the centre to get to know them and assist with the transition to their new home. A health and social care professional commented on another example where the service had stepped in to support two people. They told us, "[Staff] did an outstanding job in stepping in and providing accommodation, support and care for [people who used the service] on short notice."

People were supported with their dietary needs and had nutritional needs support plans in place. Malnutrition Universal Scoring Tools (MUST) were completed for each person. MUST is a tool used to help identify people at risk of malnutrition. Two of the people whose care records we viewed were fed via a PEG and copies of the dietitian's feeding regimens were included in the care records. Another person had been referred to a speech and language therapist (SALT) as they had dysphagia. Dysphagia is difficulty chewing and swallowing food, and the person had a specific support plan in place for this. Staff had received specialist training from health care professionals to support people with their dietary needs and specific information had been provided on dysphagia, reflecting current best practice.

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 and found the service was working within the principles of the MCA, and conditions on authorisations to deprive a person of their liberty were being met. The registered manager maintained a matrix of renewal dates for all DoLS that had been applied for.

People had indicators of wellbeing in place. These included the requirements for each person on how the service would promote their health and wellbeing, and captured their individual communication needs. These included a list of people's positive and negative actions that staff were to look out for so appropriate support could be provided.

People had hospital passports in place. A hospital passport contains important information about the person should they be admitted to hospital. People also had health action plans in place that included details about their health and the support they needed to stay healthy. This was to be taken whenever the person accessed healthcare services such as a GP or other medical appointments. Care records included evidence of involvement from healthcare specialists such as GPs, dietitians, SALT and physiotherapists.

The national early warning score (NEWS) monitoring system was in place for two of the people who used the service. The registered manager had sent consent forms out to all the parents of people who used the service but only two had so far responded. NEWS is a digital tablet system that monitors the health of

people, including blood pressure, oxygen saturation, temperature, pulse, weight, height, respiration and pain. It helps to understand any trends and identifies any potential problems at an early stage so they can be acted on.

The premises were purpose built and suitably designed for the people who used the service. The premises included six specially adapted bedrooms with en-suite bathrooms. Appropriate signage was in place. The corridors were wide and bedrooms and bathrooms were spacious to accommodate wheelchairs and mobile beds. Tracking hoists were fitted to the ceilings to enable people to be transferred between beds, chairs and bathrooms. Bathrooms were large and included specialist sensory baths. One of the family members we spoke with told us their relative liked visiting the centre because of the "whirlpool bath".

Good

Is the service caring?

Our findings

Family members were complimentary about the standard of care at Grindon Mews Short Break Centre. They told us, "It's really nice. I'm really, really happy with it", "The care is excellent" and "If [Name] wasn't happy, she wouldn't get out of the car." A health and social care professional told us, "They [staff] provide excellent care." Another health and social care professional told us "[Staff] provided a high level of exceptional care."

We observed staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity. People were assisted by staff in a patient and friendly way.

Staff respected people's privacy and promoted dignity. We saw staff knocking before entering people's rooms and closing bedroom doors behind them. Care records described the choices and preferences people had made with regard to their personal care. For example, "I like a wash down on a morning and a shower on an evening", "I don't like my face washed and am not keen on having my teeth brushed, it is easier to brush my teeth once in my chair" and "When I'm dressed, please make sure my pockets are tucked in and my trousers are not ruffled on the legs, make sure I'm all neat and smart." Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

People who used the service had limited independence. Care records described how staff were to support people with tasks they were unable to complete themselves. For example, "I require 2:1 staff support with all aspects of my personal care", "I am totally dependent on others to make sure I get from one place to another" and "I need two staff to assist me with my hoisting and personal care. Talk me through and let me know what is happening next."

The registered manager showed us a case study that demonstrated how the service had supported a person and their family members following a family illness and subsequent bereavement. Staff provided emotional support to the family and assisted with transport to the service and to attend appointments. Staff had received a thank you card from the family for helping them at this difficult time.

People had communication passports in place that described how the person communicated, how staff could help them communicate, things they enjoyed doing or places they enjoyed going, eating and drinking needs, and what their eyesight was like. Records showed people were given information in a way they could understand and the communication support they needed. For example, one person communicated via facial expressions. Staff were advised to speak slowly and clearly, give the person choices and plenty of time to answer, and ensure the person was involved in conversations and activities.

When required, people's religious and spiritual needs were documented. For example, one person previously attended church on a Sunday but recent discussions with their family members confirmed they no longer attended church services.

We saw that records were kept securely and could be located when needed. This meant only care and

management staff had access to them, ensuring the confidentiality of people's personal information as it could only be viewed by those who were authorised to look at records.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The registered manager told us one of the people using the service had an independent advocate.

Good

Is the service responsive?

Our findings

Care records we looked at were regularly reviewed and were person-centred. Person-centred means the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account. Each person's care record included an 'All about me care plan' which provided staff with information on people's daily needs and routines. This included personal information such as next of kin, GP contact details, hobbies and interests, things that make the person happy or unhappy, details of their daily routine and any other important information.

People's mobility needs were clearly documented and moving and handling support plans and assessments were in place. Many of the people who used the service were immobile and required the use of a wheelchair. Overhead tracking hoists and slings were used to transfer people and appropriate guidance was provided for staff to ensure people were safe and reassured when being transferred. For example, one person was likely to stiffen when being transferred which made it difficult to fasten their safety belt. Staff were advised to reassure the person and wait until they relaxed before carrying out the transfer. Another person had been assessed by a physiotherapist as being able to use a specialised beanbag for positional changes. Specific guidance on using this was included in the person's care records. Care records also included photographs that staff could use as a guide, such as the use of mobility equipment.

People had targets they were working towards. These were documented and recorded how staff could support them to achieve their targets. For example, one person wanted to meet new people and make friends. Staff were to encourage new friendship groups and allow them to build relationships with other people who used the service.

Daily notes were maintained for each person during their stay at the centre. These included how well the person had slept, personal care carried out, diet and nutrition, and activities they had taken part in. Hourly logs were completed to provide detailed information on the support provided to people.

A 'Summary of stay' record was completed at the end of every respite visit and given to family members. These included an update on outings and activities, meals, health and wellbeing, sleep, any other important information, and photographs of activities the person had taken part in. This enabled family members to gain an insight into their relative's stay at the centre.

None of the people using the service at the time of our inspection visit were receiving end of life care. However, the provider had a 'Care at the end of life' pathway in place for one person that was currently dormant. The registered manager attended regular multi-disciplinary team (MDT) meetings regarding this person's palliative care and told us the pathway would become 'live' when advised by the person's clinical care team. Additional guidance was also in place such as easy to read documentation regarding making choices and how the person may feel at the end of life. The registered manager and team leader had received training in end of life care at a local hospice.

Daily and night-time routines were important to the people who used the service and were clearly

documented in their care records. Some people received additional support in the form of audio/visual monitors to enable staff to monitor their wellbeing. These had been agreed in consultation with family members and relevant professionals.

We found the provider protected people from social isolation. Care records described activities people enjoyed. For example, one person liked to be outdoors but not when it was cold or wet. They also enjoyed going to the cinema, bowling, listening to music, cookery and massage. Another person enjoyed head massages and reflexology, going out in the car and visiting a local centre, especially the ball pool. Care records described how staff were to support people to continue to access the activities they enjoyed.

The service had a sensory room that people enjoyed using. There were large, communal lounge areas that contained a variety of activities including a large, tilt and touch interactive screen, postural learning stations and sensory equipment. For people who enjoyed cookery or helping in the kitchen, some kitchen work surfaces could be lowered so people could assist the staff. There was also a secure outdoor space and garden and we observed one person helping to water the plants. One person in particular enjoyed one to one interactions with staff and being involved in group activities. A family member told us, "They have plenty of outings and a lovely outside space."

We saw a copy of the provider's complaints policy that was available in an easy to read format. Complaints we viewed had been appropriately dealt with. Records included correspondence with the complainant and details of action taken. A process was in place to analyse complaints data to identify any trends or patterns to aid continuous improvement. The registered manager told us they also recorded any concerns as "there was always something you could learn from". None of the family members we spoke with had any complaints to make. They all told us if they did, they would speak with the registered manager.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. They had been registered since the location was registered with CQC in June 2017. We spoke with the registered manager about what was good about their service and any improvements they intended to make in the next 12 months. The registered manager told us they were really proud of what they had achieved at the service in the 12 months since it had opened. The registered manager told us they had created strong working relationships and worked closely with a range of health care professionals, including learning disability nurses, physiotherapists, SALT and occupational therapists. They told us, it was about "getting things right for the person" and "It's about the person and we always put the person at the centre."

The registered manager told us family members had come to them and said they can now go on holiday for the first time and were comfortable leaving their relative in the care of the centre. Family members we spoke with confirmed this. They told us, "The management is excellent. They check up and make sure everything is ok", "I've got absolutely no faults whatsoever. I couldn't recommend them enough" and "I would recommend it to anyone."

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

We saw photographs of people accessing the local community and taking part in activities. The registered manager told us as they were a short breaks service, they had less opportunity to link with local community organisations but people did access events such as community fayres, coffee mornings and took part in a recent charity walk.

Staff we spoke with felt supported by the registered manager and told us they were comfortable raising any concerns. The registered manager told us, "I have a lovely team and I'm very proud of them."

Staff were regularly consulted and kept up to date with information about the service. Staff meetings took place regularly. The agenda for the most recent meeting included compliments, new policies, repairs and maintenance, a proposed new rota system, and updates on the people who used the service.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. The registered manager maintained a 'Care plan tracker' that was used to ensure all the care records were kept up to date. Regular audits were carried out and included infection control, health and safety, kitchen food preparation and storage, and medicines. No actions had been identified in the most recent audits we viewed however all were up to date.

The registered manager completed monthly reports for operational and human resources requirements that were sent to the provider. They told us they attended the provider's monthly managers' meetings and

information from these meetings was cascaded to their staff team.

'Carers' meetings' took place every two months. This was an opportunity for carers and family members to visit the centre to discuss any issues and receive updates on the service. The lead commissioner from the local clinical commissioning group (CCG) also attended the meetings. At the most recent meeting in April 2018, the registered manager provided an update on the questionnaires that had been sent out to carers and family members in February 2018. Nine questionnaires were returned and the results were analysed. The feedback received was positive with no negative responses. Some of the comments included, "[Name] is really settled, all girls are lovely, getting better each stay", "All doing a really good job. [Name] is happy to come" and "Care and attention to loved one is great."

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.