Partnerships in Care (Cleveland) Limited

Cleveland House

Inspection report

Greaves Hall Ave
Banks
Southport
Lancashire
PR9 8BL

Date of inspection visit:
25 February 2016
01 March 2016

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28 April 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
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 25 February & 1 March 2016, the first day was unannounced.

The registered manager was present throughout the inspection. 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.

Cleveland House was first registered with the Care quality Commission on 12 November 2014. This was the service's first inspection since its registration.

Cleveland House is a purpose built 32 bed care home with nursing, where clinical care is provided in a homely environment. All rooms are en-suite with their own wet rooms. Each room has patio doors to enable people to access their own outside space. The home has four specialist service areas for people who may have a variety of physical disabilities as well as either acquired brain injury, intellectual / learning disability, or mental illness associated with conditions such as epilepsy or sensory impairment. The space is divided into four eight bedded units on two levels. Its location in Banks, in between Preston and Southport, offers easy accessibility for visitors and to local amenities.

At the time of our inspection the home was using the two units on the ground floor, as service provision was being gradually implemented alongside the recruitment of specialist staff. There were 11 people living at the home at the time of our inspection, all of whom had an acquired brain injury.

The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns.

All the people we spoke with told us they felt safe at the home.

We looked at how medicines were ordered, stored, administered and recorded. We spoke with the senior carer who had responsibility for administering medication on the first day of the inspection and observed medication being given to people over the lunchtime period.

Staff understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was good and we saw that all staff had received recent training in both areas. However we found some issues within care planning documentation regarding compliance with the MCA and with formally gaining people's consent. We made a recommendation about this.

We saw that staff attended regular training via the staff training matrix we were given and found staff to be knowledgeable about their role.

People and relatives were very complimentary about the approach of the staff team and the care they received.

Relatives we spoke with said they could visit the home whenever they wished to without restriction. They told us that staff called people by their first name and knew the people they were caring for well.

People we spoke with and their relatives told us they knew how to raise issues or make complaints. They also told us they felt confident that any issues raised would be listened to and addressed.

We found care plans were easy to read, navigate and contained good information. However we found a few issues with certain sections of people's care plans not being signed or dated. We have made a recommendation about this.

We spoke with staff and asked them how the service demonstrated good management and leadership. The responses we received were very positive.

We saw that a wide range of audits took place at the service that were stored within a 'Quality Assurance Audits file'.

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.

The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns.

The home had effective recruitment procedures in place which were always followed.

There were enough suitably qualified and trained staff to care for the assessed needs of the people at the home.

Is the service effective?

Requires Improvement

The service was not always Effective.

Staff understanding of MCA and DoLS was good and we saw that all staff had received recent training in both areas. However we found some issues within care planning documentation regarding compliance with the MCA and with formally gaining people's consent.

Staff had access to on-going training to meet the individual and diverse needs of the people they supported.

Staff told us they felt supported in their role and that they received a thorough induction prior to them starting work. All of the staff we spoke with talked positively about how the home was managed and that they were able to discuss issues freely with the registered manager or senior staff.

Is the service caring?

Good

The service was Caring.

People told us that they could make themselves understood through various modes of communication and that their relationship with staff was positive.

People were treated in a kind, caring and respectful way. People and relatives we spoke with confirmed this.

We saw within people's care plans that referrals were made to other professionals appropriately in order to promote people's health and wellbeing.

Is the service responsive?

Good

The service was Responsive.

People we spoke with and their relatives told us they knew how to raise issues or make complaints. They also told us they felt confident that any issues raised would be listened to and addressed.

We found plans of care to be person centred, which outlined clear aims, objectives and actions to be taken. These provided staff with detailed guidance about people's assessed needs and how these needs were to be best met.

Is the service well-led?

Good

The service was Well-Led.

A wide range of updated policies and procedures were in place at the home, which provided the staff team with current legislation and good practice guidelines.

People and relatives we spoke with told us the culture within the home was caring, empathetic and pleasant.

Staff told us that the team management were supportive.

Cleveland House

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 25 February & 1 March 2016, the first day was unannounced.

The inspection was carried out by the lead adult social care inspector for the service. An expert-by-experience and specialist advisor were also present during the first day of the inspection. The expert by experience spent time talking with people who lived at the home, their relatives who visited and made general observations of how staff interacted with people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor spent time looking at people's care plans, medication management processes and whether the home was compliant with Mental Capacity Act and Deprivation of Liberty legislation. The specialist advisor was a registered learning disability nurse who also had experience of working with people living with neurological conditions.

We spoke with a range of people about the service; this included two people living at the home who could verbally communicate with us, two people who could not verbally communicate but could respond to questions via other communication methods, five visiting relatives and six members of staff including nurses, support workers, the registered manager and service director for Partnerships in Care (Cleveland) Limited.

We spent time looking at records, which included five people's care records, four staff files, training records and records relating to the management of the home, which included audits for the service.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe at the home. People told us they had not experienced any negative behaviour such as bullying or intimidation from staff or other people at the home. The two people we spoke with who could not communicate verbally with us responded positively when we asked them if they felt safe at the home and with the staff providing their care. All except one relative we spoke with also confirmed this to be the case. One relative we spoke with told us, "I can go home from here knowing my loved one is safe."

One relative we spoke with had some concerns for their loved one's welfare and we discussed the concerns they raised with us with the registered manager. Regular meetings had been set up with the person's social worker and the home to address the family member's concerns, which was an ongoing process. We were satisfied that the home were acting upon the concerns the family had, and by accessing the person's social worker to act as an independent advocate were doing so in as professional a manner as possible and ensuring that the person's safety and best interests were at the forefront of these discussions.

The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns. Staff members spoken with said they would not hesitate to report any concerns they had about care practices to senior members of staff. Staff were also able to name external organisations they would report potential safeguarding issues to, such as the Care Quality Commission and Local Authority.

There had been two reported safeguarding issues made by the home within the previous 12 month period prior to our inspection. Both had been closed down by the Local Authority Safeguarding Team. Within the Local Authority safeguarding investigation reports they had concluded that appropriate assessments and risk assessments were in place for the people involved and that care plans were thorough and reviewed appropriately.

We spoke with the registered manager of the home regarding staffing levels. They were confident that staffing levels were in place at all times to meet the needs of the people in the home. This was observed to be the case during the inspection, by viewing staffing rotas from the beginning of 2016 and through feedback we received from people and their relatives, with the exception of one. Staff also confirmed staffing levels to be sufficient to meet people's assessed needs. The relative who told us they felt staffing levels were not appropriate was the same relative who had concerns about the service, which were being addressed in conjunction with the commissioners of their loved one's care.

We were told that agency staff were not used and that short notice absenteeism was covered by contacting the existing staff team or by the use of a small bank of staff or by local 'sister' homes within the organisation. From speaking with the registered manager and service director it was evident that the recruitment of skilled staff was a priority for the home to enable additional people to come into the service. Help with recruitment was being given by a registered manager from another home in the group and by senior management to enable the home to reach its full potential and utilise the other two units on the first floor which were empty

at the time of our inspection. We were given assurances that additional people would not be accepted into the home until the service was confident that the correctly skilled and experienced staff were in place, which showed that the emphasis was on the quality of care provided rather than to simply fill current vacancies.

We saw that a number of risk assessments were in place for people at the home when we reviewed care planning documentation. These included risk assessments for pressure care, falls, dependency, continence and MUST (Malnutrition Universal Screening Tool). Risk assessments were seen to contain good detail and were appropriate for each individual. However we found some risk assessments had not been reviewed for a number of months and some had not been dated when completed. One person had been in hospital for a period of time and had arrived back at the home three weeks prior to our inspection. Risk assessments for that person had not been reviewed following their stay in hospital. We discussed the need to regularly review people's risk assessments with the registered manager, particularly if any changes in people's circumstances had occured, such as following a stay in hospital. We were assured by the registered manager that this would happen as a priority. We were told that whilst some risk assessments for some people had not been updated within care planning documentation that staff were aware of people's needs and that the issue was a recording issue. This was confirmed when speaking to staff who were very knowledgeable regarding people's needs and the risks associated with their care and treatment.

We looked at how medicines were ordered, stored, administered and recorded. We spoke with the nurse in charge who had responsibility for administering medication on the first day of the inspection and observed medication being given to people over the lunchtime period. We checked medication administration records (MAR) to see what medicines had been given. The MAR was clearly presented to show the treatment people had received. The nurse informed people of the medication she was giving and gained consent prior to giving. We saw that if medication was refused it would be written on MAR chart and recorded on the back of it. MAR sheets were colour coordinated with blister packets which meant it was easy for staff to read.

All medication files had a photo of the person, GP information, pharmacy information and diagnosis information with the MAR charts. The nurses had introduced a quick view sheet to show when each person had been prescribed antibiotics over the past year and allowed for easy access to this information. Due to people's disabilities they were frequently prescribed antibiotics and staff needed this information to hand when speaking with the person's GP.

All the people we spoke with told us they received their medicines on time and knew why they were taking their medicine. Nobody was given their medicines covertly and nobody had responsibility for taking their own medicines although a policy was in place in the event of either scenario. Controlled drugs were stored securely and we saw that medicines that needed to be kept at a low temperature were refrigerated appropriately and that minimum and maximum temperatures were recorded daily. The nurse was aware of how to manage a medication error or near miss, they stated they would check the policy, ensure the person was safe, inform the appropriate people and complete an incident form.

During our inspection we looked at the personnel records of four people who worked at the home. Appropriate police clearances via disclosure and barring checks were sought for all staff. We found that prospective employees had completed application forms and had attended structured interviews. This helped the management team to determine if applicants met the required criteria, in accordance with company policy. All necessary checks had been conducted, which demonstrated robust recruitment practices had been adopted by the home. This meant those who were appointed were deemed fit to work with this vulnerable client group and therefore people's health, safety and welfare was sufficiently safeguarded.

We looked at issues pertaining to premises safety. The home was purpose built and the involvement of professional advisors had been sought during the building process. This included issues such as fire safety. Lancashire Fire and Rescue service had inspected the home and deemed it to be compliant. We saw that appropriate signage was on display with regards to fire regulations and that fire equipment was serviced. Appropriate environmental risk assessments were in place for other issues such as legionella and failure of utilities and power.

We observed good practice regarding infection control processes. The home presented as very clean and tidy and we saw cleaning schedules in place. At the time of our inspection there was no dedicated housekeeping staff due to the service only being approximately one third full occupancy so support workers were undertaking cleaning schedules. The home had undertaken infection control audits which covered a range of issues such as outbreak management, hand hygiene, personal protective equipment, sharps handling and waste management. For January and February 2016 the home had attained scores of 99%. Staff we spoke with were knowledgeable about infection control procedures and told us that there was plenty of personal protective equipment available.

Requires Improvement

Is the service effective?

Our findings

We asked people who lived at the home if they felt staff were competent and suitably trained to meet their needs, the responses we gained were positive. One person told us, "Staff are very able, they go above and beyond the call of duty." Another person who was unable to verbally communicate with us indicated they were happy with the staff who cared for them. Relatives we spoke with were also happy with the approach and competence of staff.

We saw that staff attended regular training via the staff training matrix we were given and found staff to be knowledgeable about their role. We found evidence also within staff files, of training undertaken, such as safeguarding, moving and handling, medication, infection control, health and safety and food hygiene. We saw that some staff had also received specialist training such as tracheostomy and vent training. Staff confirmed that they undertook regular training and that it was of a good standard and that they could request specialist training if required. One member of staff we spoke with told us, "A lot of training is done as a team. This is helpful. Most training is face to face with some e-learning that is usually done as a back-up."

We also saw good evidence that staff had regular supervision and were able to raise issues within this forum. Staff we spoke with talked positively about their peers and told us that they felt they were part of a team. The registered manager told us that a few appraisals had taken place and that the service was looking to programme appraisals in for all staff in the coming months.

Staff told us they felt supported in their role and that they received a thorough induction prior to them starting work. All of the staff we spoke with talked positively about how the home was managed and that they were able to discuss issues freely with the registered manager or senior staff.

We were also told that communication within the home was good. We saw evidence that team meetings took place and that handovers took place at the beginning and end of each shift to ensure that staff were aware of how people had been during the previous day or night. One member of staff spoken with told us they felt handovers were not comprehensive enough as there was no paid time given between the previous shift finishing and the new shift coming on. We discussed this with the registered manager who told us that this issue had been discussed and that there was an expectation that ten minutes either side of each shift would be given by staff to ensure and effective handover took place. Only one member of staff we spoke with saw the current arrangements as an issue.

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

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

called the Deprivation of Liberty Safeguards (DoLS).

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

Staff understanding of MCA and DoLS was good and we saw that all staff had received recent training in both areas. However we found some issues within care planning documentation regarding compliance with the MCA and with formally gaining people's consent.

We found some capacity assessments had been undertaken however we found these were not done consistently for each person. We found documentation within one person's care plan regarding finances and future placements completed by their psychologist. This stated that the person lacked capacity and a decision needed to be made in their best interests via a best interest meeting. We could find no evidence of a best interest meeting taking place.

The registered manager told us that they would look at undertaking capacity assessments for all people and discuss with the Local Authority if some people needed a DoLS referral. We have made a recommendation about this.

Only two of the eleven people at the home were able to eat a regular diet, the other people received nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) tube. The two people who ate a regular diet had their food brought into the service via a specialist catering company which catered for people who needed their food to be at a certain consistency to aid with swallowing. Foods of different textures were prepared to resemble regular food even if the consistency was altered. One of the two people who ate a regular diet was a vegetarian; they told us they were offered choices and that their diet was catered for adequately. The other person told us that they were happy with the choice of food on offer and they had enough to eat. All the people we spoke with had no concerns with being offered plenty to drink.

It is recommended that the registered manager ensures capacity assessments are undertaken for all people at the service and that a discussion takes place with the Local Authority regarding the possibility of some people needing a DoLS referral.

Good

Is the service caring?

Our findings

People and relatives were very complimentary about the approach of the staff team and the care they received. One person told us, "Staff are very kind, I'm made up with them, I can't fault them." A relative told us, "There is a lot of love here at Cleveland."

People told us that they could make themselves understood through various modes of communication and that their relationship with staff was positive. Those people who were unable to verbally communicate did so by blinking their eyes, using an alphabet board, giving a thumbs up or down or by using assistive technology such as 'eye gaze'. 'Eye gaze' is an eye-operated communication and control system that enables people with disabilities to communicate, interact and maintain independence. By looking at control keys or cells displayed on a screen, people can generate speech either by typing a message or selecting pre-programmed phrases. Staff were observed to be patient and caring with people when communicating with them and displayed a good understanding of people's needs and abilities.

Staff we spoke with told us they had very close relationships with people and their families due to the nature of the care given at the home. One member of staff told us, "Relationships with people and their families are very open and transparent. Families do come to us with questions and worries and we try our best to give them answers. I have absolute confidence in the people I work with and in twenty years of nursing I can honestly say it is one of the best places I have worked in. Staff here are very caring."

Relatives we spoke with said they could visit the home whenever they wished to without restriction. They told us that staff called people by their first name and knew the people they were caring for well. One relative told us that due to the personal nature of the care at the home that staff called their relative by a nick name, which their relative liked and preferred.

All of the relatives we spoke with told us that they were involved in care planning and reviews of care, only a few of the people we spoke with who lived at Cleveland House told us that they were involved. When asked no-one indicated that they felt this was an issue and were happy for their relatives, the home and other professionals to take a more active part in this process. As far as day-to-day decisions were concerned people felt they had a say in what they wanted to do and were happy that they could make choices.

We saw within peoples care plans that referrals were made to other professionals appropriately in order to promote people's health and wellbeing. Examples included referrals to GP's, specialists and social workers. A regular team of occupational therapists and physiotherapists visited the home and a dedicated therapy room, complete with specialist equipment, was in place at the home for visiting professionals to utilise.

The home had close links with Queens Court Hospice in neighbouring Southport who gave advice and guidance for people nearing the end of their life. The home was attempting to forge links with a number of local businesses to give the home a profile in the community.

Good

Is the service responsive?

Our findings

People we spoke with and their relatives told us they knew how to raise issues or make complaints. They also told us they felt confident that any issues raised would be listened to and addressed, although no-one we spoke with had made a complaint. The home had a complaints policy in place which was up to date and contained information for people to make formal complaints directly to the home or organisation or to relevant external organisations such as the Care Quality Commission. The home had not received any formal complaints during the twelve month period prior to our inspection. One relative told us, "I had a minor concern that I discussed with the (registered) manager and they listened in a positive manner and acted upon what I said. You can't ask for more than that."

We examined the care files of five people, who lived at Cleveland House. We found documentary evidence to show that people had their care needs assessed both externally by healthcare professionals prior to moving to the home, and by staff at the home. We saw some evidence that people had input into their care plans if they wanted to. There was a section entitled 'Background' at the beginning of each care plan which gave a detailed summary of people's background, medical condition and history. There was also a section entitled 'service user social profile'. However, for one person this was not completed.

We found care plans easy to read, navigate and contain good information. They were indexed and personal to each individual's specialist needs. They were stored securely and staff we spoke with knew how to access them and told us that they did read them and have an input into their content. Staff told us they thought care plans were of good quality and contained sufficient information to provide care for each person to a good standard. However we found a few issues with certain sections of people's care plans not being signed or dated. This varied from person to person but included background information, social profiles and some care planning documents. This tied in with some care plans not being reviewed in a timely manner, for example one person had been in hospital and their care plan had not been reviewed following their readmission to the home. We discussed this with the registered manager who was aware that some care plans were in need of review. We have made a recommendation about this.

There was no formal activities coordinator in post at the time of our inspection; this was mainly due to the fact that the service was only operating at approximately one third capacity and the abilities of the people at the service were limited in terms of traditional activities. However we did see that each person had their own therapy file which detailed any therapies undertook. The home had its own dedicated therapy room and on the second day of our inspection we saw that visiting physiotherapists and occupational therapists visited the home to undertake various therapy sessions with people.

The home had different areas for families to use apart from people's bedrooms and relatives were able to use purpose built visitor kitchen facilities and lounge areas if they wanted to do so. Each person's room also had level access to an outside patio area which either looked onto the contained garden area or front of the home. We saw some good innovation in terms of enabling people to visit their relatives. One family who lived a distance from the home and did not drive had their taxi fare paid for and another relative had their bus pass paid for to enable them to visit without having to worry about the cost of doing so. There were

other specific examples such as the home paying for one person's taxi on Christmas day so they could go to the family home and celebrate with their family and young children. The registered manager told us that the home were looking to source their own vehicle but in the meantime had a contract with a local taxi firm, and were also looking at other options to assist people getting into the community or to help relatives visit the home regularly.

We saw that people were able to make choices in a number of areas. This included how they wanted their rooms decorated. We saw in all the rooms we went in that people had brought a large number of items with them including pictures, photographs, ornaments and other personal items. This helped create a more relaxed environment which was important given that there was a lot of clinical equipment within people's rooms. We also saw that people chose what to watch on television, when to wake, go to sleep and for those who could what they wanted to eat and when.

We recommend that processes are put in place to ensure care plans are reviewed in a timely manner, particularly following a change in a person's condition or following a stay in hospital, to ensure that staff are aware of any changes to a person's assessed needs.

Good

Is the service well-led?

Our findings

All the people we spoke with told us how approachable the manager and staff were at Cleveland House. They told us they could discuss any issue they may have and know that they would be listened to. They told us that everyone working at the home was approachable and friendly.

We spoke with staff and asked them how the service demonstrated good management and leadership. The responses we received were very positive. One member of staff told us, "You can always talk to a nurse or manager." Another member of staff said, "We have a good relationship with (registered manager) and get all the support we need." No staff we spoke with raised issues with the management team at the home or for the wider organisation.

Staff told us that regular staff meetings were held and we saw evidence of these. The registered manager told us that the aim was to have six weekly meetings which all staff attended and then a separate nurses meeting followed. Topics discussed at the last meeting in January 2016 included; care planning, professional visits, paperwork, communication, training, rotas and staff supervisions. A record was in place in terms of which staff attended meetings. As well as staff team meetings monthly management meetings took place.

One member of staff we spoke with told us that they felt staff handovers could be improved. They told us that staff were expected to stay behind and deliver handovers unpaid and that this affected the quality of them. We discussed this with other staff and no-one else highlighted this as an issue. We spoke with the registered manager about this who told us that staff handovers had been discussed with staff and that there was an expectation that they would take place ten minutes either side of each shift. All barring one member of staff told us that staff handovers were of good quality and they felt handovers helped them care for the people at the home.

We saw that a wide range of audits took place at the service that were stored within a 'Quality Assurance Audits file'. These included recent medication, health and safety and Infection Control audits that had all taken place a few weeks prior to our inspection. All the audits we saw were very detailed, covering a wide range of areas and were scored as a percentage. Any issues found were highlighted and immediate actions taken. For example within the Infection Control audit a lack of paper towels and liquid soap within a bathroom was found and rectified the same day. All audits scored in the high 90's and issues found were minor. Previous audits seen compared well to the more recent audits undertaken.

We observed a positive culture throughout the service. Staff showed a good team working ethos and appeared to have established positive relationships with colleagues, people who lived at the service and their families. All the staff we spoke with told us they had a commitment to providing a good quality service for people who lived at the home. We found the service to have clear lines of responsibility and accountability.

Prior to the inspection we checked to see if the home had submitted information to the Care Quality

Commission in line with its statutory obligations. In the previous 12 month period prior to the inspection no notifiable incidents had occurred at the home. We discussed notifications with the registered manager who was knowledgeable about their responsibilities.

We spoke with the service director who had responsibility for three services within the Partnerships in Care group. They told us that senior management were very supportive and 'hands on' with the homes in the group. They talked through the different types of support they gave to registered managers in terms of advice, guidance and more formal support. The registered manager confirmed this to be the case when speaking with them.