MacIntyre Care

The Cherries

Inspection report

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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

Overall summary

This inspection took place on 16 and 18 June 2015 and was unannounced. The Cherries is a residential home providing care and support to six men with learning disabilities.

The home had a registered manager in place. 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.

The home was experiencing uncertainty about its future. This was because the local authority who owns the building had informed the provider approximately two years ago of their plans to relocate the service. The impact of this had led to low staff morale and a number of staff left due to perceived job insecurity. At the time of

Summary of findings

the inspection we found the provider had recently taken the decision to continue to invest in the service. This was because although they were still uncertain of the future of the home, they recognised that the needs of people living in the home were paramount, and people continued to require support and care on a daily basis.

During our inspection we found some areas required improvement, such as the garden decking area and the number of staff employed within the service. These areas had also been identified by the registered manager and area manager and work had started to be undertaken to resolve these issues.

People appeared happy living in the home. They were familiar with their surroundings and they were relaxed and comfortable. Interactions between staff and people were sensitive, humorous respectful and friendly. People's choices were respected and they were supported to be as independent as possible.

Each person had a care plan in place which recorded how care was to be provided to the person. Risk assessments highlighted identified areas that may pose a problem to the individual or staff. These were regularly updated to ensure people's welfare was maintained. We did however find that mental capacity assessments had not been completed. This meant staff could not be confident of people's consent to the care being provided. We have made a recommendation about the training of staff in relation to mental capacity assessments. Records showed, where decisions had been made on behalf of people these were done in consultation and people's best interest.

Staffing levels had been assessed in line with people's needs. However the registered manager and area manager had taken action to review the number of staff available to ensure staff and people were safe during the day and at night.

Staff were knowledgeable about the people they cared for, and took appropriate action to assist people to maintain their health and wellbeing. Staff were supported in their roles. They received training, supervision and encouragement from the registered manager and deputy manager.

People told us they liked the food, and we saw this was available to people throughout the inspection. People were supported to eat and drink where necessary, and they were involved in making choices about what food was provided.

Regular audits were carried out by the registered manager and the area manager. Findings were fed back to the provider and themes and trends were looked for to prevent reoccurrences and to improve the future quality of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe

People were supported by staff who knew how to protect them from abuse, and were aware of each person's individual needs.

Care plans and risk assessments were reviewed, and staff met regularly with people to discuss their care. If concerns were identified these were discussed with the manager and/or relevant others and appropriate action was taken.

Good

Is the service effective?
The service was mostly effective.

General knowledge about the Mental Capacity Act 2005 (MCA) and how to implement this into the care provided was limited. No mental capacity assessments had been completed with people. This meant staff could not be certain people were consenting to the care they were providing.

Staff worked well as a team and support was available from the home's management.

Requires improvement

Is the service caring?
The service was caring.

Staff demonstrated their respect and knowledge of people by the way they spoke about them and to them.

People told us they were treated kindly be the staff and they were well looked after.

Good

Is the service responsive?
The service was responsive.

Staff supported people with their chosen lifestyles, i.e. accessing the local community and participating in activities and holidays.

People's health needs were monitored, and staff responded quickly if individual health needs changed. Staff were aware of what each person needed to maintain good health.

Good

Is the service well-led?
The service was well-led.

Systems were in place to monitor the quality of the service, where concerns were raised appropriate action was taken.

Good

Summary of findings

Staff and relatives told us the registered manager was approachable and consulted with them when necessary. They told us they trusted the registered manager and had confidence in their skills and knowledge.

The Cherries

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 16 and 18 June 2015 and was unannounced.

The inspection was carried out by one inspector. Before the inspection we reviewed previous inspection reports and other information we held about the home including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about. We also asked the provider to complete 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 improvements they plan to make. We used this information to plan our inspection.

We observed how care was provided to people, how they reacted and interacted with staff and their environment.

We spoke with two people who lived in the home, three relatives and four staff including the area manager. We received information from one local authority worker and we spoke with one health care professional. We examined four people's care files, care recording charts and records related to the medicines people received. We read a range of records about how the service was managed including policies and procedures and audits. We reviewed two staff recruitment and training files.

Good

Is the service safe?

Our findings

People told us they felt safe living in the home; this was echoed by their relatives. They felt confident the home and the care provided was safe.

We spoke to the registered manager and the area manager about the staffing levels in the home. They had recently reviewed the needs of people in the home, and the provider had agreed the funding for additional staff to ensure people's needs were met. At the time of the inspection they were advertising for four extra staff. Documents verified this. Two relatives told us they thought there were enough staff employed in the home to meet people's needs. One relative and one person told us they thought more staff were needed. They told us on some occasions when they had visited only one staff was at the home, whilst the second staff member was out supporting someone in the community. They were concerned about the safety of people in an emergency situation. With the planned increase of staff numbers this meant this risk would minimised.

The provider had completed a document which highlighted the assessed number of staff required to maintain a safe service. The normal working ratio was two to three staff during the day and one awake staff at night. The assessed minimum number of staff required during the day and night was one. We discussed this with the registered manager and asked what would happen in the event of an emergency. Protocols were in place to contact staff who were not working and request they attend the home to offer support. The registered manager had assessed the risk of only having one staff member awake at night and told us they were planning to change a vacant room into a sleeping in room for a second staff member. This would minimise the risks associated with one member of staff working alone at night.

Staff received training and knew what indicators of abuse were and how to report concerns. The local authority procedure for reporting concerns of abuse was displayed in the staff office. There had been no safeguarding concerns in the home since our last inspection.

Where people required medicines, trained staff administered them. Medicine administration records were kept up to date and showed people received their medicines as prescribed by their GP. Medicine profiles were in place in each person's care plan, this described whether the person understood what medicines they were taking and why, how their medicines should be administered to ensure they were given safely. Each person had a medicine cabinet in their own room to ensure privacy when medicines were dispensed and guarantee the security of the medicines.

Records showed all staff had completed training in infection control. Staff were able to describe to us how they protected people from the risk of infection, for example by wearing protective clothing such as gloves and aprons when assisting with personal care.

Risks to people's safety had been assessed. Records showed recent assessments and audits had been completed related to the environment and included areas such as fire safety, water temperatures and the garden area. When reviewing the water temperature records we noted an error. The records incorrectly showed the temperature of a cold water tap being 60C. We checked the temperature and found this was incorrect and the water temperature was safe. The registered manager said they would speak to the staff member and ensure the records were kept accurately in future.

The registered manager had identified areas of risk in the garden area, where the decking had become worn and unstable and paving slabs had become un even. Action had been taken with requests sent to the head office for contractors to carry out the work necessary to make the area safe. The equipment and premises had service contracts for equipment for example fire equipment, to ensure they were safe to use and well maintained. Regular audits of the building and the environment were completed by the registered manager and sent to the area manager.

The service operated safe recruitment procedures. Staff files contained Disclosure and Barring Service (DBS) checks, references including one from previous employers and application forms. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with adults. Identification documents and completed health checks had also been completed

Requires improvement

Is the service effective?

Our findings

People told us they liked the food provided in the home. They said "The food is very good." Relatives told us people received enough to eat and drink. One relative told us a person's weight had increased and their general health had improved since the new manager and deputy were in place.

We observed people were supported to eat and drink sufficiently to maintain their health. We saw jugs of drinks were available to people and those who were able helped themselves to hot drinks. Menus were chosen by the people living in the home during a regular residents meeting. A pictorial menu was available to remind people of what had been agreed for each meal. Where people required support with their food intake, we saw this was offered by staff. Staff ate with people at the dining room table offering any additional support or encouragement when needed.

Records showed people's preferences for food and drink had been documented. People's nutritional needs had been assessed and care plans reflected how people's needs were to be met. One person with a diet related illness received support from the district nurses and local GP. One staff member was due to attend training to have a clearer understanding of the illness and to enable them and other staff to improve the care provided.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) set out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Documents showed some mental capacity assessment forms had been completed, however these were completed by external professionals and they were not up to date. For example, one person had a mental capacity assessment completed by a health professional in 2013 regarding an invasive medical procedure.

There were no mental capacity assessments in place for the care people were receiving at The Cherries. Staff had a basic understanding of the MCA but were not able to describe to us how this applied to the people they worked with in terms of how to carry out a mental capacity assessment.

This meant staff could not demonstrate they had assessed people's mental capacity to make specific decisions for themselves. Furthermore they could not be certain of a person's ability to consent to the care they were receiving. Current records showed staff, relatives and professionals were acting in people's best interest. Where people were being lawfully deprived of their liberty, the registered manager had applied to the supervisory body for authorisation to put restrictions in place to ensure people were safe.

We discussed with the registered manager our concerns about the lack of mental capacity assessments. Whilst they were able to describe to us what the MCA meant, they lacked confidence in implementing the assessments. Training records showed 75% of staff had attended training in MCA, however only one person had attended training in the last year with the majority attending in 2012. The registered manager had not attended training in the 18 months since starting work at The Cherries.

From our observations we could see people were being lawfully deprived of their liberty. Best interest decisions were made by involving family members and in one person's case an advocate.

Relative's told us they were kept informed of changes made to the care a person received, and they were consulted with appropriately.

Staff told us they received induction training which included the training the provider deemed as mandatory. We looked at the training records for staff. There was a wide range of training available to staff, however, the area manager told us corporately training was being reviewed. This was because; staff were overloaded with training, some of which was not relevant to the service they worked in. The new approach will be looking at service led training. As a result the training needs of staff will be dependent on the needs of the people living in the home.

Staff said they felt supported by each other and by the senior staff in the home. Following the completion of the mandatory training they shadowed senior or more experienced staff until they were deemed to be competent to work alone. Staff told us they had received supervision

Requires improvement

Is the service effective?

and appraisal. Records showed staff received formal supervision regularly, and staff told us the manager made themselves available to speak to whenever they needed support. Staff told us they found supervision and appraisals useful as an opportunity to get feedback on their performance and how they could improve in their role. Other support included staff meetings and hand over meetings.

Where people's health needs had changed people's relatives told us staff responded quickly and appropriately.

People's care plans showed their health was being monitored and where necessary referrals had been made to other professionals with specialist knowledge. For example, one person required dental treatment, this had been arranged. Another person who had epilepsy attended a clinic where their epilepsy could be monitored.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to carrying out mental capacity assessments.

Good

Is the service caring?

Our findings

One person described the staff as "Kind" and another told us how "They look after me and make me feel safe." One relative described the staff by saying "You couldn't have better staff anywhere else. They know everything about (named person) if they are worried they ring me and we work things out together." Another relative told us they had experienced some problems with some of the staff, but stated that overall the staff were very caring.

We observed positive interactions between the staff and the people who lived in the home. Staff were gentle and encouraging when assisting people. One relative told us how impressed they were with the way staff supported a person. They said the person was always well dressed, clean and their physical needs were always met. Training records showed staff were trained in how to care for people in a person centred way. This meant staff focussed on people's wants, needs and choices and encouraged independence. A relative described the atmosphere in The Cherries as a "Home from home." Another said the person's lifestyle was the same as everyone else's, the staff supported them to do the same things as the rest of society, including going on holiday, using the local community and having a comfortable life in the home with the support of "wonderful staff."

A staff member described the home as "like a little family". Staff told us they would be happy for a loved one to reside at The Cherries as one stated they believed people were "really well looked after."

Staff were able to talk knowledgeably about the people they cared for. They were aware of people's likes and dislikes and how to communicate with each person. People and their relatives told us communication with the staff was on the whole good. Staff were able to understand a person who used their own signs and gestures to communicate. Photographs were used to communicate to people which staff members were on duty and when.

Staff understood the need for people to maintain their independence; one person had been supported to secure a voluntary position working in a local charity shop. Another person who used to be able to access the local community independently now required support. We observed how this support was available, when they wished to do so.

Staff knew how to protect people's privacy and dignity. One staff told us they ensured they gave people the time they needed to be cared for. They maintained eye contact with them when they communicated with them, and they communicated in a way the person understood. They ensured their privacy was maintained during personal care, by ensuring door were closed and curtains drawn. Another told us they treated people how they would wish to be treated, but they were there for them when they wanted support. We observed kind and encouraging relationships between the staff and the people living in the home.

Records showed people's relatives had been consulted about how they wished people to be cared for at the end of their lives. These included details such as funeral arrangements and how much involvement the family and the home should have up to and following the person's death. This ensured people's end of life preferences could be respected.

Good

Is the service responsive?

Our findings

People had lived at the home for many years. Their care needs were consistently reviewed both within the home and with family members and other professionals where appropriate. One relative told us "If there are any problems I am the first to know." Another told us they had been consulted and were involved in the person's care. People could contact the registered manager in person or by telephone.

Care plans were updated regularly to ensure the care being provided met the person's needs. Risk assessments recorded the risks involved in caring for the person and how these could be reduced. Care plans were personalised and included people's wishes. For example, one person wished to have a lie in bed in the morning, we observed how this was respected by staff. Each person had a health action plan. This included information about the person's health, allergies, health concerns, medical history, and any preventative action staff needed to take to keep the person healthy. It also included the names of professionals and contact details of those who supported the person with their health. This information could be used if the person was admitted to hospital for treatment. This would enable hospital staff to have a clear understanding of the person's requirements if they were unable to explain themselves.

Other information recorded in people's care plans included a timeline of events in the person's life. This was supported by additional more detailed information about the person's life history. This enabled staff to understand people's life experiences and how this had impacted on the person's life to date.

Where people had specific needs due to physical or mental health concerns, specialist care was provided. For example regular appointments at hospital were attended by a person with health needs. Another person who had an illness had regular visits from a district nurse. During our inspection a visiting foot care professional was attending to people's feet. They had worked over many years with the people living in the home and appeared to have a good relationship with each individual as well as a thorough knowledge of their health needs. This ensured people's feet remained healthy which was particularly important for one person whose health needs posed a risk to their feet.

Alongside people's physical and mental needs, care plans recorded people's likes; dislikes; interest; history and hobbies. People's social needs were also considered as part of the care provided at the home. During the inspection we saw two people ask for support to access the local shop, this was provided. On the second day people who were not attending day services went out on a picnic for lunch. We were told by one person they had been on a day trip to Brighton the week before our visit, and that each week they went to the local pub for fish and chips. They said they enjoyed the activities and outings. It appeared these things were important to them and their wellbeing.

In order to protect people from social isolation families and friends were welcomed into the home. One relative told us when they were unable to visit the home, staff brought the person to spend time with them at their home.

Staff knew how to support people to make a complaint or raise a concern. Each person had a link worker, who was responsible for overseeing the care provided and to raise any issues or concerns. Each month the link worker met with the person to establish what their aims or wants were and to set goals for the following month. This also gave the person and link worker the opportunity to discuss any worries or concerns. Staff told us they would raise these at the team meeting and discuss how concerns could be addressed. Staff knew how to deal with complaints and how and who to report them to. One complaint had been made in the last year. This had been dealt with in line with the provider's policy. Complaints that are made regarding the home are reported to the area manager. At a corporate level information is screened to identify themes which are addressed at a service level. This enables the service to take appropriate action when necessary to improve the service provided.

Good

Is the service well-led?

Our findings

From our observations, people living in the home felt comfortable with the registered manager and were happy to ask for support from him with their care. Staff told us the management in the home were supportive. There was an open culture and both the manager and deputy manager were accessible. We received positive feedback from a local authority employee who had been in contact with the home. They told us the registered manager was professional and caring, people and their families were involved in the care that was provided. The registered manager was knowledgeable about the people living in the home and treated people with respect.

Regular monthly visits from the area manager enabled audits and reviews of the quality of the service to take place. These included checks on how the care was provided; the health and safety of the environment; service provision and documentation. Checks also included a reported "snap shot" of the interactions between staff and people, which enabled the area manager to identify where any areas of improvements were needed. Action plans were in place to ensure where improvements were required these were followed up.

People's relatives told us the home was well managed. Most thought staff were well trained, competent and confident. One relative told us they felt staff would benefit from training in people's health care needs. They felt the registered manager was accessible and approachable. Staff spoke positively about the registered manager and the deputy manager. We were aware the service had gone through two years of uncertainty about its future. This had caused insecurities and low morale in the staff team. Support had been offered to staff by the management in the home, and it was felt by the area manager that staff morale was starting to improve.

Staff told us they felt they worked as a team and all helped each other. They said the registered manager was approachable and listened to their concerns and ideas for improvement. They could raise issues in team meetings and individually with the registered manager. Handover meetings occurred three times each day between staff going off duty and those coming on duty.

The provider had a set of values which were to be understood an implemented by staff in each service. These were based on kindness, compassion, dignity, empowerment, equality and respect, However, when we spoke to staff they told us they had read them but could not remember them. The area manager told us training was to be introduced for all staff to make it easier for staff to understand the values and how these were fundamental to the way care was provided to people. From the observations we made, staff were implementing the values in the care they were providing to people.

People and relatives had the opportunity to feedback their experiences and opinions on the running of the home by completing a questionnaire. The results of the survey were mainly positive. Where comments had been made the provider had taken action to improve the service. For example, one action was to increase staffing levels so people could get out of the home more often.

We saw copies of completed audits for safety checks and fire equipment maintenance checks. Where faults or maintenance were required we could see action had been taken to ensure the safety and reliability of equipment.

The registered manager had informed the Care Quality Commission of significant events that had happened in the home as required. They had responded to requests for information in a timely way.