Sunderland City Council

Fenwick Close

Inspection report

1 Fenwick Close, Litchfield Road
Southwick
Sunderland
Tyne and Wear
SR5 2AH

Tel: 01915493875
Website: www.sunderland.gov.uk

Date of inspection visit:
20 June 2016
22 June 2016

Date of publication:
12 July 2016

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 20 and 22 June 2016. Day one of the inspection was unannounced; this meant the provider did not know we would be visiting. Day two was announced. We last inspected Fenwick Close on 24 June 2014 and found it was meeting all legal requirements we inspected against.

Fenwick Close provides care and support for up to three people who have a learning disability. The home is one of three homes situated in its own small close that is set in its own landscaped grounds. There is one manager responsible for the management of all three homes in Fenwick Close. They have an office base on the close. The close is for the sole use of people living there, their families and staff. The home does not provide nursing care. At the time of the inspection there were three people living at the service.

The manager had been in post since February 2015. At the time of the inspection they were not registered with the Care Quality Commission. The last registered manager cancelled their registration on 18 April 2016.

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.

Relatives we spoke with said they thought their family members were safe. One relative said, "There's always staff around." Staff confirmed they were well trained and there were enough staff to meet people's needs.

Safe recruitment procedures were in place and people had been trained in recruitment so they were invited to attend panel interviews.

Medicines were administered, recorded and stored in a safe manner.

There had been no safeguarding concerns raised. A procedure for recording, reporting and investigating any concerns was in place and staff understood what they should do if they had any concerns.

Risk management plans were in place. Two were dated 2008 and 2012. They had been reviewed and the manager said the information was still relevant but could be updated. Other risk management plans were person centred, specific and detailed.

Personal emergency evacuation plans were in place and staff understood how to evacuate people in an emergency. One staff member said, "We do simulated evacuations with [people], it's about two minutes to evacuate, everyone copes well. People know the drill."

Accidents and incidents were recorded, investigated and analysed for lessons learnt. There was a procedure for recording and investigating complaints but none had been received. Relatives told us they had no reason

to complain.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was understood by staff. They were aware people had authorised DoLS in place and they knew how to support people with making decisions in their best interest.

People had the involvement of external professionals such as speech and language therapy, the community learning disability team, district nurses, dentists and opticians.

We observed warm and caring relationships between staff and people. One person said to a staff member, "You're lovely you are, I like you." Relatives said they were happy with the care provided. One relative said, "They are happy and looked after and that's the main things, that's what's important."

Care records were detailed and person centred. One relative said, "I was involved in care plans and I go to the review meetings, it's all explained to me."

Detailed communication passports were in place to support effective communication and understanding between people and their staff. Hospital passports were in place to support hospital staff to know vital information about people should they ever be admitted to hospital.

Each person had an activities timetable, which meant they had a routine. It also meant there was social engagement and community involvement.

A range of quality assurance systems were in place to audit the quality of the service and to identify any improvements. Peer reviews were also completed where managers from another service completed the audit.

Staff and relatives were happy with the management of the service. One relative said, "The manager is fantastic." They added, "There are no improvements that could be made, I'm happy with everything."

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.

Relatives and staff told us they thought their family members were safe and there were enough staff to meet people's needs.

Safe recruitment practices were followed. People had been trained in recruitment and were invited to attend panel interviews to support the recruitment of their own staff.

Medicines were managed and recorded in a safe way.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge to support them to meet people's needs.

The Mental Capacity Act was understood and staff knew how to seek consent from people before supporting them.

People were supported to ensure they accessed health care as and when needed.

Staff supported people to ensure they had a well-balanced and nutritious diet which met their specific dietary requirements.

Is the service caring?

Good

The service was caring.

Relatives said they felt their family members were well cared for.

Staff had warm and compassionate relationships with people and treated them with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care records and routines were person centred and detailed.

Activities and social engagement were a priority for people. One relative said, "They have a better social life than me!"

Pictorial complaints information was available for people. Relatives said they knew how to complain but had never had reason to do so.

Is the service well-led?

Requires Improvement

The service was well-led.

The manager spent time in the service and people were relaxed and comfortable with them.

One staff member told us the manager was, "Fantastic." They said, "The staff team is fantastic, I can't praise them enough."

There were a range of quality assurance tools used to identify any areas that needed improvement. We saw identified actions were met.

Fenwick Close

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 20 and 22 June 2016. Day one of the inspection was unannounced. This meant the provider did not know we would be visiting. Day two was announced.

The inspection team was made up on one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We also contacted the local authority commissioning team, and the safeguarding adult's team. We did not receive any information of concern.

During the inspection we spent time with the three people living at the service. We contacted two relatives by telephone. We also spoke with the manager, one senior care staff, four care staff and one apprentice.

We reviewed two people's care records and four staff files including recruitment, supervision and training information. We reviewed three people's medicines records, as well as records relating to the management of the service.

Due to the complex needs of some of the people living at Fenwick Close we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

Some of the people living at the house had complex communication needs so were not able to communicate with us using speech. One person did say, "It's lovely here." We observed other people to be relaxed and engaged with their staff.

Relatives we spoke with said they thought their family members were safe. One relative said, "Oh yes, they are very safe. They are never on their own, there's always staff around." Another relative said, "Yes, [family member] is safe the staff are really fantastic."

Staff understood the potential signs of abuse, such as bruising or changes in behaviour. They were knowledgeable about the procedure to follow if they had any concerns. One staff member said, "I would record and report it. I'd also look at the reasons behind it. Bullying could be safeguarding, or financial abuse, I'd report it all." There had been no safeguarding concerns. However, a procedure was in place for reporting, recording and investigating any concerns.

Risks to people and staff had been assessed and risk management plans were in place. The risks in relation to scalding and slips and trips during personal care were in people's care plans and contained generic information. The generic assessment of scalding risks was well managed and there were instructions for staff to follow in the event of an emergency.

Risk management plans in relation to communicating needs through behaviour where in place but one was dated December 2012. It had been reviewed in March 2016 however it had not been re-written for four years. We raised this with the manager who viewed the risk management plan and explained the information was still relevant. They agreed it could be updated to reflect the person's current presentation more and started work on the re-assessment straight away.

Epilepsy risk management plans were in place and contained detailed information on the type of seizures people lived with, any triggers and how staff should support people if they were to experience a seizure. People also had specialist pillows which some people with epilepsy used to minimise risk. The manager said, "People's epilepsy is well managed, we haven't seen anyone have a seizure but staff are trained and know what to do just in case."

Risk assessments for choking, eating and drinking were in place and had been developed by the speech and language therapist. Detailed information on the persons seating position was included as was detail on the support the person needed.

Personal emergency evacuation plans were in place and included the specific support each person would need in the event of an emergency. One staff member said, "Evacuation plans are in place, we do trial runs and at the monthly meeting with [people] we talk about it so they know what would happen." They added, "We do simulated evacuations with [people], it's about two minutes to evacuate, everyone copes well. People know the drill."

A business continuity plan was in place and included information on the action to take in emergencies such as loss of accommodation, loss of heating and loss of cooking facilities. Peoples' care records also included emergency information sheets and missing persons sheets which included vital information that staff needed to know in the event of an emergency.

Accident and incident reports were completed. The manager said, "They are sent to the health and safety team and we get information back." They showed us a spreadsheet which recorded the number and type of incidents each month and said, "It shows a reduction in the number of incidents." They went on to say, "The group meets every other month and we look for lessons learnt and triggers."

Health and safety checks were completed regularly and all necessary servicing of equipment and utilities were in place.

All the staff we spoke with said there was enough staff to meet people's needs. One staff member said, "Oh yes, there's definitely enough staff to support." Each person had one to one support whilst in their home. We saw there were always a minimum of three staff on duty. Overnight support was provided by one waking night staff member and one sleep in staff member. One relative said, "There's enough staff, there's always three staff if not more."

Safe recruitment procedures were followed which included an application form and interview. Two satisfactory references were required along with a clear disclosure and barring service check (DBS). DBS checks are used to support providers to make safe recruitment decisions about staff who will be working with vulnerable adults. DBS checks were renewed every five years. The manager explained they were introducing an annual disclaimer where staff were required to declare any new convictions.

The manager said, "We need to be careful to choose staff with the right values. Customers [people] have been trained in recruitment. At panel interviews we invite people to be involved. We use videos [about social care] and customers [people] talking about what they want from staff – knowledge, empathy, which is used to recruit our staff." They added, "We have recruitment evenings and events to stress the importance of the job and the role staff play in people's lives. Customers [people] attend these events."

We observed a staff member administer medicines. They were aware of hand hygiene and washed their hands and wore gloves whilst administering medicines. A monitored dosage system was used. This meant the pharmacy put people's medicines into blister packs according to the time of day they needed to be administered. The pharmacist also provided pre-printed medicine administration records (MARs) which staff checked against the medicine labels before giving people their tablets to ensure they were correct.

MARs were signed only after the person had taken their medicine. We saw there were no gaps in the recording of medicines. Any medicines that were not in the MDS system, such as 'when required' medicines were counted on every administration to ensure the correct number of medicines were held in the service.

Specific protocols for the administration of 'when required' medicines were not in place. However the information on how to recognise if a person might need their medicine, such as due to pain, was recorded in the medicine care plan. There was specific and detailed information on how to support people to take their medicines which included what to say to people, whether they preferred their medicines to be in a pot or in their hand and what drink people preferred with their medicines.

Good

Is the service effective?

Our findings

We spoke with staff about the support and training they received to enable them to fulfil their role. Staff told us they attended regular supervision meetings for support and to discuss their performance. They also said they had an annual appraisal. Records confirmed staff attended supervision meetings on a regular basis as well as having their performance assessed by regular observations. The manager said they liked to work alongside staff so they could assess performance. They also explained they sought feedback from staff colleagues so this could be included in the staff member's annual appraisal.

One staff member said, "I had a full induction, policy and procedures, protocols, time to read care plans. [Person] keeps me right don't you?" The person responded with, "I do." Another staff member said, "I did two weeks induction at the Leechmere Centre for all my training and I'm now on week three shadowing." The manager explained the induction process was very detailed and was linked to the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

Staff told us they felt well trained. One staff member said, "I've done moving and assisting, infection control, first aid, I'm in the middle of my diploma level two." They went on to say, "I've done safeguarding, mental capacity, epilepsy and SUDEP awareness." SUDEP is sudden, unexpected death in epilepsy prevention.

A training matrix was in place which showed staff had been trained in moving and assisting, mental capacity and deprivation of liberty safeguards, safeguarding adults and medicines management. Some staff had received training in equality and diversity, whilst others had completed national vocational qualifications (NVQs) in health and social care.

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 so that they can 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. The provider had submitted applications for all the people living at the service, all of which had been authorised. Staff understood the need to follow the requirements of the DoLS, including the use of bed rails in some people's best interest.

One staff member said, "It's about making sure [people] are looked after through the mental capacity act." They added, "It's so people are protected in all aspects through making best interest decisions." Formal best

interest decisions had been recorded as part of the DoLS authorisations and had involved staff, family members, a best interest assessor and a relevant person's representative (RPR). A RPR represents and supports the relevant person in all matters relating to the DoLS. Including, if appropriate, triggering a review and using an organisation's complaints procedure on the person's behalf. Day to day best interest decisions were recorded within care plans and involved care staff and management.

All the people living at the service had involvement with speech and language therapy (SALT) who had produced guidelines for supporting people with meals. The guidelines were available in the kitchen area for staff to follow and staff were able to explain, in detail, how people needed their meals and drinks prepared. One staff member said, "We use thickener and record how many scoops are used, it's one scoop per 100ml of fluid so we know how much people are drinking as we know the size of cups." They added, "If people are using different cups we always measure the fluid so we know how much thickener to use."

We observed people were supported at mealtimes in line with the guidance from SALT. One person said of their meal, "Mmm, that's lovely it's my favourite." One staff member said, "The menu on the board is planned on a Sunday night with people, but we always ask what they want before a meal. Even if it's planned everyone can change their mind can't they."

People had separate health care files which included hospital passports which are used to provide vital information for hospital staff if a person needs to be admitted for any reason.

Health files contained all the information in relation to health notes, medicines, dentist, chiropody and opticians visits. There was also information and guidance from the district nurse, the SALT team, psychology, psychiatry and the community learning disability team.

Where people had a specific diagnosis there was information in people's care records about the characteristics of the condition. This supported staff to understand some of the features of people's behaviour and support needs.

Good

Is the service caring?

Our findings

People who were able to express themselves using speech expressed happiness with the staff who supported them. One person said of a staff member, "You're lovely you are, I like you." With their permission they showed us their room which was very personalised with photographs and sentimental ornaments and posters. Each person had chosen their own furniture and had been involved in decisions about the décor.

Relatives told us the service was caring. One relative said, "I'm quite happy, [family member] is well looked after, they are happy and looked after and that's the main thing, that's what's important." Another said, "I'm always made to feel welcome. It's a lovely place." Another said, "[Family member] is in good hands, its lovely. [Family member] is friends with everyone and the new staff are really good too."

We observed a very warm, relaxed and homely environment. Staff were attentive to people's needs and understood their communication well. We observed one person sitting watching television in the lounge with a support worker and an apprentice. Staff asked them if they wanted to go out and person's face lit up with a huge smile. Staff asked if the person needed some chocolate and the response was one of delight. Staff then said, "You don't like tea though do you?" and the person shook their head. This meant staff were able to understand the person's communication and the person was able to acknowledge their understanding of staff conversation.

Staff always sought to involve people before offering any support. For example, they asked if one person wanted to transfer from a comfortable seat to their wheelchair ready to go out. The person said yes and behaved in a way which staff explained meant the person was excited. Staff explained to the person how they were going to move the chair and why and sought consent before they did so.

Another person spent time in the kitchen area looking out of the window whilst the staff chatted to them in a relaxed and caring manner. The person initiated physical contact, putting their hand out to staff who responded by holding the person's hand. The person also made a specific gesture which staff understood to mean that the person wanted a hug. Staff asked, "Do you want a hug?" and waited for an appropriate response before doing so. One staff member said, "Appropriate contact is very important for people, it has to be on their terms though."

Staff were sensitive to people's needs and ensured people's privacy and dignity was respected at all times. Staff always sought permission before supporting people; they responded to people's requests appropriately. For example, when people indicated they wanted the support of a specific staff member. Staff were conscious to support people in a discrete manner.

People were involved as much as possible and house meetings were held with the people living at the service. One staff member said, "House meetings are held where people can express their wishes and desires."

The manager said, "Family members are involved in care planning and reviews, everything is run past the

family." One staff member said, "We have annual review involvement from family and professionals, they are always invited." Relatives confirmed their involvement in the care of their family members.

Information was recorded on people's family members and friends birthdays and significant dates. The manager said, "We support people to send gifts at Christmas and birthdays."

We asked about advocacy. Information on advocacy was available. People had the involvement of family members so did not currently have the involvement of an advocate, but some people did have the involvement of a relevant person's representative in relation to their DoLS authorisation.

Good

Is the service responsive?

Our findings

People had care records which were written from a person centred perspective. They included information about people's history including events that were important to the person, important people, family birthdays, religious beliefs, likes and dislikes. There was also a summary of the person's medical history and medicines. This meant staff had easy access to any vital information about the person if it were needed in an emergency situation.

Care plans promoted people's independence and choice in relation to home involvement, social interests and community activities, exercise, health and personal care. Care plans included people's goals and aspirations and were specific to the person. Due to people's complex needs staff said it was difficult to include people in care planning. One relative said, "Yes I'm involved in [family members] care. The staff call if [family member] is poorly or has had a fall. I always get invited to reviews and we go through everything." Another said, "I'm involved, the staff call or send a letter if I need to know anything." They added, "I was involved in care plans and I go to the review meetings, it's all explained to me. Anything at all they always let me know."

Annual reviews were held and attended by the person and their family members, as well as staff who worked with the person. As well as reviewing the past year there was a focus on the person's goals and aspirations for the forthcoming year. Goals were included in the person's care plans such as saving for holidays and special events.

As well as care plans people had detailed morning and evening routines, which were specific to the person's needs and preferences. Information included the way people liked to be woken, when they liked their breakfast and personal care. There was detail on the areas where people were independent and able to meet their own needs, and the areas where prompts or physical support from staff were needed. This promoted peoples independence and maintenance of skills.

Each person also had detailed communication passports which included the things staff and others, such as health care professionals, needed to know about the person's communication. This included how staff and others should communicate with the person, such as using short sentences, and how the person would communicate back. There was information on the 'dos and don'ts' of communication such as 'don't ignore me' and 'don't tell me what to do.' For people who communicated using behaviour such as nipping or hitting out, this was described, the reasons why the person behaved in this way was recorded and how staff should respond was very clear.

Behaviour support plans had been developed with the input of health care professionals. Staff understood the strategies they needed to follow to support people but were also aware of the need to review the strategies if they weren't working for people.

People were actively supported and encouraged to take part in day to day activities, such as shopping. One person expressed they liked to go and do the main shopping for the house, with support from the staff and a

shopping list. Another person stayed at home. Staff said, "They are a home bird and can't cope with too much sensory stimulation so they are supported to get any bits and bobs that we need."

The manager said, "There's lots of family involvement, they often donate things for the summer fayre and the proceeds are donated for the company charity." We saw photographs of events such as a garden party for the Queen's birthday. One person had a season ticket for the football and they were supported to attend regularly with one of their friends.

Each person had an activities timetable which staff were knowledgeable about and supported people to maintain. One person had a pictorial timetable which was used so they knew what activity was happening now, and what would happen next.

We asked relatives about the activities available for their family members. One relative said, "[Family member] goes out quite a lot, they have a better social life than me!

People had a pictorial complaints policy and service user guides which were kept in their houses. The relatives we spoke with said they had no concerns at all about the care provided but they did know how to complain if they needed to. One relative said, "I know how to complain, but I haven't had course to do so." Another said, I've no complaints, they treat [family member] really good."

The provider had 'Tell us what you think' leaflets to encourage people and their relatives to share comments. There had been no complaints since the last inspection but there was a detailed procedure for how to manage any concerns or complaints received.

A 'Tell us what you think' policy was available and relatives had shared some feedback with the manager. This included comments like, 'very happy with the service' and 'very positive about the placement, the activities [person] is involved in, we are kept informed of everything which happened and feel this line of communication is very important.'

A family forum was held by the managing director and all relatives from all services were invited. The manager said, "This gives the opportunity for carers [relatives] to meet up. We also invite carers [relatives] to some of the activities and events so they can meet everyone and get support from each other." The last forum had been held in January 2016.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post since February 2015 however they were not yet registered with the Care Quality Commission. The last registered manager cancelled their registration on 18 April 2016. This meant the registered manager condition was not being met. We discussed this with the manager who explained they had submitted an application to be registered. We checked this and found an application had been submitted however amendments were required and we were awaiting a new application.

The manager was accountable and responsible for the management of the three services within Fenwick Close. There were senior support workers in each of the three houses who supported the manager with the day to day responsibilities within the homes. The manager had an active presence in the services and was known to people, their relatives and the staff teams.

We asked staff about the management of the service. One staff member said, "The manager has been brilliant, absolutely fantastic." They added, "I love it here, I absolutely love it." When asked why they said, "The staff, the management and of course [the people.] They all have their own characteristics." Another staff member said, "Nothing could be done better, we are like one big family." A third staff member said, "The manager is fantastic, I can't fault them, they've really supported me. The support has been immense, the staff team are fantastic, I can't praise them enough." The staff team had been nominated and awarded a 'Doing the right thing' certificate to acknowledge the support they offered each other. Two staff had been named 'Employee of the month' for the degree of involvement they supported people to have with company competitions.

Staff meetings were held regularly and one staff member said, "We can add things for discussion, either put a note in the communications book or on the agenda." They added, "We all know what's going on, it's really good, we are kept informed." Team meeting agendas included updates from the company, as well discussions around training, rotas, health and safety, competitions, policies and risk assessments.

The manager said the communication was good from the company, and there were team briefs from the senior management. The plan was to use this as a tool to ensure front line staff had a formal mechanism to feedback to senior management. The manager said, "The idea is to integrate and involve staff more."

We asked relatives and staff if they were happy with the way the service was run. One relative said, I'm very happy with the communication and with the manager." Another said, "The manager is fantastic! [Manager] is excellent." They added, "There are no improvements that could be made, I'm very happy with everything." One staff member said, "Yes, it's managed well. We have some new staff and the training is ongoing but there's always regular staff on shift." They added, "New staff are adhering to things well. It's lovely, it's a good staff team who care." Another staff member said, "It's a good company to work for, the directors available, you can phone them anytime. They visit events and they always know what's happening in services, they know all our names."

Organisational health and safety and business meetings included discussions around lessons learnt in

relation to safeguarding, and accidents and incidents. Information was also shared about incidents from other organisations that were in the public domain to assess if there was any learning for the organisation. For example, an accident that had happened whilst using a hoist was analysed and 'bed side guides' had been introduced which included the information staff needed to support people with mobility needs.

Additional organisational meetings included a learning and development group, which the manager was part of and a Care Quality Commission and company standards meetings where managers discussed the standards CQC inspected against and how they were meeting the requirements. Meetings were also held with all the managers in the 'hub' area to share best practice and lessons learnt, as well as discussing care records, policies, peer reviews and training.

A range of quality assurance systems were used to assess the compliance and quality of the service provided. Area's assessed included health and welfare, medicines, staff files, care records and training. Monthly manager's checklists were completed and any actions highlighted within the audit were discussed with the senior support worker for them to action. Although actions were not always signed off as complete we were able to see that actions had been completed. The manager also explained that if they had not been completed the action would be carried forward onto the next audit.

The manager explained that peer reviews were also completed where managers from other services visited and completed an audit. They said, "We aim to complete four a year so we've had two done so far. I complete an audit afterwards in response to their report to make sure any actions are completed."

Medicine audits were completed on a weekly basis. This audit included staff training, completion of staff competencies and an audit of MAR charts. No concerns were noted.