Care Management Group Limited

Care Management Group - New Dawn

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 27 and 28 June 2016 and was unannounced.

Care Management Group - New Dawn provides accommodation and support to a maximum of 20 people with a learning disability or autistic spectrum disorder. It does not provide nursing care. At the time of our inspection there were 20 people living in the home.

There was a registered manager in post. 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.

Risks to people, including those from the premises, were identified and managed. Incidents and accidents were assessed and discussed so action could be taken to minimise the likelihood of a reoccurrence. There was a firm emphasis on safeguarding people living in the home. Staff understood their responsibilities and how to report any concerns.

Safe recruitment practices were in place. There was mixed feedback regarding staffing levels; however the service ensured shifts were fully covered through the use of agency staff. There were appropriate measures in place to ensure agency staff were supported and understood people's support needs.

Medicines were managed and stored safely. There was guidance in place so staff knew how to administer medicines and they received regular training and assessments of their competency in the administration of medicines.

Staff were supported to deliver effective care through comprehensive training and good team work. Staff were encouraged to provide care in the least restrictive way. They understood the importance of providing choice and supporting people to make decisions.

People's individual dietary needs and preferences were catered for. Meals were seen as an opportunity to enhance people's quality of life. Staff worked closely with health care professionals to ensure people's nutritional and health care needs were met.

People were supported by staff who cared for them and knew them as individuals. People living in the home had complex communication needs. The service understood the importance of promoting an understanding of non-verbal communication and had utilised different systems to help people communicate.

Staff supported people to maintain important relationships and access the community. Activities were varied and tailored to people's individual needs and preferences.

The care provided was responsive and timely, it met people's individual needs and preferences. The service had received no complaints in the last year. Relatives told us they knew how to complain and felt comfortable and able to do so.

Team working was encouraged in the service. Staff felt listened to and able to contribute ideas. There was good leadership and management in the home, staff understood their role and the registered manager took action to address areas for improvement.

Care records did not always contain sufficient information. There were effective quality audits in place which had identified this was an area for improvement. The provider and registered manager were committed to delivering a good quality service and the registered manager took action to drive forward a quality service.

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.

Staff understood their responsibilities regarding adult safeguarding and knew how to recognise and report concerns.

Risks to people were identified and well managed, including risks from the environment and premises.

Medicines were managed safely.

Staff were recruited following safe recruitment practices.

Is the service effective?

Good

The service was effective.

Staff received good training and support from their colleagues which helped them to provide effective care.

Staff provided care in line with the principles of MCA and DoLS.

People were supported to eat and drink enough. There was collaborative working between staff and health care professionals to ensure people's nutritional and health care needs were met.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who promoted people's dignity.

There were individual communication systems in place to help people understand the care provided and express themselves.

Is the service responsive?

Good

The service was responsive.

People received care which was personalised and responsive to

their needs.

Activities were varied and tailored to people's needs and preferences.

Relatives knew how to complain and felt comfortable to do so.

Is the service well-led?

Good

The service was well led.

Records relating to people's care needs did not always provide sufficient information and required some improvement. However, this issue had been identified and the provider was taking action to make improvements.

There was strong leadership in the service. Team working was supported and encouraged.

The quality of the service was monitored and the registered manager took action to make improvements where required.

Care Management Group - New Dawn

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.

The inspection took place on the 27 and 28 June 2016. It was unannounced. The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We did not request a Provider Information Return (PIR) form from the provider before this inspection. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We reviewed other information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us.

People living in the home were unable to tell us verbally what they thought about the care provided to them. We observed how care and support was provided to people throughout the day and how people were supported to eat their lunch time meal. During our inspection we spoke with nine support workers, one lead support worker, an agency staff member, the cook, deputy manager, and the registered manager. After the inspection visit we spoke with four relatives and two health care professionals.

We looked at two people's care records, two staff recruitment files and staff training records. We checked the medicines records for three people. We looked at quality monitoring documents and accident and incident records. We saw records of compliments and complaints and minutes of staff and residents' meetings.

Good

Is the service safe?

Our findings

The relatives we spoke with felt people were safe living in the home. One relative said, "I don't have any safety concerns about [name]." They went on to tell us they felt staff were good at balancing people's rights and protecting them from harm. Another relative told us they knew their relative was safe in the home. They said, "I don't come home anxious."

The staff we spoke with understood their responsibilities to safeguard people from harm. One member of staff told us, "Anything we notice, like a mark, we report." From speaking to staff and reviewing minutes of staff meetings it was clear the registered manager ensured there was a firm emphasis on safeguarding people living in the home. Discussions regarding safeguarding responsibilities were encouraged in staff team meetings.

Information regarding safeguarding, including numbers to contact was on display in the entrance of the home. This meant relatives and other people visiting the home knew how to raise safeguarding concerns. The registered manager had reported safeguarding incidents to the relevant authorities and the Care Quality Commission, as required. This showed the service was able to recognise and report safeguarding concerns correctly.

Risks to people were identified, responded to, and managed. The health professionals we spoke with were positive regarding how the service managed and responded to risks. Risk assessments were in place and were specific to each person. These covered areas such as accessing the community, moving and handling, eating and drinking, medication, specific health conditions, and behaviour that challenges. People's care records contained information and guidance for staff to help them manage identified risks. During our visit we observed staff following this guidance when providing care to people. The staff we spoke with demonstrated in our conversations with them that they understood the individual risks to people living in the home and how to manage these.

Incidents and accidents were recorded on separate documentation and passed to the registered manager. The registered manager analysed each event and considered what action was required to mitigate the likelihood of the event reoccurring. For example, we saw in one case there had been an increased frequency of incidents in behaviour that challenged for one person. We saw the service had contacted the person's doctor to review their medication and explore the cause behind the incidents. The staff we spoke with told us incidents and accidents were discussed at team meetings and staff shared ideas about how further incidents could be prevented. This showed the service was proactive in managing and trying to reduce risks in the home.

Records showed the risks to people from the premises were also managed. Regular up to date checks and servicing had been carried out on areas such as electrical equipment, moving and handling equipment, the water system, and fire safety. This helped ensure that the home was a safe place for people to live and work in.

We received varied feedback regarding staffing levels in the home. All the staff we spoke with were clear that staffing levels did not impact on people receiving the care they required. However, two staff we spoke with felt additional staffing would improve the amount of activities offered for people. Another member of staff felt additional staff would be useful at times. They said, "Everything can be a bit rushed." A staffing calculation tool was not used however the registered manager was able to provide us with a clear rationale regarding staffing levels and how they ensured there were sufficient staff to meet people's needs.

The registered manager and staff told us a number of staff had recently left and this had meant the service had to rely on agency staff. We saw the registered manager had a checklist in place for agency staff to ensure they understood their roles, responsibilities, and people's care needs. A member of staff confirmed that agency staff work alongside permanent staff so that support is easily available.

On the first day of our inspection two agency staff who had been booked for the day had not arrived. This had meant the deputy manager and registered manager had needed to provide this cover. We saw that this ensured there were sufficient staff to meet people's needs although it meant that both the registered manager and deputy manager were not functioning in their management roles. The registered manager assured us this was a one off occurrence and had taken action to ensure this did not happen again.

Staff files showed safe recruitment practices were being followed. This included the required character and criminal record checks, such as references and Disclosure and Barring Service (DBS) checks, to ensure the person was suitable to work in the home. Several staff who had started work recently in the home confirmed these checks were in place prior to them starting.

Medicines were managed safely. Prescribed medicines were stored securely. We looked at three medicines administration records which were correctly completed. We also checked three medicines and saw the stock count was accurate. We saw there was clear guidance in place for staff on how to administer 'as required' medicines and medicines that required external application. Staff recorded when external medicines were opened and when they should no longer be used. This ensured staff were using medicines that were safe to use.

Records showed staff had received training in medicines administration. We saw there were regular monthly audits on medicines to ensure they were being managed safely. The deputy manager told us they tended to work alongside staff administering medicines in the morning which meant they could monitor practice regarding the administration of medicines closely. The management team carried out yearly observations on each staff member's practice regarding medicine administration.

Good

Is the service effective?

Our findings

The staff we spoke with felt they were supported to deliver effective care to people. All the staff we spoke with confirmed they received regular supervisions and appraisals. Staff said the registered manager and deputy manager were approachable and supportive. They told us a team approach was encouraged and staff worked together to ensure people's needs were met. A member of staff told us staff would discuss people's needs together and check the care they were providing was sufficient. An agency member of staff told us they were supported by the staff working in the home and this helped them ensure they were providing effective care to people.

Records showed staff received a range of training which was specific to the needs of the people they supported. All the staff we spoke with felt the training provided gave them the information they needed so they knew how to care for people living in the home. Several staff spoke with enthusiasm about the training they had received and how this had helped them understand people's needs. One member of staff said, "Training is really informative." A health care professional told us how the home had sought out additional training so they could meet the specific needs of one person. This demonstrated the service was proactive in ensuring staff had the knowledge they needed in order to meet people's individual needs.

New staff were supported by a formal induction which gave them the support they needed to undertake their role. Staff spoke positively regarding their induction and the support provided when they first started work in the service. We saw new staff completed the Care Certificate which comprises of the minimum standards that should be covered as part of induction training for new staff.

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 in their best interests and legally authorised under the MCA. The application procedures for this in care home and hospitals are called 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 had received training in the MCA. The staff we spoke with demonstrated an understanding of the MCA and incorporated this in to the care they provided. They understood the importance of offering choice to people and how to support the people they cared for to make decisions. We saw in one case staff had recognised one person had difficulty making a complex and potentially serious decision regarding their diet. Staff had requested a specialist health professional carry out an assessment of their capacity.

We saw the service was mindful of the use of restraint in the home. There was clear guidance in people's

care plans for staff to ensure that the care provided was as least restrictive as possible. We saw staff followed this guidance when providing care. For example, we saw one person needed to sit in a specialist seat when eating and drinking. A seat belt was used to ensure they were sitting in the correct position in order to limit the risk of choking. We saw staff ensured they only used this seat for minimal periods of time and when required. Staff recognised when the person wanted to leave the seat and took action to ensure they could do so.

The registered manager demonstrated they understood their responsibilities in relation to DoLS. We saw where restrictions were in place regarding people's care this had been recognised and DoLS applications had been made to.

People were supported to eat and drink enough. The cook demonstrated they were committed to ensuring people received good quality meals that they enjoyed; they recognised that this could enhance people's quality of life. Most of the people living in the home were unable to tell staff their food preferences. We saw kitchen staff closely monitored what people appeared to enjoy eating and what they did not so they could ensure people were provided with food they enjoyed. The cook told us they worked closely with specialist health care professionals to ensure the menu offered enough variety and met people's individual needs. A health care professional we spoke to confirmed this. There was information available in the kitchen so that that staff were aware of any individual special dietary requirements and what equipment people required at mealtimes. We observed the support provided over lunch time and saw that where required people received one to one support.

People at nutritional risk were identified and guidance was available for staff to ensure these risks were managed. The cook told us they closely monitored what people ate. They discussed with staff any changes in weight so they could adjust people's meals accordingly. Where necessary people were weighed monthly and we saw staff took action if changes in weight were a cause for concern. Staff worked closely with dieticians and speech and language therapists to ensure people's nutritional risks were managed.

Relatives we spoke with told us the service was proactive in ensuring people's health care needs were supported. One relative told us if staff, "Ever had any slight problem they immediately call the doctor." A health care professional told us the registered manager advocated for people to ensure they received the health care they required. They went on to say staff, "Always contact in a timely way." People using the service had individual health action plans which are personal plans to support people using the service keep well and be healthy. Records showed people were supported to access a range of health care professionals when required.

Good

Is the service caring?

Our findings

People had positive and caring relationships with staff. The relatives we spoke with praised the care provided. One said, "As I get old I know [name] is going to be alright and that's important." A relative told us staff were, "Very caring." A second relative said that there was, "A lot of affection there for the people that live [in the home]" whilst a third relative told us they felt staff were dedicated to ensuring people had a good quality of life. We observed on one occasion a member of staff had returned from holiday and were warmly greeted by one person in the home who told them how much they had missed them.

We observed during our visits that staff interacted with people in a kind and caring way. For example, on one occasion we saw a person was becoming upset. A member of staff immediately intervened; they took action to find out the reason and provided them with reassurance. A health care professional told us, "[Staff have] got the person at the heart of what they are doing."

Staff spoke warmly and enthusiastically about the people they supported. They spoke about people positively and emphasised people's strengths and abilities. Several of the staff we spoke with told us the best part of their job was seeing people in the home enjoying themselves and having a good quality of life. One member of staff told us, "[People in the home] have a lovely life and they deserve it." Another said, "You're involved in [people in the home's] lives and you care about them and the care and support they get."

All the staff we spoke with could tell us about the people they supported in depth; this included knowing their history, family, likes and dislikes. Each person in the home had a key worker. A key worker is someone who is responsible for an individual and makes sure that their care needs are met and reviewed. Several relatives and a health care professional singled out the strong relationships people had with their key workers. One relative told us their relative's key worker "Takes a strong interest in [them]." Another relative said their relative had, "A fantastic relationship" with their key worker. A health care professional told us the person they had supported had a good relationship with their key worker. They said the person's key worker, "Seemed to really understand [name's] non-verbal communication really well." This demonstrated people were supported by staff who knew them well.

Most of the people living in the home had complex communication needs. The staff we spoke to understood the importance of people's non-verbal communication, such as gestures and certain behaviours, so that they could understand what the person was trying to communicate to them. A member of staff told us, "We notice slight differences in mood or expressions."

Records showed that each person had a communication plan. This provided staff with individual guidance about how to communicate with each person. We saw throughout the home there was a good amount of visual material to assist people to understand what was happening in the home. For example, we saw there were photos of staff with the names to show who was working that day as well as an activities board with pictures and photos. Staff used communication tools that were individual and varied. For example, some people had communication books whilst staff used objects of reference for other people. These tools helped

people to understand the care that was provided and assisted them to make choices

Relatives told us they observed, and felt, staff treated people in a respectful way. The staff we spoke with were able to give us practical examples of how they promoted people's dignity. We saw staff knocked on people's doors before entering and spoke to people in a polite, respectful manner. One member of staff told us, "We are guests in their home."

The relatives we spoke with told us they felt involved and welcome in the home. One said, "Whatever time, day or evening, I pop in." Another relative told us staff, "Always make us feel welcome."

Good

Is the service responsive?

Our findings

People received care that was responsive to, and that met, their individual needs and preferences. Relatives and health professionals told us people received responsive and timely care. One relative told us, "[Staff] just adapt to what [name] needs." A member of staff told us, "Everyone has a different routine." Whilst another member of staff said, "Care is personalised to them."

Care records we looked at detailed people's individual needs and included their personal preferences. This included topics such as what the person liked to do, their life history, religious beliefs, important relationships, and preferred daily routine. Staff demonstrated that they knew people as individuals and could tell us about people's histories, likes, and dislikes. For example, we observed a person enjoying talking to a staff member about their history and family. The staff member was able to participate in the conversation and showed a good knowledge of the person.

We saw each person's key worker completed monthly reviews of the person's physical and mental health needs, what activities they had participated in, and any changes to their care. Staff told us people and their representatives had a yearly care review which provided them with an opportunity to discuss their care needs and review the support provided. Relatives confirmed this and told us they were involved and consulted, where appropriate, on their relative's behalf.

The service supported people to maintain important relationships. Regular events, such as tea parties, were hosted at the home and invitations were sent to people's family and friends. The home had a day centre on site which they and two other homes owned by the provider used. People were supported to access the centre on a regular basis and staff encouraged people to make friendships with people living in the other homes. Relatives we spoke with gave us examples of the support staff provided to ensure their relationships with their family member were sustained. They told us people's key workers regularly up dated them on how their relative was and what they had been doing.

There were a range of activities on offer that were individual to people's needs and preferences. On the first day of our visit a person told us how they liked to visit the home's chickens and other animals in the garden. On the second day of our inspection we saw staff were supporting them to walk round the garden and see the animals. We observed some people with dual sensory loss were supported to access activities that stimulated their senses. Staff told us one person with dual sensory loss loved the feeling of water and we saw on one of the days we visited they had been supported to access a Jacuzzi in the home.

A relative we spoke with told us how pleased they were that their relative was supported to access lots of different activities. They said, "[Staff] have done things with [name] that I would never have thought they could do." The staff we spoke with felt there were sufficient activities for people. A member of staff told us there are, "Lots of trips." Staff gave us examples of trips out which included going to the theatre, cinema, a music festival, bowling, and shopping. We saw records and photos which evidenced this. The service also supported people to go on holiday every year. A relative told us, "[Staff] take [name] on marvellous holidays."

The service had a lead member of staff for activities and community access. They told us they were keen to support people to have links to the village in which they lived. They gave us several examples of how they had supported people to be involved in their local community. The service participated in fundraising for charity. Staff told us people living in the home chose which charity they wanted to support each year and participated in fund raising. A member of staff told us this was really important to people and gave people a sense of pride and worth.

There was information on display in the home to show people how to make a complaint. We reviewed the compliments and complaints records. The service had not received any complaints in the last year and a number of compliments were on file. Relatives told us they knew how to raise concerns and they felt comfortable to do so. One relative told us, "If there is a problem we can raise it and it's addressed."

Good

Is the service well-led?

Our findings

Care plans did not contain sufficient, accurate, and up to date information regarding people's needs. We looked at two people's care records. Whilst most areas of people's care had been covered there were several instances where the care being provided wasn't fully detailed in people's care plans. For instance, it was recorded that one person was being treated for a pressure area however there was no care plan or risk assessment in place regarding this. Another person had lost 3.5 kilograms over a six month period but there was no care plan or risk assessment in place regarding this. In both cases we saw action had been taken to respond to and manage the risk. However, a lack of records in this area meant staff did not have sufficient written guidance around these risks. We also saw that one person's food and fluid charts were not always completed. This meant staff would not have been able to establish from these records whether the person was at risk of not eating or drinking enough.

Whilst the service was following the requirements of the MCA and DoLS in their practice, records relating to this were not always sufficient. The care plans we looked at did not contain any information regarding people's ability to make decisions and whether they lacked capacity in certain areas. Not all the paperwork relating to DoLS applications had been fully completed to evidence why DoLS applications had been made and why this was in the person's best interests. For example, one person had been assessed as lacking capacity in this area but no best interests decision was documented, whilst a DoLs authorisation had been sought for another person without an assessment of their mental capacity.

However, we saw the provider undertook regular and extensive quality checks and that the issues relating to record keeping had been identified by the provider. This showed there were effective audits and quality checks in place. The registered manager told us they were aware some improvements were needed, and they felt changes in staffing and the reliance of agency staff had impacted in this area. They said they were prioritising resolving this issue as they felt once resolved this would have a positive impact on record keeping. On our second day of inspection they had discussed with the provider how they could make improvements in this area. This demonstrated the registered manager and provider were open, transparent, and keen to address any areas of concern. Whilst we saw record keeping was an area for improvement, there were effective systems in place to identify this prior to our inspection and the provider had considered what action was required in order to make improvements.

The registered manager also monitored and addressed the quality of the care provided. We saw they carried out monthly audits and reported these to the provider. These covered areas such as medication errors, incidents and accidents, and staffing. Records of staff meetings showed the registered manager addressed issues regarding quality and encouraged high standards amongst staff. There was also a yearly quality survey carried out with people, visitors, and staff. The majority of responses were positive and we saw where minor issues had been raised these had been followed up and addressed.

The relatives and health care professionals we spoke with talked positively about the home and the care provided. One relative told us the home was, "Absolutely fantastic" whilst another said, "I take my hat off to them [the staff]."

The staff we spoke with also spoke positively about working in the home. They told us team work was encouraged and the service communicated clearly with the staff. One staff member said, "We all know what's going on." There were regular staff meetings and staff told us they were encouraged to discuss the service and suggest changes that might make improvements. One staff member said meetings were, "Free and open" whilst another said, "New ideas are always welcome." There were also regular residents meetings taking place and the minutes of these meetings showed people were consulted on the running of the service.

All the staff, relatives, and health care professionals we spoke with praised the register manager and deputy manager's leadership and management of the home. One relative told us, "[Registered manager] is an exceptional person and works their socks off." A health care professional told us their experience of the registered manager was, "Firm but fair" and, "Clear on expectations." Staff told us the registered manager worked closely with them and knew what was happening in the service. One staff member told us the registered manager was, "Not a manager that shut themselves away."

Staff were also positive of the support given by the registered manager. One member of staff told us the registered manager knew staff well and would check on their welfare. Other staff told us the registered manager addressed any concerns raised and dealt with issues in a constructive and motivating manner. A staff member said, "If you have any concerns and speak to [registered manager], they will implement or investigate and come back to you with an outcome."

Staff and relatives told us the provider was visible and responsive. Staff told us their responsibilities and role were clearly communicated. We saw the provider had regular meetings with staff so they could hear about what was happening at a provider level and in other home's the provider owned. A number of the staff we spoke with had a clear idea of the goals, vision, and issues facing the service overall.