Care Quality Commission

Royal Mencap Society

The Old Rectory

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

Overall summary

We inspected The Old Rectory on 3 November 2014. This was an unannounced inspection. At our previous inspection in December 2013, the service was meeting the legal requirements.

The Old Rectory provides accommodation for up to seven adults with a learning disability who need support with personal care. There were seven people living in The Old Rectory when we visited.

At the time of the inspection 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.

People who lived at the home told us that they felt safe living there. The manager and staff understood their responsibilities to protect people from harm as much as possible. There were appropriate policies and procedures in place which helped staff to minimise risks to people's safety.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). No

Summary of findings

one was subject to a DoLS authorisation at the time of our inspection. For people who were assessed as not having capacity, records showed that their families and other health professionals were involved in discussions about who should make decisions in their best interests.

People's care and support needs had been assessed and risks to their health and welfare recorded. These were reviewed regularly by staff and, if required, input from other health or social care professionals was sought. People living at the home were involved in discussions about their care and support.

Current and relevant professional guidance was followed regarding the management of medicines.

Staff were appropriately trained and skilled and provided care in a safe environment. They all understood their roles and responsibilities. The staff had also completed training to ensure that the care provided to people was safe and effective to meet people's individual needs. Staff had effective support, induction, supervision and training.

People were treated with respect and their dignity was upheld. The staff were kind, attentive and compassionate.

People's food and drink needs were managed as part of a weekly discussion between people living in the home and their key workers. This included making decisions about what to eat, where to buy the food and who would help to prepare and cook it. Options and choices were always offered where one person did not, or could not, eat the prepared meal. People living in the home were conscious of the need to eat healthily whenever possible.

Staff felt supported by the manager and assistant manager.

The provider had a quality assurance system and regularly sought the views of people living in the home, family members, staff and other health and social care providers. People knew how to make complaints and the provider responded to complaints appropriately. Where a complaint triggered a change in the service the manager shared learning with people living in the home, the staff and with the senior management team.

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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 kept safe because staff understood their responsibilities to protect people from harm and to maintain and keep up-to-date people's care plans and risk assessments. People living at the home and staff knew how to raise concerns with the manager. Medicines were managed safely.

There were enough staff to meet people's needs. The manager checked that staff were suitable to deliver personal care before they started working at the home.

Good

Is the service effective?
The service was effective.

Staff had the relevant training, skills, support and guidance to make sure people received the care and support they needed.

Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and obtained people's consent before they delivered care and support.

People had a choice of meals and received dietary input if required. They were also provided with access to other health and social care professionals when they needed it.

Good

Is the service caring?
The service was caring.

People were treated with respect and kindness by staff who supported them.

Staff were knowledgeable about people living in the home and knew how they should be supported and cared for.

People's needs for privacy and dignity were respected by staff.

Good

Is the service responsive?
The service was responsive.

People's needs had been assessed and they were involved in planning their care. They were encouraged by staff to maintain their interests and friendships.

People were confident that any concerns they may raise would be dealt with appropriately and sympathetically.

Good

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

People living in the home, their relatives and other healthcare professionals were encouraged to share their thoughts, experiences and views about the quality of the service. This helped the provider to make improvements to the service it offered.

Good

Summary of findings

Staff were given support and guidance in their everyday working practices which encouraged them to challenge themselves to improve the services they delivered.

Quality monitoring systems were used to identify and manage risks as well as identify emerging risks. Accidents and incidents were thoroughly investigated and the provider made sure that any learning from these was shared across the home and wider organisation.

The Old Rectory

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 3 November 2014 and was unannounced. One inspector carried out this inspection. Prior to the inspection we carried out a review of all information we held about the provider. For example we considered safeguarding notifications, enquiries and complaints received. A provider information return (PIR) had been received from the provider at the time of the inspection. 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.

During this inspection we spoke with the manager, assistant manager, two key workers and three people currently living at The Old Rectory. We also spoke with an adult skills trainer who worked with people living in the home to further develop their day to day living skills.

Good

Is the service safe?

Our findings

People living at The Old Rectory told us that they felt safe living there. One person living there told us, “The staff keep me safe from harm, they look out for me”. They added that if they didn’t feel safe for whatever reason that they would speak to their key worker or the manager. We noted that people and their families were asked if they felt safe living at the home as part of their care reviews.

The manager ensured that people living in the home received appropriate support to enable them to live life to the full whilst at the same time balancing the need to keep them safe. People living in the home told us how important it was to be safe and not to take unnecessary risks. For example, one person was preparing vegetables for the evening meal. They showed us how to use the vegetable knife safely.

All the staff we spoke with had received training in safeguarding adults and understood their responsibilities in how to keep people living in the home safe and how to protect them from harm. They could tell us what they would do if they had any safeguarding concerns and who they would report them to. One member of staff told us about the home’s whistle blowing policy and showed us where the policy and guidance was kept.

For people who had different ways of communicating, the staff used a system of picture cards. These enabled them to express their feelings, for example one card had “Help” written on it. Staff could then quickly assess the person’s needs and respond promptly.

People living in the home had individual risk assessments in place and these had been regularly reviewed. These reviews were one of the ways which the manager used to ensure people’s individual risks were captured and appropriate support put in place. Regular reviews of risk assessments helped staff build up an in-depth knowledge of people living in the home. Care plans we looked at contained clearly written risk assessments where people had been identified as being at risk. Staff were able to tell us about specific risk assessments in place for individuals.

There were appropriate emergency plans in place should a significant emergency occur and people had their own emergency evacuation plans in place. For example, we asked people living in the home what they would do in the event of a fire. One person showed us a notice and then took us to the exit door. They added, “We go over there, where it’s safe”. People knew where the fire exits were and where people would gather in the car park, safely away from the building. Notices and photographs were placed around the building to guide people to appropriate exits. A recent visit by the fire officer had resulted in new fire doors being installed and a new fire alarm display board being placed in the manager's office.

There were enough staff on duty to meet people’s needs. The manager carried out thorough recruitment and selection procedures. This included identifying any gaps in employment history and establishing reasons for such gaps. We were assured that the provider made sure only suitably qualified, skilled people of good character, were employed to work at The Old Rectory.

Medicines were kept safe and securely locked away. When necessary other health care professionals were involved in the decisions about the safe administration and taking of medicines. For example, where swallowing issues presented, speech and language therapists were involved in helping people take their medicines appropriately and safely. Medicines were recorded both in care plans and medication administration records (MAR). People living in the home told us what their medicines were for and when they took them.

Good

Is the service effective?

Our findings

All staff were up-to-date with their training with the exception of two new employees currently going through induction training. Their induction training included shadowing experienced staff and gaining an understanding of the people living in the home. The progress of new staff was checked regularly by the manager to ensure they had the skills and knowledge to do the job required.

Regular staff appraisals took place and if additional support was required, this was quickly arranged. There was a 'top talent' system in place for staff which offered career progression. Regular discussions took place between management and staff where strengths and weaknesses were identified and discussed. Discussions also took place about good practice and how it could be shared.

All staff had named persons who provided them with regular supervision to ensure they were working effectively with the people they were supporting. All staff had received an annual appraisal within the last 12 months.

Staff were encouraged and supported to do a diploma in health and social care. They were also encouraged and supported to do distance learning training relative to their job role ensuring they could deliver quality care and support to people living in this home. Staff told us how well supported they were by the provider and manager and how confident they were that they had received the right training to carry out their role.

We discussed the Mental Capacity Act 2005 (MCA) with staff. Each member of staff we spoke with confidently outlined best interest decisions and demonstrated an understanding of what deprivation of liberty meant. We also observed during the inspection that consent was sought by staff before any care or support was provided. Where people did not have capacity to consent to care or treatment we saw that mental capacity assessments had been completed and a decision made to provide care or treatment in the person's best interests. This met the requirements of the Mental Capacity Act 2005 (MCA).

We asked staff how they dealt with behaviour that may challenge whilst making sure they protected people's individual rights. We were given one example where changes had been noted. Staff told us how they monitored the situation over a period of time and involved other healthcare professionals.

People were encouraged be involved in planning their meals and to eat healthily. One person told us, "We have the healthy heart lady come in to see us lots. She tells us about the sorts of food we are eating." Preparation and cooking of meals was supervised whilst at the same time allowing for, and promoting, independence. We saw notices in the kitchen relating to people's individual dietary requirements. For example, we saw information relating to one person's needs regarding chewing food and how this could be achieved safely. Staff were aware of this guidance and worked with people to follow this guidance.

We observed that people living at the home were encouraged to openly discuss with their key worker any concerns they may have about their health and welfare. People were supported by staff to undertake regular GP visits, hospital visits, chiropody visits or other healthcare professional visits. Staff gave us examples of how they supported people with medical appointments with people who found it difficult to say how they felt.

Good

Is the service caring?

Our findings

Staff involved people with their day-to-day care and support. They treated people with compassion and kindness.

We observed conversations where people were asked their opinion and whether they agreed with what was being asked of them. We saw that people were treated respectfully and in a dignified way. One person told us, “I’m happy here. The staff make me happy”.

At the time of the inspection staff and people living at the home were working with an external company to choose and fit new blinds and curtains. The manager and assistant manager were seen to encourage people to be involved in these decisions and assured them that their opinion would be listened to.

People living in the home were enabled to take part in the assessments and planning of their care, if they wished to. These reviews included, where possible, family members.

A culture of openness and honesty between staff and people living in the home was evident. People living in the home that we spoke with told us how The Old Rectory was their 'home' and how important it was to them.

Where people’s requests for assistance could not be dealt with immediately, explanations were given and understanding reached. For example, one person asked for assistance when a staff member was busy on the telephone. The staff member explained that they could not deal with the person’s request at that moment but that they would find them as soon as they were off the telephone. The person making the request then said “That's okay, I can wait.” We observed that the staff member sought out the person concerned at the first available opportunity.

People told us what they would do if they felt they needed someone to talk to who wasn’t a member of staff. One person showed us the notice on the notice-board for advocacy services. They said, “I can speak to them if I need to”. We noted that the manager had provided access to advocacy services such as Independent Mental Capacity Advocacy services (IMCA).

Both staff and people living at the home told us what respect and dignity meant to them and why it was important. Staff told us how they were trained to ensure people were treated with respect and dignity. There was a ‘family atmosphere’ within the home which meant that any concerns about respect and dignity, or human rights, were discussed openly and honestly.

People were encouraged and supported to develop and maintain relationships with people important to them. Visitors to the home, both family and friends, were encouraged. Where contact with family members was restricted by personal circumstances the manager took great care to ensure that some degree of contact was maintained if at all possible. The manager also supported those people living in the home who did not wish to establish or maintain relationships.

Good

Is the service responsive?

Our findings

We observed a discussion taking place between one person and their key worker about the type of coat to wear if it started to rain whilst they were out shopping. At all times the key worker supported this person to make the decision about the best type of coat to go out in whilst allowing them to make the final choice. The key worker then suggested that it was the person's own decision what to wear and that they would not prevent them from doing so but felt they needed to outline the risks.

One person told us, “If I wanted to stay indoors tomorrow I’d place my slippers outside my bedroom door at night”. We asked their key worker about this and were told, “Yes, if [service user] leaves their slippers outside then we know it’s a “duvet” day next day and we respect that”.

We looked at two people's care records and support plans. These contained regular reviews, risk assessments, changes to personal preferences and choices, likes and dislikes and what was important to them. Each person was also provided with a communication book which detailed any changes or requests they may have and which was readily available for staff to access.

For people with could not express their requests verbally tools had been developed which would support them to express their needs or preferences. These cards had pictures or symbols on them of things which were important to them. For example a picture of a drink or food. These cards were carried around in wallets or handbags. Larger similar cards were used for communicating within the home. We also noted the use of association techniques, such as pointing out objects which had meaning to the person, using facial expressions and the act of showing a person what was needed or expected.

We noted that regular key worker meetings took place and included people living in the home. Goal setting, risk assessments, how to make or respond to complaints, current policies and procedures and person centred support plans were discussed at these meetings.

People were encouraged to be responsible for day-to-day tasks of living in the home. This could be cleaning, laundry, emptying bins or being responsible for the care and welfare of the chickens. We also noted that staff and people living in the home, took part in community events. This included working with the parish council and taking part in community events such as table top sales.

Where people did not wish to participate in social or community events the manager worked with them to develop their own specific interests. These included going swimming, going to the gym, social outings with specific or favourite groups of like-minded people, and special events such as pantomimes, birthday celebrations or seasonal celebrations. One person told us about their favourite T.V. character and showed us a collection of newspaper cuttings and photographs. They told us that staff also found photographs and gave them to them.

We spoke with people living in the home who told us, or showed us, what they would do if they were unhappy about something. They all emphasised the confidence they had in the manager to, 'sort things out'.

At the time of the inspection no complaints had been made or received. There were however notices around the building on how people or families could make a complaint if they wanted to.

Good

Is the service well-led?

Our findings

People living in the home and staff were able to demonstrate their involvement in developing the service. This involved not just listening to other people's views and opinions but included discussions about what was best not just for the individual but for everyone living in the home.

To reinforce good quality management systems the provider undertook regular feedback with all staff. This allowed staff to express their thoughts and provide feedback to management about how they thought the home was run. The provider felt that this was an essential way to get a feel for how staff felt the organisation operated. One staff member told us, “It’s good that we get the chance to feedback honestly like this”.

The provider had their own internal quality assurance systems which were reviewed regularly by the manager and submitted to the head office quality control team. Regular audits took place in the home and the results of these were also reviewed by the head office quality assurance team. These audits included medicines and risk assessments. Learning from audit results was shared with staff and people living at the home. Where areas for potential improvement were identified the manager and assistant manager initiated action plans and follow-up review sessions to check whether improvements to the service were being made. Where action plan results impacted on people using the service or staff members these were discussed with them.

The manager had a system to identify, analyse and review accidents and incidents. They took learning from accidents and incidents and this was shared with the senior management team and other staff.

The manager told us about the extended services they had developed as part of improving people’s lives. This included working with a local county council specialist to work with and develop specific educational programs for people with learning disabilities. For example, the local library was working with people living at the home to develop educational courses specific to their individual needs and which covered life skills. These courses included basic maths and English as well as a “You’ve got talent” class which was aimed at encouraging independent living and improving self-esteem. People living in the home told us about their attendance at these courses and how much they enjoyed them.

The manager, as part of the home’s commitment to improve people’s lives and encourage independence worked with other local healthcare specialists. This assisted people who were transitioning to new or secondary health concerns; for example one person’s transition to living with dementia. This process was supported by open discussions with the person concerned on ways to manage this transition and to enable them to understand the symptoms as they developed. We also established that the manager was undertaking internal discussion and research at management level about people's needs and wishes to develop meaningful and intimate relationships, should they wish to do so. This told us that the manager took great care to ensure that not just people's physical needs were being met but that their emotional needs were also being fulfilled.

Staff also took part in the provider's own ‘Shape your future’ meetings. These took place at least four times a year and were intended to support staff to progress their career and progress to Mencap’s ‘Top Talent’ programme.

The provider was supporting the manager to complete their level 5 in Mencap’s leadership and management studies. They were also supporting the assistant manager to complete the ‘Aspiring Managers’ Mencap course. This demonstrated the provider's commitment to encouraging and supporting people's career progression.

Both the manager and assistant manager took a hands on approach to caring for people living in the home. They liked to get to know them and to understand them as well as the staff looking after them. They told us that one of the benefits of doing this was that they got to get a feel for what was going well and possibly not so well in the home. They added that this was a good way of capturing niggles before they escalated to problems.

People told us they knew how to make a complaint and staff told us how they responded to complaints. However, the manager’s approach to complaints or concerns was to work with people to resolve them at the earliest opportunity. Staff also told us that they were confident that if they identified an emerging issue that they could discuss this with the manager.

Good

Is the service well-led?

Regular surveys took place locally, regionally and nationally. The surveys covered people living in the home, family members, staff and other visiting healthcare professionals. Results of local surveys were shared and action points agreed at the regular service user and staff meetings which took place. An example of survey results being implemented was taking place during this inspection. This included the installation of new blinds and curtains, choice of paint colour for room decoration and discussions about furniture.

People's care records and information were kept safe and securely locked away. Likewise, staff records were kept securely stored. The manager had a computer recorded data management system which backed information to the provider's head office system.