New Life Care Services

New Ridley Road

Inspection report

27-29 New Ridley Road
Stocksfield
Northumberland
NE43 7EY
Tel: 01661 1844112
Website: N/A

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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

New Ridley Road is a care home that provides accommodation, care and support for up to nine people with physical and personal care needs. There were nine people living at the home at the time of our inspection.

The home had a registered manager who had been registered with the Care Quality Commission to manage the service since October 2010. 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.

Most people who lived at the service were unable to communicate with us verbally due to the nature of their condition. Those who could told us that they felt safe living at the home. There were systems in place to protect people from abuse and channels through which staff could raise concerns. Records showed, and the registered manager confirmed that no safeguarding matters had

Summary of findings

arisen within the 12 months prior to our inspection. We saw that two safeguarding incidents from the previous 12 months had been handled appropriately and referred on to the local authority safeguarding team for investigation.

A process was in place to assess people's needs and the risks they were exposed to in their daily lives. Regular health and safety checks were carried out on the premises and on equipment used during care delivery. Care records were regularly reviewed and medicines were managed and administered safely. Recruitment processes were thorough and included checks to ensure that staff employed were of good character, appropriately skilled, and physically and mentally fit. Staffing levels were determined by people's needs.

Staff records showed they received regular training and that training was up to date. Supervisions and appraisals for staff were conducted regularly and staff confirmed they could feedback their views during these meetings with the registered manager.

CQC monitors the operation of Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act (2005). These safeguards exist to make sure people are looked after in a way that does not inappropriately restrict their freedom. We saw the registered manager had applied for DoLS for the majority of people living at the home. In addition, although people's ability to make informed decisions had been assessed, and the 'best interest' decision process was followed in practice, these decisions were not always fully documented within people's care records. The registered manager gave assurances that going forward records held in relation to this would be improved.

People told us, and records confirmed that their general healthcare needs were met. We saw people's general practitioners were contacted where there were concerns about their welfare and other healthcare professionals were also involved in their care such as psychiatrists. We saw that people's nutritional needs were considered and specialist advice was sought and implemented where necessary.

Our observations confirmed people experienced care and treatment that protected and promoted their privacy and dignity. Staff displayed caring and compassionate attitudes towards people and people's relatives spoke highly of the staff team. People had individualised care plans and risk assessments and staff were very aware of people's individual needs. Regular activities took place within the home and we saw people enjoyed trips out into the community.

Systems were in place to monitor the service provided and care delivered. Where issues were identified, action plans were drafted and monitored. We received positive feedback about the leadership and management of the home, from people, their relatives and staff.

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?

Good

The service was safe.

People appeared comfortable in their surroundings and when interacting with staff. There were systems in place for referring matters of a safeguarding nature to the relevant local authorities for investigation which we saw had been followed.

Staff skills and their suitability to work at the home had been checked before they commenced employment and relevant health and safety checks on the premises and equipment used in care delivery had been carried out regularly.

Staffing levels were sufficient to safely meet people's needs and medicines were managed safely.

Is the service effective?

Good

The service was effective

People experienced care that was individualised and effective in meeting their needs. Staff were skilled, experienced and supported to maintain their skill sets and they told us they received regular supervisions and appraisals.

People's nutritional needs had been assessed and where appropriate people received the support they needed to eat and drink sufficient amounts. People had input into their care from external healthcare professionals, as and when necessary.

There was evidence that consideration had been given to people's ability to make informed choices in line with the Mental Capacity Act (2005) and applications had been made to the local safeguarding team to ensure that no person had their freedom inappropriately restricted.

Is the service caring?

Good

The service was caring

Staff displayed caring and compassionate attitudes when delivering care. People were given choices wherever possible and people's relatives spoke highly of the staff team.

People were treated with dignity and respect and their privacy was promoted.

Where people needed an advocate to act on their behalf, we saw that the registered manager had arranged this.

Is the service responsive?

Good

The service was responsive

People experienced care that was individualised and the service responded to their needs. Where necessary staff requested support from external healthcare professionals to address concerns.

People's care records were individualised and person-centred. They were reviewed regularly, and where necessary, updated in light of changes in people's care needs.

Summary of findings

Complaints about the service were rare and the manager told us there had not been a complaint received by the service in the 12 months prior to our inspection. People, their relatives and staff were given the opportunity to feedback their views about the service via the manager directly, in meetings or via the completion of surveys.

Is the service well-led?

Good

The service was well led

People, their relatives and external healthcare professionals spoke highly of the registered manager with whom they said they enjoyed a positive working relationship.

The registered manager had systems in place to monitor care delivery and ensure that people received safe and appropriate care. Audits were done regularly and any identified issues that needed to be addressed were formulated into action plans so this could be monitored.

New Ridley Road

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 checked 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.

We visited the home on two separate dates; 9 and 10 December 2014. This inspection was unannounced.

The inspection team consisted of an inspector and a specialist advisor with experience of working in mental health and learning disability services.

Due to an administrative error we did not receive information from the provider in advance of the inspection. However, we reviewed information that we held about the home, including statutory notifications, serious incidents and safeguarding information that the provider had notified us of within the last 12 months. In addition, we contacted the commissioners of the service, the local authority safeguarding team, Healthwatch (Northumberland) and a member of the community learning disability team, in an attempt to obtain their views about the care provided at the home. We did not get a response from all of the people we contacted. However, where we did, we used the information that they provided us with to inform the planning of our inspection. Following our inspection we spoke with two care managers overseeing the care of six people who lived at the home and the feedback they gave us has been incorporated into this report.

During the visit we spoke with one person living at the home who was able to engage with us verbally, five people's relatives, three members of staff, the deputy manager and the registered manager. We walked around the home, observed the care and support people received and reviewed a range of records related to people's care and the management of the service. These included looking at five people's care records, seven staff files (including recruitment, training and induction records), all nine people's medication administration records and records related to quality assurance, auditing and maintenance certifications.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a tool used to observe care which helps us understand the experience of people who were unable to communicate their views and feelings to us verbally.

We reviewed all the information that we gathered prior to the inspection, and at the inspection, to form the basis of our judgements and this report.

Good

Is the service safe?

Our findings

Only a small number of people who lived at the home were able to converse with us verbally. One person told us, "I like it here. I like the staff. I am fine." We spoke with people's relatives following our visit to obtain their opinions of the service and one relative told us, "I have no concerns whatsoever. I can't fault the home or staff, I honestly can't."

We observed staff whilst they delivered care and supported people. They adopted moving and handling procedures that were both appropriate and safe and we had no concerns about people's safety or how they were treated by staff.

We discussed the concept of safeguarding and whistleblowing with both the registered manager and staff. They were able to tell us about what constituted abuse and the procedures they would follow if they witnessed harm or abuse. Each member of staff we spoke with was aware of their personal responsibility to report incidences of this nature. The registered manager told us and records confirmed that there had been no safeguarding incidents within the 12 months prior to our inspection. We saw the registered manager had dealt with historic safeguarding and whistleblowing cases appropriately and referred to the relevant local authority for investigation in line with protocols.

Records were maintained of accidents and incidents that occurred so they could be monitored. These records showed there had been three accidents and/or incidents in the home since January 2014. The registered manager had recorded the circumstances and any injuries, treatment and remedial actions taken as a result. The registered manager told us, "We just don't have many accidents here."

We reviewed people's care records and found that risks which people were exposed to in their daily lives had been assessed and written instructions were in place for staff to follow about how to manage and reduce these risks. Where relevant, there were assessments related to nutrition and choking risks. Speech and language teams (SALT) were involved in people's care and had drafted specific care plans and risk assessments for staff to follow. Any resident identified as at risk from skin damage had a regular tissue viability assessment and use of body maps were evident in their care records. There was also evidence of care reviews taking place involving outside professionals including GP's, local authority case managers and other health and social care professionals such as social workers, district nurses and psychiatrists. This meant that multidisciplinary teams looked at people's care, the risks associated with it, and if care provision was safe.

We looked at staff files in order to assess if recruitment procedures were appropriate and protected the safety of people who lived at the home. We saw that application forms were completed including previous employment history, staff were interviewed, their identification was checked, references were sought from previous employers and Disclosure and Barring Service (DBS) checks were obtained before staff began work. Records showed staff had completed a health questionnaire prior to starting work. This meant the registered provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were fit, appropriately qualified and physically and mentally able to do their job.

Staff told us staffing levels were sufficient to meet people's needs and our observations confirmed this. We discussed people's dependency levels with the registered manager and she told us that two people required the support of two members of staff for moving and handling procedures. The registered manager told us if external activities or excursions were planned, she increased staffing levels to accommodate these. Most of the staff team had worked at the home for a number of years and the registered manager told us any shortfalls in staffing, for example due to sickness or annual leave, were covered internally by other members of the staff team.

We reviewed each person's medication administration records (MARs) and found that these were well maintained. A current photograph of each person was attached to the MAR to ensure there were no mistakes of identity when administering medicines. Protocols were in place for the administration of 'as required' and homely medicines. The records contained instructions in the use of Percutaneous Endoscopic Gastrostomy (PEG) feeding tubes for people who could not take food by mouth. All medicines were prescribed in accordance with NICE guidelines and were within their expiry date. Medicines were stored appropriately and we saw systems were in place to account for and dispose safely of medicines that were no longer required.

We saw there was an emergency contingency plan in place which contained a list of emergency contact details for staff

Good

Is the service safe?

to use should this be necessary. We saw instructions were in place for staff to follow in the event of, for example, a fire, an electrical power failure, or a gas leak. We saw there was a personal emergency evacuation plan (PEEP) in place for each person, which gave staff instructions about how to support each individual to exit the building, should this be necessary.

We looked at the management of risks within the building and found that regular fire and health and safety checks were carried out and documented. Equipment was serviced and maintained regularly and we saw safety checks were carried out on for example, electrical equipment, the electrical installation within the building and gas supplied equipment. We saw evidence that legionella control measures were in place to prevent the development of legionella bacteria, such as checking water temperatures and decontaminating showerheads on a regular basis. However, the registered manager confirmed that a legionella risk assessment of the building had not been carried out in line with the requirements of the Control of Substances Hazardous to Health Regulations 2002 (COSHH) and the Health and Safety at Work Act 1974. She told us this had been overlooked and by the end of our inspection she had put arrangements in place for a legionella risk assessment of the property to be carried out.

Good

Is the service effective?

Our findings

We asked the people we could converse with, about the care they received. One person told us, "I like it here." Following our visit to the home and as part of the inspection we spoke with the relatives of three people who were not able to communicate with us verbally. They all told us they were very happy with the care that their relation received and they had no concerns at all about the service and care delivered. One relative said, "I can't fault them at all. X is very happy, I don't have to worry about them at all." Another relative told us, "I can't tell you how happy X is. I think what makes the service is the staff. They really know the residents; it is a very personalised service. The staff are in tune with X (relation). X communicates via noises but he can let you know when he is not happy. The staff read him very well and they know what his different noises mean."

We asked two healthcare professionals linked with the home for their views about the effectiveness of the service. They both spoke highly of the care that they saw delivered and of the staff who worked there. One healthcare professional said, "The home seem to manage people's needs well – those with high and low dependency. They have a very good handle on people's needs and their personal stories."

We asked staff about the needs of the people they supported and cared for, and they gave us detailed information which tallied with our own observations and the information written in people's care records. For individuals who were unable to communicate verbally, they were able to tell us how they had learned to read their facial expressions, noises they made, or changes in behaviours, to establish their mood and whether or not they were happy with a particular action or personal care task. Staff displayed an in-depth knowledge of people and their needs, which we saw they used to provide effective, personalised care.

The service provided a detailed eight week structured menu. There was a variety of healthy foods and meals and people's personal likes and dislikes were referenced within their care plans. Where people had specialist dietary requirements or nutritional needs, we observed staff supported them appropriately and ensured they got the food and fluids that they needed, safely, in order to remain healthy. In addition, food and fluid intake charts were used to monitor that people ate and drank sufficient amounts. People were weighed regularly to ensure that any significant fluctuations in their weight were identified and where necessary, referred to external healthcare professionals for advice and input.

We looked at how people's general healthcare needs were met and found evidence that people were supported to attend routine appointments, for example, at the opticians to check their eyesight. In addition, people had input into their care from healthcare professionals such as doctors, occupational therapists, speech and language therapists and psychiatrists whenever necessary.

Information in people's care records indicated consideration had been given to people's levels of capacity and their ability to make their own choices and decisions in respect of the Mental Capacity Act 2005 (MCA). The registered manager told us she had systematically made applications for Deprivation of Liberty Safeguards (DoLS) and was reviewing the mental capacity of all the residents in accordance with good practice. DoLS are part of the Mental Capacity Act 2005. They are a legal process which is followed to ensure that people are looked after in a way that does not inappropriately restrict their freedom. For example, a DoLS application would be necessary where a person with limited or no capacity needs to remain under constant supervision to protect their safety and wellbeing. These applications and decisions are made in people's best interests by the relevant local authority supervising body.

There was evidence that some decisions about individuals care had been made in their 'best interests' in line with the MCA. For example, we saw such a decision had been made about one person remaining at the home. We contacted a healthcare professional linked to the home who told us that the registered manager kept them informed about all issues linked to people's care. However, although there was evidence the registered manager followed the principals of 'best interest' decision-making in practice, improvements were needed to the records retained about these decisions as they did not always fully explain who had been involved in the decision making process, and what discussions had taken place. The registered manager told us that this would be addressed.

We asked staff about their training requirements and if they were equipped with the appropriate skills to fulfil their roles. They told us they felt supported by the registered manager and that they were able to maintain their skills by

Good

Is the service effective?

refreshing training as and when required. One member of staff said, “There is plenty of training and that. I feel that I have the skills I need. It’s good here.” Another member of staff told us, “My induction was fine and I have done training in medication, safeguarding and moving and handling.” Staff files showed that they had received training in key areas such as infection control and safeguarding, and a training matrix helped the registered manager track when this training needed to be repeated. We saw that staff had also received training in areas relevant to the needs of the people they supported. For example, staff were trained in diabetes care, oral hygiene and PEG feeding.

Staff told us and records confirmed they received regular supervision and appraisal from the registered manager or deputy manager. Staff said they felt supported. We saw that supervisions and appraisals were used as a two-way feedback tool through which the registered manager and individual staff could discuss work related issues, training needs and personal matters if necessary.

Good

Is the service caring?

Our findings

One person told us, “Staff are good.” We asked people’s relatives if they found the staff and service caring. They all spoke highly of both the staff team and the registered manager. One relative said, “I am full of admiration for the staff and the care they deliver to X. There is a real rapport between staff and residents.” Another relative told us, “I would give the home 30 out of 10! I can’t fault them at all. The staff are wonderful.” One healthcare professional told us, “There is a happy atmosphere in the home and people’s families always give us good feedback too.”

We reviewed some comments written by people’s relatives in questionnaires sent out to gather their views. These included; “I am always very impressed with the care given to residents. X is given first class support and the staff and management are to be commended”; “X has the best, thank you”; and “As ever the standard of care, the quality and dedication of the staff are the key to a happy atmosphere at New Ridley Road. In particular, X’s keyworker Y shows real commitment to him and his wellbeing”.

We observed care delivery and watched how staff interacted with people. We saw many pleasant interactions when staff were supporting people, for example when assisting them with meals or moving and handling. Staff engaged with people compassionately and respectfully, and there was a calm, happy atmosphere within the home. We saw staff spoke with people who could not converse with them when delivering care, ensuring that they were kept informed at different stages. We saw and heard one staff member assisting a person with lunch say, “Right X are you ready? Is that good? Is it going down alright?”

We saw that staff delivered care which promoted and protected people’s diversity, dignity, privacy and independence. For example, we observed staff closed people’s bedroom doors when delivering personal care. People who were able to, moved around the home independently, and we saw that staff encouraged them to do as much as they could for themselves. Staff we spoke with understood the importance of privacy and dignity when supporting people with personal care. Private space was available for people to enjoy time with their families alone when they visited the home. Staff gave us examples of how they maintained people’s dignity and respected their wishes. In addition, people’s diverse needs were considered. For example, one member of staff told us a vicar visited the home regularly to meet people’s spiritual needs.

We observed that staff explained in advance about the care that they were about to deliver. They displayed caring and compassionate attitudes towards people resulting in them experiencing positive care delivery. People’s relatives told us they were kept informed about changes with people’s care and they felt fully informed. Care plans reflected people’s life histories and staff were knowledgeable about people’s likes, dislikes and the activities they liked to pursue.

We saw pictorial signage was used around the home to inform people. For example, there was information about what people should do in the event of a fire and how to exit the building in an emergency. Certain individuals also had sensory lighting and equipment in their bedrooms relevant to their needs, creating a calming environment.

We asked the registered manager if any person living at the home accessed advocacy services. She told us that usually people’s relatives acted on their behalf. At the time of our inspection one person living at the home had an advocate in place who was assisting a person with a financial matter. The registered manager told us she had good links with people’s care managers and would contact them to arrange an advocate if necessary to arrange this.

Good

Is the service responsive?

Our findings

People's relatives told us they felt involved in their care and staff were very aware of, and met their relations needs. They said the service was responsive to changes in their relations' needs. One relative commented, "We are involved in any decisions made about X or his care." Another relative said, "I don't have to worry about X at all, they (staff) do everything they need to."

We spoke with one person who told us they had enjoyed several trips out into the community with the support of staff, during the Christmas period. These included going to the pantomime and dining out for Christmas lunch. Some people who lived at the home attended day centres weekly, where they were able to pursue a variety of different activities. We saw that people were supported to maintain close links with their families and the service operated an 'open door' policy where family members could visit the home at any time.

The service operated a keyworker system where individual staff members were allocated to individual people living at the home. Keyworkers had responsibility to ensure that individual's care needs were met, regularly reviewed and their care records updated. Staff told us that all relevant parties were kept informed as and when needed, in respect of any changes in people's care needs.

Care was very much person-centred. Staff told us they gave people who could not communicate verbally as much choice as possible in relation to day to day decisions. They told us they could read when people were happy or not and what they liked and disliked, via how they expressed their emotions and particular expressions and behaviours they adopted.

We looked at people's care records which contained a comprehensive set of care plans that reflected the assessed need of people's conditions. These related to a variety of needs such as personal care, medication, nutrition and family contact. There was evidence of pre-admission assessments and of systematic reviews and evaluation to ensure that people's care remained appropriate, safe and up to date. Care monitoring tools such as food and fluid monitoring charts and charts for monitoring people's continence were in place. In addition, the service used handover summary sheets, daily evaluation records and a diary system to pass information between the staff team and respond to any issues that may have been identified. People's bedrooms were equipped with specialised personalised chairs and beds and other necessary adaptations. Each room was individually furnished and decorated for the festive season.

External healthcare professionals told us staff were responsive to people's needs and they had involved general practitioners and specialists in people's care when needed, to promote their health and wellbeing. Records we reviewed confirmed this. One healthcare professional linked to the home said, "Staff gave me a very good overview of 'X' and what they liked to do. They have good access to OT's (occupational therapists) and I know they get them involved where they need to."

We saw that a complaints policy and procedure was in place with details about how to complain and the timescales involved. There was also information about how to complain in a written and pictorial format in people's individual care records. This showed the service had responded to people's needs and presented them with information in an appropriate format for their needs. The registered manager told us that there had been no complaints within the 12 months prior to our inspection.

The registered manager had systems in place to gather the views of people's relatives in order to measure the standard of service delivered and to address any concerns raised. We saw staff and residents meetings took place monthly and surveys were sent out to people's relatives to attain their views. We reviewed some of the feedback received from a recent relative's survey and found all relatives gave positive praise. Staff told us they had the opportunity to feedback their views either at staff meetings, in supervisions or appraisals, or by approaching the registered manager directly.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post who had worked at the home for over eight years. It was clear through our discussions with them that she knew people well and sought to secure the best possible outcomes for them. Our records showed the registered manager had been formally registered with the Commission since October 2010. She was present on both of the days that we inspected the home.

We received very positive feedback from people and their relatives about the registered manager. One person said, "I like 'X' (registered manager)." When we asked people's relatives if they thought the home was well led, they all, without exception, said it was. The relatives we spoke with told us they enjoyed a positive relationship with the manager and said the home had a friendly atmosphere. One relative commented, "The manager is great. She is very nice and welcoming. 'X' (registered manager) is lovely." Staff also told us the registered manager was extremely approachable and operated the service well. One member of staff said, "I feel supported – 'X' (registered manager) is great." Another member of staff told us, "It is well-organised here and well-run. I enjoy coming to work."

External healthcare professionals told us the registered manager engaged with them regularly, respected their professional judgement and responded to any advice given. The registered manager told us she liked to work in partnership with other agencies and she enjoyed open working relationships with these agencies. The atmosphere within the home was positive and the staff team told us morale was good. The registered manager told us she promoted an open culture and anyone could approach her at any time to raise concerns, issues, or to ask for assistance.

We found the registered manager had an overall assurance system in place to ensure that staff delivered care appropriately. Monitoring tools such as food and fluid intake charts were in place. Night shift staff completed checks on people regularly throughout the night and they were guided by people's overnight needs by a summary of information that was held communally. In addition to this the registered manager had systems in place to; monitor people's changing continence needs; their weight; any future health related appointments; a staff communication book for passing messages between staff; and a shift handover book where any issues that needed to be addressed or actioned were recorded. These tools enabled the registered manager to monitor care delivery and then identify any concerns should they arise.

The registered manager told us and records showed that a range of different audits and checks were carried out to monitor care delivery. These included medication audits, infection control audits, and health and safety audits/ checks. We saw that following the findings of these audits, where issues were identified that needed to be addressed, an action plan was drafted to be used to drive through improvements in standards. This meant the registered manager had a tool in place to monitor that identified issues were suitably addressed and by which to measure progress.

We saw that staff meetings and meetings for people and their relatives took place on a monthly basis where a variety of issues related to the operation of the service and people's individual needs were discussed. The registered manager told us that a manager from one of the provider's other homes completed what was termed an 'Outcome 16' visit on a monthly basis. This was essentially an overall audit which recorded general observations and looked at complaints, accidents and incidents, safeguarding and whistleblowing issues (if any). The registered manager told us the paperwork related to these 'Outcome 16' visits was forwarded to the provider by the completing manager once done and that they did not get any feedback about these visits, unless an issue was identified that the provider wanted to address.

We had concerns that there was a lack of communication and support for the registered manager, from the provider, at this service. When asked, the registered manager told us no management meetings took place and she had not had a supervision or appraisal meeting for approximately two years.

Following our inspection we discussed our concerns the provider's representative, who is referred to by the Care Quality Commission as the 'Nominated Individual'. They told us there had been an area management role vacancy recently, but that this had now been filled and the area manager had started visiting the service monthly to carry out quality monitoring assessments. The nominated individual also advised that the area manager would be reintroducing supervisions and appraisals for the registered manager and that appropriate systems were in

Good

Is the service well-led?

place to feedback concerns to senior management, should they be identified. The nominated individual assured us they were fully aware of how each of the company's individual services performed and they operated a traffic light system to rate their own services in terms of concerns and risks, so they could provide more input to the services where improvements were required.