Diagrama Healthcare Services Limited

Cabrini House 1 (Diagrama Healthcare)

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 unannounced inspection took place on 22 October 2018. At our last inspection on 7 and 8 April 2016 we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Cabrini 1 is one of three small separate care homes run by the provider in the same road that provides accommodation care and support to seven people with learning difficulties and some physical disability or health needs. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection there were six people living at the home.

The service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. So that people with learning disabilities and autism using the service can live as ordinary a life as any citizen

The service had a registered manager. 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. They were aware of their responsibilities' and had submitted notifications as required. They were aware of their legal requirement to display their current CQC rating which we saw was on display at the home and on the provider's website.

At this inspection we found there were systems to monitor the quality of the service although the provider did not carry out their own separate recorded quality checks but relied on the managers own audits. The provider was in the process of reviewing their quality assurance systems at the time of the inspection.

We have made a recommendation that the provider seeks appropriate guidance on the implementation of new quality monitoring systems. We will check on the progress with this at the next inspection.

There were effective safeguarding procedures in place to protect people from the risk of abuse. Staff understood the different types of abuse and knew who to contact to report any concerns. There were processes in place to learn from accidents and incidents. Individual risks to people were assessed and detailed guidance provided to staff to reduce risk. Medicines were safely managed.

There were sufficient numbers of staff at the service. The environment had been adapted to meet people's needs. The service was clean and staff understood how to reduce the risk of infections.

Staff received sufficient training supervision and support to fulfil their roles and responsibilities. New staff completed an induction when they started work and staff received regular training and supervision that helped them support people's individual needs.

Prior to joining the service people's needs were carefully assessed in partnership with people, their families and health and social care professionals where relevant.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

People were supported to meet their dietary and nutritional needs safely and provide them with sufficient choice. The service worked with health and social care services and professionals to maintain the good health of people they supported. The service supported people when they moved between services through effective communication to ensure their care and support were coordinated well.

People and relatives told us staff treated people with kindness and consideration. Staff respected people's individuality and promoted their independence. People were involved as far as possible in decisions about their care.

People's care and support was responsive and personalised to their needs. The service used positive behaviour support (PBS) where appropriate. This is a person-centred approach to supporting people who display or are at risk of displaying behaviours which may require a response with the aim of improving their quality of life. The service promoted equality and people's diverse needs were respected and supported. Information was available in a range of formats.

People were supported to engage in the community and in activities that they enjoyed. People were supported to socialise, learn new skills, and maintain relationships. People and their relatives knew how to complain about the service should they need to. Information was available in a range of formats.

Relatives, staff and professionals gave positive feedback about the management of the service and said their views were listened to. We saw there were areas where the service worked to keep up to date with best practice and share learning in the team. There was a clear ethos of providing good quality person centred care at the 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? The home remains rated Good.	**Good**
Is the service effective? The home remains rated Good.	**Good**
Is the service caring? The home remains rated Good.	**Good**
Is the service responsive? The home remains rated Good.	**Good**
Is the service well-led? The home remains rated Good.	**Good**

Cabrini House 1 (Diagrama Healthcare)

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 unannounced inspection was carried out by a single inspector and took place on 22 October 2018. Before the inspection we reviewed the Provider Information Return (PIR). This is information providers are asked to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the other information we have about the home such as notifications. A notification is information about important events the provider is required to send to us by law.

During the inspection we spoke with three people using the service and a relative, three staff members the registered manager the intervention manager and area manager. Some people using the service could not express their views verbally about the support they received, so we spent time observing the care and support provided and tracked that this matched with guidance in their care plan.

We looked at three care plans, four staff records and other records related to the running of the service such as environmental checks, minutes of meetings and audits. After the inspection we spoke with five other relatives by phone. We also contacted health and social care professionals and local authority commissioners for their views.

Good

Is the service safe?

Our findings

People continued to be protected from harm. People told us they felt safe from the risk of harm, abuse bullying or discrimination. One person said, "The staff are good. I am safe with them." Relatives told us they though their loved ones were safe; one relative remarked, "It's perfectly safe. I have no worries like that." Another relative commented, "It's very safe, people are well looked after." We saw that people appeared relaxed and comfortable in the presence of staff and in the way they were supported by staff.

Staff received regular training in relation to safeguarding. They were knowledgeable about the kinds of possible harm or abuse that could occur to people and their responsibilities under safeguarding processes. They were familiar with the provider's whistleblowing policy and what to do if they had concerns. Safeguarding referrals had been made appropriately by the manager of the service where they had identified a concern and action was taken to protect people from harm. The service had worked alongside the local authority and CQC had been notified as required.

The service looked to learn from safeguarding, any errors or accidents. Any medicines errors, or near misses were tracked and discussed with individual staff members in supervision and in team meetings. The registered manager told us they tracked any safeguarding alerts to check for any patterns and identify any learning from the process to feed into improvements which were discussed at staff meetings and at monthly manager's meetings. For example, we saw learning from one safeguarding issue had been to ensure staff carried identity cards when they were out.

There continued to be measures in place to reduce infection risk. The home was clean. People were encouraged to keep their rooms tidy and clean and staff supported people to keep the communal areas clean. Relatives told us the home was always clean when they visited. One relative told us; "The place is always clean when I go there." Staff received training on infection control and knew how to prevent and reduce the risk of infection. We observed hand-washing facilities and use of personal protective equipment (PPE) to reduce the risk of infection.

Risks to people were assessed before they joined the service and guidance was in place for staff to reduce the likelihood of risks occurring.

Medicines continued to be safely stored, managed and administered. Staff received training on the administration of medicines and competency assessments were also conducted to ensure they could carry out this role safely. People's medicines were reviewed annually or sooner if there was an issue to ensure their health needs were addressed. Medicines administration records (MAR) contained important information such as any allergies and were up to date with no gaps. There was a process to identify any medicines errors promptly and when these occurred action was taken through supervision and team meetings to address any learning. For example, we saw where a recording gap had been previously identified this was discussed with the staff member concerned.

There were enough suitably trained staff to meet people's needs. We had some mixed feedback in relation

to staff turnover at the home but found there were enough suitably experienced staff to meet people's needs. Some relatives told us they thought there were sufficient numbers of staff. One relative said, "It's not an issue at all. There are always staff to help my family member make phone calls and when we go there, staff are there when you need them." Another relative said, "I think there are enough staff but they are not always familiar. A lot of staff have left."

The registered manager told us staffing levels were flexed to meet the needs of the people at the home and there was an additional staff member who floated between the provider's services a well as care coordinators working across the homes. Agency staff were employed to cover some shifts and staff sickness and the registered manager tried to use the same agency staff wherever possible. There were no agency staff present on the day of the inspection and our observations were that people were supported in a timely way either in relation to their individual needs.

Appropriate recruitment checks were completed before staff started to work at the service to verify their suitability to work in health and social care. These included applicants identity, employment history, character and employment checks, disclosure and barring checks and proof of right to work

Good

Is the service effective?

Our findings

Most people had lived at the home for a number of years. Where people had been more recently admitted their needs were assessed based around best practice guidance in relation to learning disabilities and autism such as from NICE (National Institute for Health and Care Excellence) to understand if and how the home might meet these needs.

Areas of needs assessed included physical and mental health, behaviour, eating and drinking, socialising, accessing community facilities and personal care. The assessments included consideration of best practice guidance in relation to learning disabilities and for example in the use of any necessary equipment for example, epilepsy monitors or positive behaviour support planning where this was identified as a need.

People were supported by staff who had the appropriate knowledge and skills to meet their needs. Staff new to the service received an induction that followed the care certificate, the standard set for workers new to health and social care. There was also a period of shadowing established staff to ensure new staff understood their role. A staff member told us, "The shadowing and induction is very good and important to help understand people's needs." Staff received regular training on a range of subjects relevant to the support they offered and to people's needs such as epilepsy training.

Staff told us and records confirmed they received regular supervision and annual appraisals. These were documented and supervision sessions included a follow up on previous actions agreed as well as opportunities to reflect and learn about practice and consider developmental needs.

People received the support they needed to meet their nutritional needs. People were enabled to choose the food they ate; we saw some people had been engaged in shopping for their meals. Care plans detailed the support people needed and any dietary requirements or risks. Guidance was provided to staff in relation to possible choking risks. People's weight was monitored regularly to identify any concerns and a choice of drinks was offered frequently throughout the day.

We observed the lunch time meal experience. People were empowered to prepare their own lunch with varying degrees of support and encouragement. Where people were unable to express their views verbally about the food they wanted, they were offered a visual display to select from. People's cultural needs in respect of food choices was catered for.

Regular handover meetings were held to discuss people's needs and alert staff to any changes; to enable the staff to work consistently as a team. People were supported to ensure their needs were met appropriately when they used other services. Staff liaised regularly with other services, for example day centres or colleges where people attended to ensure care and support provided were consistent and any changes were communicated.

People were supported to access healthcare services they needed to maintain their health. Care records contained details in relation to any health needs and feedback from health care professionals who visited

such as district nurses or from hospital appointments. People also had a communication passport to aid communication about their needs to hospital staff when visiting hospital.

People's rights in relation to consent were protected. 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

Staff told us and we observed that people's consent was sought before they supported people. For example, we saw staff ask people if they wanted help with aspects of their activities, personal care and making a meal. Staff understood the importance of asking for consent. One staff member told us, "We always ask people if they want support first. It's really important that they are happy with what we do."

Staff told us most people had capacity to make day to day decisions. Where people were assessed as lacking capacity to make a decision, for example, in relation to medical treatment best interest meetings were held with relevant people. The support of an independent mental capacity advocate was sought where appropriate.

We found DoLS applications had been appropriately made to protect people's safety and there was a process to track the expiry of any authorisations and monitor that any conditions were complied with.

The home environment was suitably maintained and adapted for people's needs. There were accessible toilets and bathrooms or showers at the home and equipment was available for people who needed it. There was no lift but there were bedrooms on the ground floor as well as upstairs to cater for differing levels of mobility; people's rooms were personalised. There was access to communal areas to sit and relax in and a garden which we observed people enjoying during the inspection.

Good

Is the service caring?

Our findings

People continued to be supported by staff who were kind and caring. One person said, "The staff are good. I like the staff." Relatives all commented that the staff were kind. One relative said, "Its brilliant. I am so glad [my family member] is there." Another relative commented, their family member, "Is always happy to return there when they visit me which is a good thing." We observed people engaged and interacted with staff willingly and enthusiastically and staff interacted in a calm and caring manner with people.

People's communication needs were identified and assessed as part of their care plan. Communication plans detailed how staff could communicate effectively with people and understand their nonverbal cues. Staff were knowledgeable about people's body language and nonverbal communication cues. We saw they offered people choices in how and when they received support and that they looked for any signs of agreement and disagreement. They were aware of how to recognise any triggers that might cause distress, such as noise levels and how to reduce people's anxiety levels.

Staff told us some of the people at the home had lived there for a number of years and they had known them since they were children and so longstanding staff knew them very well. Some relatives told us they thought staff went, "above and beyond," with a very personal caring touch. For example, one relative told us how a staff member had come in on their day off to accompany their family member to hospital and made a birthday cake with their favourite theme in mind.

People continued to be involved in making decisions about their care and treatment as much as possible. We observed staff consulted with people about how they spent their day and provided choices or suggestions where people were unsure. People had a named worker who spent time with them and was responsible for aspects of their care. This encouraged a meaningful relationship where people would develop confidence to express themselves and any concerns. Where people were unable to express their views, relatives told us they were kept fully informed and consulted about their family member's care. A relative said, "They do ask our view and let us know about any changes."

Care plans included detailed personal information about people's likes, dislikes, background and histories. This enabled staff to understand the people they supported and what might influence their moods or choices. People were provided with a service user handbook with information about the home. This was in a range of formats to aid understanding.

People were encouraged to do things for themselves for example prepare their lunch and keep their rooms clean. A staff member said, "It is rewarding to support people to do as much as they can themselves." Care plans detailed which aspects of their care and support people could manage and which they required assistance with. Staff were knowledgeable about people's needs with regards to any protected characteristics under the Equality Act 2010 and supported them appropriately for example in relation to their disability or culture.

Staff maintained an understanding of the importance of dignity and respect and observed examples of how

they tried to ensure this. Such as covering people up while they received personal care and closing curtains. Staff were aware of the importance of confidentiality about people's information and we observed records were held securely and confidentially.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs. People had individualised care plans that detailed the care and support they needed and provided guidance for staff to follow in terms of their preferred routines and how much they could do for themselves. Plans we reviewed reflected people's current needs and included information about their preferences and dislikes. Care plans were reviewed regularly to ensure they were accurate. Staff were aware of the details in people's care plans and their preferences in the way they received support.

Where appropriate, the service worked with relevant health professionals including nurse practitioners and the behaviour intervention team to develop positive behaviour support (PBS) plans to provide detailed and a consistent approach in relation to any behavioural challenges. These plans were included as part of people's care plans.

Information was displayed around the home for people in accessible formats in line with the Accessible Information Standard. This standard requires services to identify, record, share and meet people's information and communication needs. For example, information about how to raise concerns was displayed in the service to aid understanding and other documents such as care passports were also in an easy read format. Where people's spoke dual languages, there were phrases and key words available for staff to aid communication and understanding.

People's needs for stimulation and socialisation were met. People were supported to access the community for example to attend college day, centres, or take part in individual or group activities. Some activities included building on life skills such as cooking. On the day of the inspection one person was visiting relatives and another person was at the day centre. Some people were supported to do food shopping and other people were involved in separate activities of their preference including enjoying the garden which we saw reflected in their care plan. People had their own activity plans although some activities were enjoyed by a group such as horse riding or going to the gym. Staff explained that as some people had lived together for a number of years they had formed close bonds and enjoyed spending time together.

People spoke enthusiastically about their summer holiday they had enjoyed and staff told us how people had been supported to choose their holiday through visual displays.

Since the last inspection the provider had appointed an intervention manager to support the home's development for a period. They told us they had just started working with people and staff at the home to develop improved goals for people which empowered them, supported their growth and the development of their skills and independence as well as increased integration into the community. We saw this was in the early stages of progress at the inspection.

People's diverse protected needs and characteristics were identified, and plans had been put in place to address these needs. For example, in relation to people's disability or health needs, specialist equipment was provided. People's cultural needs were respected in relation to their diet or care routine. Staff told us

they had days to celebrate and enjoy the foods of other cultures and people were supported to enjoy food from their culture. Staff told us people could be supported to attend places of worship where this was their choice.

There was a complaints process and information about how to complaint was available in a range of formats for people at the service. People told us they would, "speak with Staff" if they were unhappy about anything. Relatives told us they knew how to make a complaint and were confident any issues would be addressed. We saw complaints were responded to and managed in line with the provider's policy.

People and their families had been consulted about their wishes and preferences for care at the end of their lives. Where appropriate an IMCA was consulted to better ascertain people's wishes. No one was in receipt of end of life care at this inspection.

Good

Is the service well-led?

Our findings

People and their relatives told us they thought the home remained well run and organised. A relative said, "It's very good there. The manager is visible and approachable." Another relative said, "The staff work well and are organised and helpful." People told us they knew who the manager was and they were "nice." A recent report from a local authority who commissions the service was positive and told us they thought the home was "well managed."

There was a registered manger in place who had been registered manager of the service since 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. They were familiar with the responsibilities of being a registered manager and had submitted notifications to us as required and their current inspection rating was displayed at the service.

There were systems to monitor the quality of the service. There were regular weekly and monthly medicines audits, care plan audits and a health and safety audit. They were also accredited under ISO9000 which is a system of quality management standards. The registered manager had monthly meetings with the provider where any safeguarding, accidents or incidents were discussed and learning considered and monthly visits from the area manager.

However, the provider did not carry out their own separate recorded checks or reports of the service; which meant that it was possible some issues may be missed or not be promptly identified. The registered manager told us that the organisation was reviewing how they carried out their quality assurance.

We recommend that the provider seeks external guidance on the implementation of new quality monitoring systems. We will check on the progress with this at the next inspection.

Staff told us that the registered manager continued to lead the staff team effectively and promoted good quality care. They were aware of their responsibilities and they worked well together. One staff member said; "We are a good team here, we help each other, it's for the good of the people here." There were regular staff meetings and we saw these discussed the provider's values of appreciating people's uniqueness, being non-judgmental open and striving for excellence. Staff meetings were occasionally attended by the Chief Operations Manager and Chief Executive of the organisation.

People and their relatives' views were sought using comments boxes and surveys. The annual survey and areas of learning was shared with people and their families. The registered manager told us that in response to feedback about staff changes they had included an update in a newsletter and included photos of staff to help relatives identify them more easily. Contributions to questions for future surveys were also requested. Relatives told us they received a regular newsletter with updates about the home and were invited to attend provider social events throughout the year.

The home worked in partnership with health and social care professionals including the practice nurse and contributed to local authority reviews of people's care. Staff liaised effectively to promote people's needs and rights for example in relation to best interests' decisions and the appointment of independent mental capacity advocates (IMCA's).

The home looked to improve and learn. The Chief Operations Manager and Intervention Manager spoke with us about the support provided to staff to encourage them to further empower and enable people at the service to engage as actively in the community as possible. We saw the chief executive had visited and spoken with staff about their vision for the service to encourage staff commitment to changes.