Albany Care Homes Limited

Falmouth House

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

The inspection took place on 1 October 2018 and was unannounced. This meant the provider and staff did not know we would be coming.

We previously inspected Falmouth House in August 2017, at which time the service was rated requires improvement. At this inspection, the service was rated good.

Falmouth House is a 'care home'. People in care homes receive accommodation and nursing or 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.

Falmouth House accommodates a maximum of 10 people with a range of mental health needs. The service is split across three floors. Nursing care is not provided. There were eight people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager was also responsible for the management of the provider's other small service nearby and was supported by a deputy manager.

At the previous inspection we found care plans were not always person-centred and people's aspirations and goals and achieving them were not always well planned. At this inspection we found improvements had been made in both regards.

There had been improvements in the fabric of the building since our last inspection, including some new flooring and redecoration to people's rooms. The provider showed us the plans for further refurbishment of the premises on an ongoing basis. The service was generally clean although at the time of inspection the provider was awaiting the new cleaner to start, meaning care staff were currently covering cleaning duties.

The care service had been registered for a number of years, in a converted terraced house, and had not 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. We found however, despite the building not being in line with current best practice guidance, that people with learning disabilities using the service could live as ordinary a life as any citizen and were supported by staff to do so.

Medicines administration practices were safe, with staff trained appropriately and their competence assessed annually by the deputy manager. Staff demonstrated a good knowledge of people's medicinal

needs.

Risk assessments were in place and were specific to people's individual needs and circumstances. Staff demonstrated a good working knowledge of these risks and described what factors to look out for that may indicate people becoming more at risk.

Staffing levels were appropriate to the needs of people who used the service and rotas were planned in advance.

All staff understood their safeguarding responsibilities and were committed to making sure people were safely cared for. People who used the service felt safe and secure.

Training and support was effective, with the induction giving new staff introductions to each person's needs. Training ensured staff had the core skills required. Staff told us they were well supported.

People had a choice of meal options and had been encouraged to try healthy alternatives such as salad.

People were supported to have maximum choice and control of their lives in the least restrictive way possible. The policies and procedures in place supported this practice. Staff had received training in the Mental Capacity Act (2005) and consent was evident in care planning and through day to day interactions.

Care plans contained sufficient guidance for staff to ensure people's needs were met and that visiting healthcare professionals could understand people's recent health and wellbeing. These care plans had been reviewed and audited to check for required changes and updates.

People who used the service gave positive feedback about how staff were patient and respectful with them. External professionals provided us with similar feedback about the interactions they have observed. The provider had introduced a dignity competence assessment and all staff treated people who used the service as respected individuals.

Activities provision was still a work in progress, with one member of care staff taking the lead alongside care duties. They had organised arts and crafts recently. People who used the service had been consulted on what activities and outings they would like to take part in and the provider assured us they would continue the good work started.

There had been no complaints but people who used the service were clear they knew how to complain and to whom, if they needed. This information was available in easy-read formats in a communal area, as was safeguarding information.

People had been asked about their preferences regarding end of life care, although no one who used the service was in need of this at the time of inspection.

The deputy manager and registered manager interacted well with people who used the service and staff. The culture was open, inclusive and the atmosphere welcoming. People felt at home and reassured due to the continuity of care provided.

Audits of core processes were in place and the managers demonstrated an awareness of areas of recent good practice. The deputy manager was aware of their responsibilities with regard to making appropriate notifications to CQC.

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 felt settled in a familiar environment and supported by staff they knew well.

Risk assessments were up to date and described how staff should best support people to keep them safe.

Staff were aware of their safeguarding responsibilities.

There were sufficient staff on duty to ensure people were cared for safely.

Is the service effective?

Good

The service was effective.

Staff received an induction and training that gave them the knowledge and skills to support people well.

Staff supervisions and meetings were in place and staff told us they were well supported.

People enjoyed a range of meal options and staff had promoted healthy choices recently.

Is the service caring?

Good

The service was caring.

All people who used the service told us staff looked after them in a dignified, respectful manner.

We observed positive and friendly interactions throughout the inspection.

People were involved in decisions such as refurbishments and the employment of new staff.

Is the service responsive?

Good

The service was responsive.

Care records had been reviewed and were up to date.

Activities planning and provision had improved recently, although still required more work to ensure people were fully supported to achieve their goals.

Staff were aware of the potential for people's needs to change, and were clear on how to identify this, and what action to take.

Is the service well-led?

Good

The service was well-led.

The deputy manager and registered manager interacted well with people who used the service and staff.

The culture was open and inclusive and the atmosphere homely and welcoming.

The deputy manager maintained good oversight of core areas such as medicines and care planning.

Falmouth House

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.

We visited the service on 1 October 2018 and the inspection was unannounced. We do this to ensure the provider and staff do not know we are coming. The inspection team consisted of one adult social care inspector and one 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 service.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We contacted professionals in local authority commissioning teams, safeguarding teams and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.
Before the inspection the provider completed a Provider Information Return (PIR). 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 the inspection we spent time speaking with five people who used the service. We observed interactions between staff and people who used the service throughout the inspection, including at lunchtime. We spoke with four members of staff: the registered manager, the deputy manager and two care workers. We looked at three people's care plans, risk assessments, medicines records, staff training and recruitment documentation, quality assurance systems, meeting minutes and maintenance records. Following the inspection we contacted one relative, one advocate and two health and social care professionals.

Good

Is the service safe?

Our findings

At the last inspection we found a number of areas where refurbishment was required to ensure surfaces could be cleaned adequately. At this inspection we found maintenance work had been consistently undertaken and the environment had been improved. This had been planned and documented by the registered manager. For instance, damaged and peeling walls upstairs had been skimmed and repainted, a bathroom floor had been replaced, PVC cladding had been added in one w/c and people's bedrooms had been redecorated. Bedrooms were clean and tidy, as were communal areas.

The property is an old one and there were ongoing issues, such as toilets that required regular maintenance and a blocked drain. We saw the handyman had been employed regularly to remedy these problems on an ad hoc basis. There were ample bathing and toileting facilities for this not to have presented problems for people who used the service and no one we spoke with raised concerns about their surroundings.

Health and Safety checks were undertaken regularly by members of staff, who alerted either the handyman directly, or a manager, where they found an area of the home that required maintenance. The documentation used to record weekly health and safety checks was in the process of being reviewed during our inspection and the deputy manager was responsive to our feedback regarding how to make this document more effective and accountable.

People consistently told us they felt safe and well cared for. One person said, "Yes, it's canny here," and another, "The staff trust me and I'm safe." One relative said, "I know they are safe living at Falmouth."

Accidents and incidents were documented and analysed for patterns by the deputy manager, to establish if practices could be improved or lessons learned. We reviewed these incidents/accidents and found them to be limited and minor in nature.

Medicines were stored in a locked cupboard and the keys kept with staff at all times. We observed no excess of stock and no errors in the medicines administration records (MARs) we looked at. Weekly stock checks and monthly audits were undertaken by one member of staff, whilst the deputy manager and registered manager audited medicines administration on a six-monthly basis. Staff who administered medicines had been trained to do so and also had their competence assessed on an annual basis by the deputy manager. We provided feedback regarding the means by which this check could be documented as, in its current form, it did not demonstrate what specific areas of competence staff had demonstrated. The deputy manager agreed to review this document.

There were sufficient staff to meet people's needs. Rotas demonstrated that staffing was planned in advance and that the service did not rely on agency staff. When we spoke with staff, one said, "Someone will always cover your shift if you need to plan in a day off – it's really good like that."

Pre-employment checks remained in place for new members of staff and all staff demonstrated an awareness of their safeguarding responsibilities. The safeguarding policy was available in easy read format

for people who used the service. All people we spoke with were confident they could raise concerns should they have any.

Risk assessments were in place and specific to the needs of each person. They had been compiled in discussions with people who used the service to ensure they struck a balance between keeping people safe and allowing them to build independence and take positive risks. Risk assessments were regularly reviewed and updated when people's needs change or, for example, with the input of external healthcare professionals.

Servicing and maintenance of utilities and safety equipment was in place, for example gas safe testing, portable appliance testing (PAT), and the five-year electrical installation test. The provider had acted on advice following a recent fire safety visit and had improved the premises in a number of areas. Door retainers had been added so they could remain open for people's convenience but close automatically in the event of a fire. Thumb-turn locks had been installed in all people's bedrooms, following consultation with them, to ensure it would always be simple to exit from the inside in the event of an emergency. Additional smoke detectors had also been installed.

Personalised Emergency Evacuation Plans (PEEPs) were in place for both day and night. These help in the event of an emergency. We saw fire drills had happened recently and, in residents' meetings, saw people had been involved in discussion about fire safety in the home to ensure they understood what to do in an emergency.

Good

Is the service effective?

Our findings

People received care and support from a staff team who knew their needs well and received appropriate, relevant and regular training.

The deputy manager kept a training matrix with each staff member's training record on. This was used to inform discussions about each staff member's training needs and plan training courses for the year. These were then kept in an accessible docket on the wall in the deputy manager's office, and updated as each training course was completed. Training courses included safeguarding, Mental Capacity Act 2005 (MCA) awareness, dignity, infection control, mental health matters and fire safety. The deputy and registered manager had recently held a training session for staff on the General Data Protection Regulation (GDPR). The GDPR is a law which protects people's private information and must be followed by providers. People who used the service were also reminded of their rights at this point.

Staff who had joined the service recently confirmed their induction was comprehensive and included shadow shifts to ensure they were comfortable and confident supporting people who used the service. One member of staff did not have a care background and we saw they had been supported to complete the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

People who used the service felt staff knew them well and were sufficiently skilled. One person told us, "I get on with them. There are never any problems." One person's relative said, "Moving there is the best thing they have done. Should have done it years ago. The staff are great."

Staff we spoke with demonstrated a good understanding of people's healthcare needs and were able to tell us about how people benefitted from input from external healthcare professionals. We saw evidence of regular and varied involvement from external professionals such as GPs and nurses to ensure people's healthcare needs were met. One external healthcare professional told us, "I always have a clear update and have never had any issues with staff knowledge. They know people really well. They know what to look for."

There was a keyworker system in place which meant people's care plans were updated by specific staff who had got to know them well. People's social, physical and mental health needs had been assessed appropriately. Care plans were up to date and contained sufficient evidence about people's medical backgrounds for staff to be able to understand how best to support them.

The 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 is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw no one using the service was subject to a DoLS and

people could come and go as they pleased. In line with the principles of the MCA, people's capacity had been presumed unless there was a reason to assess it. When this was the case, mental capacity assessments had been documented to ensure people's capacity to make decisions was understood and respected.

We observed staff ensuring people consented to day to day choices such as where they would like to go and what meals they would like. People's consent had also been sought and documented in their care files. Where decisions regarding the fabric of the premises impacted on people, we saw they had also been consulted, for instance regarding the installation of new thumb-locks on bedroom doors.

The premises were appropriate for the needs of people who used the service and there were sufficient dining, communal, bathing and toileting facilities. People told us they felt the premises were suitable for their needs. The home was a converted terraced house, and as such had not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. We found however, despite the building not being in line with current best practice guidance, that people with learning disabilities using the service could live as ordinary a life as any citizen and were supported by staff to do so. For instance, people had direct access to their local community as the service was centrally located, with public transport nearby and actively encouraged by staff, whilst there were no restrictions on people leaving the home. This meant some of the principles of Registering the Right Support were upheld, such as valuing choice, independence and inclusion.

Supervisions were in place and demonstrated that staff had regular, in depth conversations with the deputy manager. Supervisions are meetings between an employee and their manager whereby the staff member can talk about training or other needs they may have, and both can reflect on areas of good practice or areas for improvement. Staff told us, "There is plenty of support – we have regular meetings and I can come to them anytime as well."

People had a choice of meals although gave mixed feedback about the standard of some meals, with two of the people we spoke with stating they would like more variety. We reviewed menus and saw there was a choice available, and that if people wanted something different they could have it. Menu discussions also formed part of the residents' meetings and we saw suggestions had been acted on.

Where people had been identified at higher risk of dietary-related illnesses we saw staff offered health choices such as salad, and that these had proved popular. The deputy manager ensured the Malnutrition Universal Scoring Tool (MUST) was used where appropriate. MUST is a tool which helps identify where people are at risk of malnutrition and puts in place measures to help prevent this.

Good

Is the service caring?

Our findings

People who used the service consistently told us they felt at home, well cared for, and that they got on well with staff. People told us staff genuinely cared for them and knew them well. One person said, "I can't fault the staff. I have no problem with them at all." Another said, "It's much better than the last place I was at," whilst another described the deputy manager as, "Saving" them from a temporary placement they had not enjoyed. One relative told us, "The staff are always lovely – I think they have everyone's best interests in mind."

We also saw that all recent surveys returned by people who used the service confirmed they felt staff were caring.

The culture was welcoming and the atmosphere homely and relaxed, with staff at all levels engaging personably with all people who used the service. People came and went when they chose and enjoyed varying levels of independence. For instance, some people walked to the local shops and along the seafront, some with the support of staff and some on their own. Other people went with staff to Newcastle to pursue their interests and hobbies and it was clear all staff we spoke with had a good understanding of the level of independence people were comfortable with.

People were encouraged to play a part in the planning of their care and the running of the home. For instance, one person enjoyed keeping busy by helping with household tasks such as meal preparation and tidying. Staff knew this and encouraged it on a regular basis.

Residents meetings were held regularly to ensure people who used the service were given further opportunities to discuss how the service was being run. We saw people had been involved in decisions about redecoration of areas of the home, including their bedrooms, as well as planning potential outings. People had taken part in the interview process during the recruitment of recent members of staff. This had constituted speaking with prospective members of staff and giving feedback to the registered manager. This meant people felt a meaningful part of the home they lived in and were given the opportunity to contribute as much as they were comfortable.

The deputy manager noted that there had been an increase in visits from family members recently and that some people who used the service had benefitted from this in terms of accessing the community more. People were also made aware of advocacy services so they could be supported in making decisions or making their opinions heard. When we spoke with external professionals they gave positive feedback about how staff involved people in day to day decisions and did not make assumptions about their needs or interests. One external professional said, "My [person] is always very calm and they get on great with the staff. I've always found them to be really close and dependable."

The majority of staff had been at the service for a number of years, as had people who used the service. Continuity of care was therefore extremely good and people were evidently comfortable in the presence of staff. Staff were aware of the content of people's care plans and knew them well.

People had been asked about their religious and spiritual beliefs and whether staff could do anything to assist them in accessing these, although we noted no one at the service had any strong religious beliefs at the time of inspection.

Staff communicated well with people. Some people who used the service were particularly anxious about particular topics and staff sensitively moved them away from these topics when they occurred and ensured people felt at ease. Where people had particular communication needs, for instance needing to be spoken to very slowly and have their understanding checked, staff were aware of this and put it into practice.

People were treated with dignity and respect and staff acted in line with the provider's expectations in this regard. Part of ongoing staff training included a dignity competency assessment, whereby staff answered detailed questions about how to maintain people's dignity in various situations.

People's rooms were well kept and individually decorated, with people encouraged to keep memorabilia important to them and to feel at home.

Good

Is the service responsive?

Our findings

At the previous inspection we found, whilst some people had achieved improved outcomes in terms of engaging with the local community, this had not always been well planned. Person-centred care planning had not always been in place, and statements linked to people's goals and aspirations were too vague.

At this inspection we found improvements had been made. The majority of 'pen pictures' we saw in people's files contained a good balance of key medical information as well as relevant information about people's life history, likes, dislikes and other notable information for staff. Each person also had a person-centred section which set out what was most important to them and what things they wanted to achieve (for instance, more independence, accessing a local attraction). One person's 'pen picture' contained limited background information and the deputy manager agreed to update this. Person-centred means that care is planned and delivered in a way that sees people as equal partners in planning and puts their needs and individualities first.

The deputy and registered manger acknowledged there was still work to be done to ensure the system they used to document people's goals was most effective for them, as well as for the service. They were using the Recovery Star model. The Recovery Star is a means of measuring outcomes which enables people using services to measure their own recovery progress, with the help of mental health workers or others. Some people who used the service had not always wanted to discuss the tool or be involved in the completion of the paperwork. The managers agreed they would review how successful the tool was after a period of months and explore whether there may be more effective ways of helping people plan and achieve specific goals.

Activities provision had also been an area requiring improvement at the last inspection, with limited planning and provision in place. We found improvements had been made in this area. The provider had given the lead role of activities to a care worker, alongside their caring responsibilities. Given the size of the service, this was appropriate. It also meant people were being encouraged to take part in activities by someone who they already knew. Recent activities included arts and crafts, film nights, a trip to Beamish and an onsite clothes shopping afternoon. We noted two people's artwork was displayed in the deputy manager's office and that, where people had a specific interest, this was encouraged by staff. Two people who used the service told us they felt there should be more activities and the managers acknowledged there was more work to be done to ensure all people who used the service consistently had the opportunity to pursue meaningful interests.

The deputy manager was aware of the risk of social isolation and the provision of activities had begun to help provide additional ways of minimising this risk. The deputy and registered manager agreed that they needed to keep trying to make links with local groups and external activities to ensure people who used the service, even if they chose not to attend such activities, had the opportunity to do so.

The provider had acted in line with the Accessible Information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information

they can understand, and the communication support they need. The provider had printed easy read versions of core policies and procedures, such as safeguarding and complaints, and placed these on the noticeboard in the dining room.

Records were accurate and up to date. Risk assessments and care plans had been reviewed and updated, whilst staff had consistently been reminded by management about the importance of accurate record keeping. We saw the service had in place a consistent handover process at each shift change and also a staff communication book to share general updates. Staff told us communication from management, and between staff members, was good. One external healthcare professional told us, "Communication is always good and they always get in touch early so we can nip anything in the bud. They are really responsive like that."

Staff demonstrated a strong understanding of what to look out for in terms of people's changing needs. For instance, one person was susceptible to infection. Staff were aware of this and had recently taken early action to involve external healthcare professionals, meaning the person received additional medical support in the early stages of an infection and recovered quickly.

Where people had mental health needs that were known to fluctuate, care plans described what indicators staff should be mindful of, which may indicate a downturn in the person's wellbeing, and seek advice accordingly. This meant staff were well placed and sufficiently informed to act when people's needs changed.

With regard to complaints, there had only been one made since the last inspection. We saw this had been followed up promptly and to a conclusion the complainant was happy with. People who used the service told us, "I know who to complain to. I've never had to though."

At the time of inspection no one using the service was receiving end of life care. We saw conversations had been broached with people about how they wanted to be cared for should their health decline and that this was documented in people's care files, where they had wanted to discuss such advance planning at this stage.

Good

Is the service well-led?

Our findings

The service had a registered manager in place, who maintained oversight of this service and the provider's nearby small residential service. With a deputy manager running day to day aspects of the service we found this worked well. Both the registered manager and the deputy manager had extensive relevant experience and demonstrated a good knowledge of the needs of everyone who used the service, as well as the policies and procedures at the service.

The registered manager had ensured there had been improvements to the provision and planning of activities since the last inspection, along with how people's personalised goals and aspirations were documented. They had also ensured there had been improvements to the fabric of the building, and more were planned.

One member of staff told us, "They always have a sit down with us and talk through any changes. You get a say in it and they respect you." We saw staff meetings happened regularly and covered a range of topics in depth, such as safeguarding, health and safety, fire safety and changes in legislation such as the General Data Protection Regulation (GDPR). The GDPR is a law which protects people's private information and must be followed by providers.

Staff told us they were well supported by management and enjoyed their roles. We found morale to be good and turnover of staff to be low, with staff working well together as an established team. External professionals expressed confidence in the leadership of the service. They told us, "I've never had any issues with the management," and, "It's an open culture there – they work together."

Staff surveys were undertaken regularly to give staff the opportunity to rate how well the service was doing and to raise any concerns they may have. These responses were wholly positive about how the service was managed. Surveys were also given to people who used the service, in pictorial formats where required, and visiting professionals. Again, all responses about how the service was run were positive.

When we spoke with people who used the service they said, "[Deputy manager] is really nice. They look after me." All expressed confidence in the leadership of the service and had no concerns.

It was evident through our observations that the deputy manager and registered manager took a keen interest in people's wellbeing and engaged with people well. This contributed to the open, inclusive atmosphere at the service and meant staff were supported by managers who acted in line with the behaviours set out in the provider's statement of purpose.

The deputy manager kept a file in the office for all staff to access, with updated best practice and newsletters from the likes of the National Institute for Health and Care Excellence (NICE) and the NHS.

Due to a lack of established links with the local and wider community, there was a risk that the service as a whole could become isolated over time. The deputy manager and registered manager assured us they

would endeavour to maintain positive links with local community groups and services.

The manager demonstrated a good understanding of when they needed to notify CQC of specific incidents. Registered providers and managers must ensure they notify CQC of major events, such as serious injuries or stoppages in the service, so that CQC can monitor the service remotely.

The office was organised. Checking and auditing processes remained in place, for example of care plans, medicines records and the fabric of the building. Where we identified documentation that could be improved, for instance the weekly health and safety check, the deputy manager acted on this advice promptly.