

Turning Point

Turning Point - 1-2 Cuthberts Close

Inspection report

1-2 Cuthberts Close
Queensbury
Bradford
West Yorkshire
BD13 2DF

Tel: 01274925961
Website: www.turning-point.co.uk

Date of inspection visit:
31 January 2018

Date of publication:
01 May 2018

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection was carried out on 31 January 2018 and was unannounced.

1-2 Cuthbert's Close 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. Cuthbert's Close accommodates 12 people across two separate units, each of which have separate adapted facilities. Both of the units specialises in providing care to people with learning disabilities.

The care 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. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There had been a change of registration in November 2016 when, a new provider had been registered. This was the first inspection of the new provider

The service had a registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People told us they felt safe. Correct safeguarding reporting procedures were followed. Staff were aware of the actions they would take to keep people safe. Correct procedures were followed to keep people's money safe.

Overall risks to people's health, safety and welfare were identified and action taken to manage the risk. Staff demonstrated a sound awareness of infection control procedures.

There was enough staff deployed. All the required checks were done before new staff started work and this helped protect people.

Medicines were managed safely.

People were provided with care and support by staff that were trained. Staff told us they had received induction and training relevant to their roles.

People were supported with their health care needs. We saw a range of health care professionals visited the service when required and people were supported to attend health care appointments in the community.

People were treated with respect and kindness and were given the opportunity to take part in a variety of

social activities.

Staff knew people's likes and dislikes in relation to food. People were offered a choice and people were observed to be enjoying the food they were prepared.

People's needs were assessed prior to commencement of the service and family were involved in the review of their care. Personalised care plans were in place and these were regularly updated or when care and support needs changed. Care plan documentation was very bulky and required consolidating.

The service was compliant with the legal requirements of the Mental Capacity Act and the registered manager understood their responsibilities under the Act.

There was an open and transparent culture at Cuthbert's Close. People respected the management team and found them approachable. Staff told us they felt supported in their roles and their views were listened to through surveys and team meetings.

The home was clean and infection control measures were in place. Some improvements were required to the decoration of the property, this had been already been identified. The manager had robust audits in place to monitor the risk and spread of infection.

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.

Staffing levels were well managed which promoted people's safety and helped to ensure a good standard of support was consistently provided to people.

Medicines procedures were robust and staff had good knowledge of the systems and the medicines being prescribed.

Relevant and up to date risk assessments were in place in people's care records.

Staff understood safeguarding principles and what to do if they were concerned about people.

Is the service effective?

Requires Improvement ●

The service was not always effective.

The service was acting within the legal requirements of the Mental Capacity Act 2005. Staff sought people's consent prior to care and support tasks.

Staff had received a variety of training to meet people's needs.

People's healthcare needs were met. The home worked alongside a range of health care professionals.

Improvements were required around monitoring people's food and fluid.

Is the service caring?

Good ●

The service was caring.

People were supported and encouraged to maintain links with the community.

Staff knew people and their care and support needs. Staff respected people's dignity and treated them with respect.

People were comfortable in the presence of staff and good relationships had developed.

Is the service responsive?

Good ●

The service was responsive.

People's care needs were assessed prior to using the service and person centred plans of care put in place.

Relatives were involved in the reviews of care and support.

People had access to activities, which they were consulted about and involved in.

Relatives told us they knew how to complain if required.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

Staff were complimentary about the management of Cuthbert's Close. They told us the management team were open, supportive and approachable.

Improvements were required to consolidate bulky care documentation.

A range of quality audits were in place to drive improvements within the service. There was a commitment to ensure continuous improvement of the service.

Turning Point - 1-2 Cuthberts Close

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 January 2018 and was unannounced.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert by experience had experience of services for people with learning disabilities.

Before the inspection, we reviewed the information we held about the service. This included notifications we had received. A notification is information about important events such as accidents or incidents, which the provider is required to send us by law. We also spoke with the local authority commissioning and safeguarding teams to ask them for their views on the service and whether they had any concerns. We reviewed the information on the 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 spoke with the registered manager, deputy manager, and four care staff. We looked at four care records of people who used the service, three staff recruitment files, training records, medicines records and other records relating to the day-to-day running of the service. After the inspection, we contacted four family members to ask them for their views on the service.

Is the service safe?

Our findings

This home was safe. The service was adequately staffed which ensured staff provided a person centred approach to care delivery. Staff's understanding of medicines and risk assessment processes helped ensure people's safety.

The service had a safeguarding policy in place. We saw staff had received safeguarding training. Staff we spoke with understood how to identify and act on allegations of abuse. They said they were confident people were safe living in the home and had not seen any concerning incidents or behaviour. Records and the manager confirmed there had been no recent safeguarding incidents occurring within the home. However, our discussion with the management led us to conclude the correct procedure would be followed should a safeguarding issue arise. People had risk assessments in place detailing how to keep them safe and reduce the risk of abuse.

The service held small amounts of personal money for people who used the service. The money was held securely and receipts were issued when money was spent. All transactions were recorded. The registered manager completed monthly audits on finances to make sure people's money was being managed properly. This helped to protect people from the risk of financial abuse.

The registered manager told us sufficient staff were employed for operational purposes and that staffing levels were based on people's needs. We observed on the day sufficient staffing was available to meet people's needs. We saw additional staff along with a driver were on rota to support with social activities and medical appointments. Staff told us staffing levels were suitable for the needs of people and allowed people to receive timely care and access a range of suitable activities.

Overall, the provider had systems in place that ensured people's medicines were managed consistently and safely by staff.

We found medicines were stored securely. Medication, which required refrigeration, was stored correctly in a separate fridge. There were records of temperature checks taking place. If medicines are not stored at the correct temperature, they may not work the way they are meant to.

We looked at the medicine administration records (MARs) and found these were well completed. We checked the stock of four medicines against the MARs and found they were correct.

Where individuals had medicines prescribed on an 'as required' basis, we found there were not always protocols in place to guide staff as to when, what dosage and how often to give these medicines. This meant there was a risk of inconsistent administration of these medicines. However, this risk was mitigated, as staff knew people well.

Some people were prescribed medicines, which had to be taken at a particular time in relation to food. We saw there were suitable arrangements in place to enable this to happen.

People had separate handwritten MARs in place for certain topical medications such as creams. The MARs included a body map of where the cream should be applied. The MARs were kept in people's bedrooms and were completed by staff when a cream was administered.

Care records demonstrated risks to people's health and safety were assessed and plans of care put in place for staff to follow. This included risks associated with equipment such as bed rails, nutrition, and health conditions such as epilepsy. These were very detailed and informed staff of how to deal with a range of scenarios. Specialist input had been sought from health professionals such as the epilepsy nurse and dietician to reduce the risk to people. We did however identify one person's moving and handling risk assessments required more detail as there was only a detailed procedure covering how to transfer them into the lounge chair rather than considering all the other types of transfer. We raised this with the registered manager who agreed to address this.

Accidents and incidents were recorded in detail and accurately. There was an open culture and staff confirmed that they were encouraged to share safety concerns with the management team, who then responded to any concerns raised. Records showed the registered manager completed thorough investigations and analysis into incidents and accidents to learn from these experiences. Lessons learnt were discussed during team meetings, shift handovers and through the communication book.

Safe recruitment procedures were in place. This helped ensure new staff were suitable to work with vulnerable people. Candidates were required to complete an application form, attend a competency-based interview, undertake a Disclosure and Barring Service (DBS) check, provide references and prove their identity. We spoke with a member of staff who confirmed the required recruitment checks had been carried out.

We found the home to be clean and hygienic although some surfaces and equipment required replacing to ensure they could be properly cleaned. For example, a chair in the lounge was ripped making it more difficult to clean. A domestic worker was employed who worked to a cleaning schedule and demonstrated they practiced appropriate infection control techniques.

We inspected records of gas safety, electrical installations, water quality, fire detection systems, and found all to be correctly inspected by a competent person. We saw all portable electrical equipment had been tested as required.

Staff had received training in fire safety and personal evacuation plans were in place detailing how to safely evacuate people in the event of a fire. However, these were all contained within individual care plans and would benefit from being in one place so they could be quickly accessed in the event of an emergency.

Is the service effective?

Our findings

People's care needs were assessed and appropriate plans of care put in place. The service worked with a range of health professionals to develop care plans that adhered to recognised guidance. Staff received training in topics such as positive behaviour support to ensure they worked to best practice guidance in managing behaviours that challenge.

Staff said there had been quite a turnover of staff recently. Family members also said they thought staff turnover was high this could mean there was a lack of familiarity of care staff. However, staff told us training and support from the provider was good.

New staff were required to complete a comprehensive induction to the service which included how to adhere to local procedures and ways of working. In addition, they received a range of appropriate training, which was delivered both face to face and via the computer. New staff without previous care experience completed the care certificate. This is a government recognised training scheme, designed to equip staff new to care with the required skills for the role.

Existing staff received regular updates in a range of subjects including positive behaviour support, safeguarding, equality and diversity and fire safety. We looked at training records, which showed training, was mostly kept up-to-date. Everyone living at the service had epilepsy. Although nurses are on duty at all times, none of the care staff had received training in epilepsy awareness which would be expected. The registered manager demonstrated this had been identified and a plan was in place to address. We did however find detailed epilepsy protocols were in place and staff were clear on what to do should people have a seizure.

Staff had recently received supervision and appraisal and told us they felt well supported. One staff member said, "brilliant support here cannot knock them". Another staff member told us, "I want to become a team leader; I am currently being supported with additional training and supervision to do this".

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. Staff had an understanding around why bed rails and restrictions had been put in place.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met.

People's capacity to consent to their care and support arrangements was assessed and we saw people's relatives and health professionals were involved in best interest decisions to help ensure people's rights were protected. We identified more information could have been embedded into each individual care plan about people's capacity to understand and consent to each individual plan of care.

Everyone who used the service lacked capacity to consent to their care and support arrangements. An assessment of the restrictions placed upon each person had been undertaken to determine whether they were likely to be being deprived of their liberty. Due to the continuous supervision and control required to ensure safe and appropriate care, DoLS applications had been made for all eight people using the service. These were all with the supervisory body awaiting assessment and as such, there were no authorised DoLS in place. We saw the provider had chased these up with the local authority as they recognised the delay could impact on people's rights.

We concluded care was delivered in the least restrictive way possible. Staff were aware of the need for DoLS applications and recognised forms of restraint such as lap belts and bed rails. It was clear from discussions with staff and review of documentation that the risks and benefits of these restraints had been considered before they were put in place, in people's best interests.

We found people's nutritional needs were met, but some improvements were required around monitoring of food and fluid.

People had access to a good range of food. We observed staff supported people appropriately and patiently at mealtimes to help ensure they consumed enough food. A varied menu was in place, which rotated on a four weekly basis but could also be personalised should someone want something different. Snacks were provided to people throughout the day.

We looked at one person who was nutritionally at risk. We saw they had detailed plans of care in place and staff were clear of the action needed to reduce the risk. This person's care records showed they required weighing two weekly. However, records showed this had not consistently taken place at this frequency. This meant that any changes in their weight might not be promptly identified as per the plan of care, putting them at risk.

The person was having their food and fluid input monitored. However, fluid input was not totalled and there was no evidence of review of the charts by nursing staff to ensure the person was getting enough to eat or drink. The person was prescribed a nutritional milkshake to have each day; however there were some gaps on the MAR chart and food charts which suggested they had not received it every day. We spoke to the registered manager who informed us this was a recording issue.

People's healthcare needs were assessed and plans of care put in place to meet their needs. Care plans were reviewed by nursing staff to ensure that they remained appropriate to people's individual needs. People had health action plans in place. A health action plan helps support people with learning disabilities to keep healthy. Health action plans contained details of health appointments attended and what they needed to do to stay healthy.

Hospital passports were in place to support effective transition between services. This meant that key information was available on people's needs should they be admitted to hospital.

Some areas of the building required redecoration and maintenance. For example, the kitchen had a new boiler fitted in August 2017, the wall had not been repainted, tiles were missing and pipe work was showing.

In the bathroom the radiator was heavily rusted, handrails were rusted. The registered manager confirmed previous decoration was undertaken in 2016.

There were a communal lounge and dining room, which were used for a range of activities and as private space to meet with family and relatives.

Is the service caring?

Our findings

Staff were caring and supportive to the people who used the service. Both staff and management were committed to ensuring that people received the best possible care in a homely environment.

We observed staff treated people with kindness and compassion. Two family members told us they felt staff were very caring and listened to them. One family member told us, "It is the best place my relative has been in, the staff provide excellent care." Staff spent time talking to people, including them in what was going on in the home, which made for a pleasant and friendly atmosphere. Staff used a mixture of verbal and non-verbal communication techniques to comfort and reassure people. Staff we spoke with demonstrated good caring values and a dedication to ensuring people lived as fulfilling lives as possible. They spoke positively and passionately about the people, they supported. One staff told us, "I love my job, I love working here".

Staff demonstrated they knew people well, their individual likes, dislikes and preferences. For example staff were able to confidently describe the food people liked, and exactly how to present it to them to give the best chance of people eating their food. One staff told us, "I know the likes and dislikes of each resident because I collected information from their family. Also I can tell from facial expressions and body language of a person, for example, [person] will spit it out if he doesn't like it, or, [person] will close her lips together if she doesn't want something to eat."

Staff knew people's favourite activities and how they liked to be communicated with. Information on people's life history was included within people's care plans to aid staff better understand the people they were caring for. However, we found more information could have been recorded within care files on people's likes and preferences, although staff knew these very well.

Staff listened to people and allowed them to make choices. We observed one person choosing to get up late they were supported in a warm and friendly way, with respect. Staff showed a person different items of clothing that they may wish to wear that day. At breakfast, different cereal was shown to people to help them choose which they preferred. Staff were able to give examples of the body language, sounds and words people used to express opinions. This information was also recorded in care and support plans to assist staff with a consistent approach.

Care records demonstrated that the service was in regular contact with people's relatives informing them of any changes in their relative's health and involving them in any decision making. We saw relatives had been informed of the outcome of the last CQC inspection in 2016 and the action taken to further improve the service. We found a lack of evidence that care plans had been formally reviewed involving people and their relatives. However, two family members told us they were very involved in the review of needs and care of their relatives.

We saw the provider had policies and procedures in relation to protecting people's confidential information, which showed they placed importance on ensuring people's rights to confidentiality, were respected. All confidential records and reports relating to people's care and support and the management of the service

were securely stored in locked cabinets in the main office to ensure confidentiality was maintained and the computer was password protected.

Staff had received training in equality, diversity and human rights. This helped ensure the service was responsive to the diverse needs of people who used the service and working within the framework of the Equalities Act 2010. Other protected characteristics are age, disability, gender, marital status, religion and sexual orientation. This information was discussed with people at the initial assessment. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Is the service responsive?

Our findings

The staff team demonstrated they supported people to engage in interests and activities both within their home and in the local community. Staff we spoke with said they were confident people's care needs were met and that people had a good quality of life.

People's care needs were assessed and a range of detailed care plans put in place, which were subject to regular review. These covered how to meet needs in areas of health and social care including managing medical conditions, ensuring personal care and social activity. These were mostly detailed, appropriate and person centred. Care plans were regularly reviewed by nursing and support staff.

People had communication care plans setting out how staff were to communicate effectively with them. We saw staff using appropriate communication techniques tailored to people's individual requirements. The manager and deputy attended training on the Accessible Information Standard. The deputy told us that communication champions had been appointed and work was in progress to make care and other documentation more user friendly to help promote accessibility to information.

Staff had received training in equality and diversity and we saw people's diverse needs were catered for. We saw no evidence that discrimination was a feature of the service.

The deputy manager told us that monthly nurse meetings and monthly key worker meetings took place where each person's care was reviewed. We saw documentation showed a review of areas such as health, clinical issues, goals and objectives. However, these had not been consistently completed.

The service had undertaken End of Life care planning with people to help ensure that they knew their wishes and preferences in this area. However, some of these needed more information recorded as to people's end of life wishes.

People had access to a range of activities. This included a weekly schedule with trips out into the community. People were supported to attend day centres, go on outings and undertake activities internally within the home. The service had its own mini-bus, which increased their flexibility to take people out.

The registered manager and deputy told us there had been no recent complaints from people who used the service or relatives. We saw when complaints had been received in other services run by the provider the learning from these had been used at this service to improve their practice and reduce the likelihood of similar complaints. This gave us confidence that the provider was committed to investigating, resolving and reducing complaints. Although the provider had a complaints procedure and suggestions box, following recent decoration of the hallway, this had not been put on the wall, which might have reduced people's access to the complaints process.

Is the service well-led?

Our findings

It was evident that the culture within the service was open and positive and that people came first. People were supported by a staff team who were proud to be part of the service.

At the time of our inspection, there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

On the day of inspection, the registered manager was a visible presence throughout the home. Staff spoke positively about the way the home was managed and told us the registered manager was approachable and listened to them if they raised a concern. The registered manager was open to ideas for improvements to the service during our inspection. It was clear the registered manager knew the care and support needs of the people who used the service.

Staff said they felt supported by the management team. Regular staff meetings and surveys were completed which offered staff an opportunity to make suggestions and provide feedback. We saw there were good person centred values in the home, centred on ensuring care and support met people's preferences and needs.

Care plan documentation was very bulky and required consolidating to make it easier to consult and ensure staff were consistently following the correct plan of care. For example, we saw a number of different care plans and protocols for nutrition for one person. In addition, the latest information from meetings and consultation with health professionals had not been added to the care plans, with this information being contained within daily records; increasing the chances, this information would be missed.

Some care plans had been changed with pen but would benefit from removing or rewording, as large sections were no longer relevant. Protocols were required for medicines prescribed on an 'as required' basis.

Some people did not have key workers or named nurses at present and the registered manager told us this was why monthly keyworker documents had not been completed. For example, one person did not have any key worker reviews for November, December or January and the deputy manager could not find any reviews for another person. However, this was a key mechanism to ensure the service stayed up to date with people's needs and objectives.

The deputy manager was aware that documentation needed improving and told us they had a plan in place to address.

The registered manager explained to us that people who used the service used to plan and go on holiday; however, these had not occurred in the last year. They said that following Turning Point taking over the service, there was confusion over holiday costing's. However, they said this uncertainty meant people had

missed out on personal holidays.

The service completed a quarterly patient safety report. This looked at any incidents, which occurred within the service, and the action taken to learn from them. Actions included updating care plans and risk assessments with new strategies and involving health professionals. The report looked at any arising risks within the service and helped senior management to understand how the service was operating.

There was a quality monitoring system in place to help drive continuous improvements to the care that people received. Audits were completed to ensure constant compliance at all times. The registered manager and other staff members conducted regular and comprehensive internal audits. There was also a monthly audit completed by the area operation manager which covered health and safety, quality governance, staffing and recruitment, out of hours checks, environment. Our observations supported these findings.