Conquest Care Homes (Soham) Limited

Robinson 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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was unannounced, which meant the provider did not know that we were coming. Our last inspection took place in October 2013, at that inspection there were no breaches in the regulations.

Robinson House provides a service for up to 10 people who have a learning and or physical disability. There were 10 people living at the home when we visited. There was a registered manager at the service. A registered manager

Summary of findings

is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We saw that there were proper policies and procedures in relation to the MCA and DoLS to ensure that people who could make decisions for themselves were protected. We saw from the records we looked at, where people lacked the capacity to make decisions, that best interest meetings were held. This was for finances, medicines and other things which affected a person's safety.

We found that people's health care needs were assessed, so that care was planned and delivered in a consistent way. From the three people's plans of care we looked at, we found that the information and guidance provided to staff was detailed and clear, and in an appropriate format. During our observations throughout the day we saw that staff clearly knew how to support people in a way that the person wanted to be supported. We also saw that people at risk of malnutrition or dehydration were effectively supported to have sufficient quantities to eat and drink.

We saw that staff respected people's privacy and dignity. This was by always knocking on the person's door or asking for permission before providing any personal care to people. We saw staff using curtains or blinds and offering space for people to talk in private.

Records we looked through and people we spoke with demonstrated to us that the social and daily activities that were provided had been decided upon by each person. People could change their minds if they did not want to do their routine activities. Staff we spoke with confirmed these alternative arrangements to ensure that people who remained at the home were supported to improve their daily living and social skills. One person we spoke with said, "I have been home for the weekend and I am now tired. Tomorrow I am going out for a pizza."

Other records we looked at such as, easy read documents showed us that people were supported to complain or raise any concerns if they needed to. There had not been any complaints since our previous inspection in 2013. We were provided with positive comments about the service from healthcare professionals. The complaints procedure was available to people in an appropriate format and if required, people could be supported by a social worker or an advocate. Our observations confirmed to us that staff responded appropriately if people were not happy, or communicated that they were anxious about something.

The provider had a robust recruitment process in place. Records we looked at confirmed that staff were only employed within the home after all essential safety checks had been satisfactorily completed. Staff we spoke with told us that they had not been offered employment until these checks had been carried out. Records viewed confirmed this to be the case.

The provider used a variety of ways to assess the quality of service that it provided. This was by involving families, advocates, social workers, health care professionals and others on a regular basis. Records were kept wherever this occurred to evidence the reasoning behind any changes to people's care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Good

Care plans we looked at showed us guidance for staff to safely support people whose behaviour was challenging. This assisted staff to respond in the right way.

Staff were well informed about how to recognise any abuse or potential abuse and also how to respond to any concerns correctly. They also understood the Mental Capacity Act 2005 and how this affected those people living at the home.

A sufficient number of staff with the appropriate skills were employed at the home. People could be assured that the home only employed staff whose good character had been safely established.

Is the service effective?
The service was effective.

Good

Care plans we looked at were detailed and provided comprehensive guidance for staff to follow and meet people's needs in an effective way. Our observations throughout the day showed us that people's needs, preferences and risks to their care had all been identified and were managed well.

Staff had up-to-date training and supervision which they used to support people. People who were not able to speak up for themselves were supported to access an advocacy services to represent them if needed.

Is the service caring?
The service was caring.

Good

Our observations throughout the day showed us that staff provided care with empathy, warmth and respect in a consistent way.

People were supported to access health care professional support in a timely manner. We saw that prompt action was taken where people required this support with their health conditions.

Relatives we spoke with were very complimentary about the care their family members had received. We also saw positive comments from a social worker in the excellent way the home cared for people.

Is the service responsive?
The service was responsive.

Good

The provider had plans to refurbish the home starting on the 15 July 2014 with replacement carpets, flooring, windows and bathrooms. This had been identified by the provider and meant that the service provider responded to the needs of people who used the service.

Relatives we spoke with confirmed that they were always kept very well informed about anything affecting their family member. The service improved people's social skills in an environment which supported their potential.

Summary of findings

Regular reviews of people's care were completed according to each person's assessed needs and with as much of their involvement as possible.

Is the service well-led?

Good

The service was well led

Relatives we spoke with were very complimentary about the way the manager led the home. One example of this was where the manager had made such a difference to people's lives at the home.

Records we looked at included care plan reviews, staff supervision, medicines administration audits, environmental audits and legionella safety inspections. The actions taken, where required, demonstrated to us that the manager provided strong leadership in maintaining a high standard of service for people living at the home.

Robinson House

Detailed findings

Background to this inspection

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

This inspection was completed by an inspector 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.

Before our inspection we reviewed the provider's information return. This is information we had asked the provider to send us about the standard of care that they were providing.

During the inspection, we spoke with six people living at the home, two relatives, three care staff and the registered manager. Not everyone who used the service was able to talk with us. This was due to people having complex care and support needs. We used staff, people's care plans and other information to help us with our communications. We also observed how people were cared for to help us understand the experience of people who could not talk with us.

We also spoke with two social workers. We asked for comments from the service's commissioners.

We also observed people's care to help us understand the experience of people who could not talk with us. We looked at three people's records and other records related to people's care, statutory inspection records, service user quality assurance survey questionnaire, staff recruitment and personnel records.

Good

Is the service safe?

Our findings

We spoke with three people supported by the service and observed three people who were not able to talk with us. We asked two people whether they felt safe and both reported that they did.

We asked three people how they let staff know if they were worried or unhappy. One person signed 'sad', another replied, "I would tell (the manager) and something would happen really quickly." Another person responded by gripping a member of staff's arm because they were distressed. Staff maintained a calm demeanour and social interaction and spoke to the others calmly throughout any incidents. This meant that staff had a very good knowledge and understanding of people's behaviours and they were able to describe these behaviours and the actions they would take if any such an incident occurred. This showed us that their responses to people's individual behaviours which challenged others, consistently ensured people's safety.

People being supported had differing levels of need. This was due to people having a range of abilities and independence. Staff were observed to be offering differing levels of support to each person depending upon each person's needs. For example, one person required support from specific members of staff and we saw that this was the case.

Records we looked at demonstrated that people's individual health risks were safely managed. This included the actions taken to ensure people's safety such as, transport safety, horse riding, accessing the community, social isolation and the need for gender specific carers. We saw that one person supported was observed going out to catch a bus. We saw from this person's risk assessment that they were safe to do this.

The registered manager and care staff had completed training on and were following the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) for people who lacked capacity to make a decision. They had also completed mental capacity assessments for people who lived at the home. For example, the provider had made appropriate applications under the MCA. Following recent legal judgements the provider was reviewing each person's care needs to confirm that appropriate safeguards were in place to ensure that people were not unlawfully deprived of their liberties. This was to ensure that people's liberty was not unlawfully restricted.

Best interest meetings had been held for situations where people's needs had changed. These meetings were attended by people's relatives, social workers and where required, health care professionals. People were assured that they would be provided with care only where they had provided a valid consent or where this was in the person's best interests.

The service also provided access to an advocacy service to support people with speaking out if they ever needed to. This was provided in easy read as well as a standard format. Staff and relatives told us that they had been supported to use this service in the past to assist their family member in being able to speak out.

During our inspection we saw and found that there was a sufficient number of staff with the right skills to safely meet people's needs. Relatives and social workers we spoke with also confirmed that this was the case, including at weekends. The manager also showed us the on-call list for staff if this was required. This meant that people were assured that there was always a sufficient number of skilled staff to safely meet their needs.

Staff were very knowledgeable about the people they supported well. They knew what made them anxious and how to re-assure them. One person asked about 'the man' (the inspector), as this made them anxious. We made sure we caused this person as little distress as possible. This meant that people were reassured and made to feel safe when changes occurred to their usual routines.

Staff we spoke had a clear understanding about the procedures for identifying and reporting any abuse, or potential abuse. As well as a service user guide in appropriate formats, information was displayed in the home so that visitors and staff had access to other organisations they could report abuse to if this was required. Relatives we spoke with told us that they felt very confident about their family member's safety at Robinson House.

Our observations demonstrated that staff had really positive relationships with the people they supported. The demeanour of all the people who were being supported

Good

Is the service safe?

was seen to be open and trusting of the staff. One person told us how the manager had explained things to help them make decisions and for them to consider staff and the other people who were supported as friends.

We saw where people required support to safely manage their diabetes that appropriate safety measures had been put in place if a person suffered from low blood sugar levels. This included access to drinks to help raise a person's blood sugar and emergency contact details if the person failed to respond to the initial support. We also saw that where people's blood sugars had not yet been safely established that regular visits and support from the diabetes nurse were in place.

Staff were only employed at the home after all essential pre-employment safety checks and the establishment of staff's good character had been satisfactorily obtained. This meant that people could be confident that they were cared for by staff who were safe to work with vulnerable adults.

Staff recruitment records and staff satisfaction surveys we looked at showed us that staff turnover was low. One care staff told us that they had come to work at the service as a result of their family member's sense of job satisfaction from working there.

Good

Is the service effective?

Our findings

Our observations throughout the day demonstrated to us that people being supported trusted the staff. Their demeanour was positive around staff and one person, living with diabetes, spoke about how the doctors, nurses and manager had explained healthy choices in their diet. This person also told us they would, "Tell (the manager), or someone who would tell the manager if they started to feel low again." They also told us 'staff would just know', if this happened.

Health records we looked at for three people who used the service showed us that each person was provided with regular health checks and GP support, including a well man or well woman clinic. Specialist support was also provided where people had such needs to ensure that they were met effectively. One person with reducing mobility and a person with complex health needs had been assessed for a wheelchair that was also an armchair. This had been designed to provide the required support and to ensure the person had unrestricted access throughout the home.

We saw that menus were planned in advance over a five week period. A different and healthy balanced meal was available every night, except Saturdays when there was a takeaway option. People were supported to choose their menus using photographs or verbally. The provision of menus in different formats ensured that people would be effectively supported with their nutritional needs.

One person who was living with diabetes told us about the registered manager of the service, as well as the doctors and nurses, explaining about healthy choices. The registered manager told them about explaining what the future held if blood sugar levels were not under control. The person clearly understood what they had been told, but told us they, "Cannot do without my chocolate."

The kitchen was open most of the time and was only locked when hot equipment was in use or where there was the potential to affect people's safety. People were observed going in and out to make their own drinks where they were able.

We saw people regularly being offered drinks and (where needed) supported to drink them. Others were observed making their own, although staff still offered them a drink. A special device for dispensing milk into hot drinks had been purchased for the kitchen to enable everyone to manage this activity independently. People were supported to be as independent as possible. People were reliably supported with a sufficient quantity of refreshment and nutrition throughout the day.

We conducted an observation of five people for 30 minutes during their evening meal. We saw that one other person preferred to eat in one of the home's lounges. This was their choice and helped reduce their anxieties. One person we saw joined the meal time slightly later and said, "I am sitting next to (another person). I am going to have my potatoes and beans." We saw that if people didn't want to eat at the meal time, or changed their mind about what was offered then staff offered an alternative choice. We saw that the meal time was not rushed and staff ensured that people had eaten sufficient quantities of food and drink. We observed that throughout the mealtime staff maintained social interaction and ensured that each person was supported effectively whilst also respecting people's independent living skills.

Training records we looked at and staff we spoke with showed us that, where people's care needs changed, staff were effectively supported with additional health care related qualifications. The manager told us that the service changed in response to people's care and support needs rather than the person having to move to an alternative staff member. One member of staff told us that when they first started their employment at the service they did not know sign language. They went on to tell us that since attending a British Sign Language course they had learned these skills which were essential to maintain effective support for people living with these support needs. During our observations we saw that staff used these skills to good effect.

Good

Is the service caring?

Our findings

Staff were observed to interact with people in a way which was both kind and respectful. Two people were engaged in detailed conversations around things they liked. One person asked about the evening meal, when it would be and telling people what they would be having. Staff were observed responding patiently to people's questions and prompts. Other people were seen engaged in jovial banter and general conversation about their hobbies and past times. Staff were heard engaging with warmth and empathy as though it interested them too.

We saw that where people engaged in activities such as, gardening and planting, staff encouraged people to take part even if they initially showed no interest. Another person was seen to be supported in their wheelchair to participate as much as they were able. When the gardening activity had been completed the registered manager went to see them and then went to the person and thanked them and praised the effect. People's support was delivered in a sincere and caring way and respected everyone who lived at Robinson House.

Staff were caring and respected people's choices. For example, people told us about their friends at church and how they no longer went to church. They went on to tell us, "I can't be bothered to get up in time." They said that if they laid in bed all day 'like 'til four or five o'clock', staff would check that they were alright and prompt them to start their day rather than let them stay in bed, but that it was up to them.

When one person living with dementia spoke very quietly and not at all clearly, staff were focussed on them completely, listening carefully and responding. Making sure they had understood what they were communicating, not just making responses which were not related to the persons' conversation.

We saw that people were able to see their family members and friends and go home if they wanted to. Staff's knowledge and awareness of what made people anxious and how they offered reassurance such as talking calmly or withdrawing from the situation which had caused the person to become anxious. Where people were no longer able to travel to see relatives the service ensured that they maintained contact in other ways such as by telephone. This was demonstrated in people's records we looked at.

Although there was no regular advocacy service available to people, we were told and saw that advocates had been brought in for specific issues including survey questionnaires. We also saw that easy read information and details about the advocacy service were available to people and their family members.

Good

Is the service responsive?

Our findings

Staff were observed treating people as individuals. This support included using signing to one person who used sign language to communicate and talking about whatever interested that person.

Plans of care we looked at showed us that where people had suffered a fall, or their health condition had changed that appropriate steps had been taken. This was to reduce the potential for recurrence or that things were put in place to ensure that people's health improved. A person told us that they had suffered a fall at night and that they had a pressure mat that would alert staff when they were out of bed. We discussed this with the manager who informed us that this fall had happened in January 2014 and that since the repositioning of the pressure mat there had not been any recurrences. People were supported with regular weight checks to identify if anyone was at risk of not maintaining a healthy weight and sensory mats to identify when a person got out of bed.

One person said that they would 'tell (the manager) and something would happen really quickly' if she had any concerns. Another person reported that they were able to go to the cinema, but that sometimes they were not able to see their chosen genre as it wasn't always suitable for the others. They told us that they were happy to wait until these films were on DVD and watch them then.

Two relatives we spoke with confirmed that since the present manager had been in post they had not had to raise any concerns. The same relatives went on to say, "If there was even the slightest concern our (family member) would tell us, using sign language or body language, straight away. They are just so settled where they live, we wouldn't want them to move unless they wanted to."

People were supported to take part in new activities where this had been identified. For example, horse carriage driving, listening to a musician who visited every six weeks, an animal contact session and day services where people learned cookery skills. Amongst other things, swimming, trips to the cinema and themed nights once a month.

The garden areas offered a hard standing area for Barbeques and eating outside but offered limited access to the plants, trees and shrubs for people who used a wheelchair. The manager told us that once the employments checks had been completed, a new maintenance person was to landscape and rework the gardens to enable everyone who used the service to access sensory stimulation and enjoy the garden, flowers and facilities.

Since our inspection on 16 October 2013 the service had not had any formal complaints made against it. Relatives told us that they had very regular communications with the managers and that any changes or improvements did not have to wait for a formal meeting. One relative said, "I can't remember the last time I had to suggest something. The manager knows our (family member) at least as well as we do." People we spoke with told us that if they had any complaints they would 'tell staff'.

Wherever possible people were supported to have holidays appropriate to their support needs. This included trips to the seaside (Blackpool) and going camping. Our observations showed us that staff were adept at reading people's demeanour and body language. For one person who made sudden grimaces which appeared initially to indicate anxiety; staff were able to explain that these indicated happiness and the person promptly demonstrated this by going into the courtyard area with a big smile on their face.

One person living with dementia also had reduced mobility. We saw that people could live downstairs if their health condition required this and that appropriate equipment had been installed for people with mobility support needs, such as a stair lift. Other equipment to support people included pressure mats to alert staff if they got up in the night. Staff reported that the buzzer 'can be heard everywhere. It's really loud'.

Good

Is the service well-led?

Our findings

We spoke with two people's social workers. They were very complimentary about the leadership and also the empowerment that the manager had offered to their staff. We were told things such as the reason they liked the home was because of consistent and high quality management. This, we were told, was evidenced by the improvements people had made in their independence and daily living skills, and also in the reduction or elimination in some cases, of people's 'as required' (prn) medications.

Relatives we spoke with told us that by keeping their (family member) occupied with social stimulation that this had helped them to reduce behaviours which had in the past challenged other people. They also told us how involved their family member was in the local community including shops, clubs and cafes.

These relatives also commented, "The home is 'very homely' and never has any unpleasant odours whatever day or time we visit. There is always such a lovely atmosphere and everyone living at the home gets on with each other. We think that with 10 very different people living together that the registered manager and social services have worked closely to ensure that people's needs can always be met."

The stability of the registered manager at the home meant that their leadership was consistent and drove improvement in the care provided. From speaking with people, staff, service commissioners, relatives and social workers we were provided with good evidence that the manager was meeting their legal obligations above the required standard.

The registered manager was supported by a regional manager. Where good practice at the home was identified, this was shared throughout the provider's other services and demonstrated how the service saw continual improvement as being standard practice. They had, over the period of a week's intensive effort, identified that a person's anxieties were caused by the number of people supporting them. This had then led to a support group of staff who could support this person.

Care staff and managers we spoke with were all passionate about working at the home and making a difference to the people who lived there. Our observations throughout our visit demonstrated staff were well motivated in the way they provided people's care with compassion and this quality of care was delivered consistently. For example, in the way staff responded to people's behaviours and the relatives we spoke with who confirmed the quality of the care that their (family member) received.

We saw records of audits completed by the provider on things such as infection prevention and control, medicines administration, health and safety, fire safety and environmental audits. This ensured that where improvement actions were identified that plans were put in place to ensure that any future potential for reoccurrence was prevented. However, we saw that some actions which had been identified did not have a date when they had to be completed by or if the action had been satisfactorily completed. The manager showed us that the shift handover book was used to record the actions but told us that they felt that having all the required information in one place would be better.

A quality assurance questionnaire survey completed in March 2014 showed us that seven people, supported by advocacy service and social workers, were satisfied or very satisfied with the service they had received. People were supported with sign language and their communication skills to respond to the questions.

Staff we spoke with, including managers told us that if ever they had the need to raise concerns about poor standards of care that they would have no hesitation in doing this. All of the staff we spoke with told us that the manager's door was always open and that if any concerns were raised the manager listened and acted promptly if this was required.

The manager explained that the shift handover and communications record was used for accidents and incidents where urgent action had been required. We saw that where incidents occurred such as people suffering a fall, an epileptic seizure or other untoward event that appropriate action was taken and that this was checked to ensure the actions taken had remained effective.

Meeting minutes we looked at showed us that the service monitored not just the views of people, staff, service commissioners, healthcare professionals and social workers but also took swift action to address any issue which affected people or the service provided. Examples included installing and acquiring alternative mobility equipment and positive comments from the service commissioners.