Community Integrated Care

The Mullion

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 Mullion provides accommodation, care and support for up to three adults who have a learning disability.

This inspection took place on 12 October 2017 and was announced 24 hours in advance to ensure someone would be at the home.

At the last inspection on 30 June 2015 the service was rated Good. At this inspection we found the service remained Good.

There was a friendly atmosphere in the home and staff supported people in a kind and caring way that took account of their individual needs and preferences. People and their families were supported to express their views and be involved in making decisions about their care and support.

There were systems and processes in place to protect people from harm, including how medicines were managed. Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to the management team.

Safe recruitment practices were followed and appropriate checks had been undertaken, which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

Staff were supported to provide appropriate care to people because they were trained, supervised and appraised. There was an induction, training and development programme, which supported staff to gain relevant knowledge and skills.

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

People received regular and on-going health checks and support to attend appointments. They were supported to eat and drink enough to meet their needs and to make informed choices about what they ate.

The service was responsive to people's needs and staff listened to what they said. Staff were prompt to raise issues about people's health and people were referred to health professionals when needed. People could be confident that any concerns or complaints they raised would be dealt with.

We received positive feedback about how the service was managed. A new manager had been in post since May 2017 and had applied for registration. There was an open and inclusive culture within the service. There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving appropriate support.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

The Mullion

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. The inspection was planned to check whether the provider was 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 was a comprehensive inspection that took place on 12 October 2017 and was carried out by one inspector. The inspection was announced 24 hours in advance because we wanted to make sure we could meet people who used the service.

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. We also checked other information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

During the inspection visit we spoke with the manager of the home, the regional manager, and three members of staff. Although we were not able to have in depth conversations with the three people living in the home, we were able to observe staff interacting with people. We looked at a range of records including care records for the three people, staff recruitment files and training records, risk assessments and medicines charts. We also looked at information regarding the arrangements for monitoring the quality and safety of the service provided within the home.

Following the inspection we spoke with relatives of the three people who lived in the home. We asked three community health and social care professionals for their views about the service and received feedback from two of them.

We previously inspected the service in August 2015 and no concerns were identified.

Good

Is the service safe?

Our findings

Most of the comments we received from relatives and health and social care professionals confirmed that the service was safe. A relative told us staff "Keep (the person) safe indoors and outside and are aware of the risks". They said "I can go to bed at night and know (the person) is okay". Another relative also told us staff worked in ways that kept the individual safe.

Two relatives commented about staff changes due to staff leaving and the difficulties of recruiting and that agency staff did not know people as well as regular staff. A health and social care professional said "The home has had historical issues with recruitment of staff which is probably my main concern. All the staff that work there are positive and caring but I do get concerned that if, for example, staff were to call in sick the shift will not be covered by someone who has appropriate training".

During the inspection there were enough staff to meet people's needs and provide care and support with activities. Staff were present when people spent time in the communal areas and people who were spending time in their rooms were suitably supported. Staff rotas were planned in advance and reflected the target staffing ratio we observed during the inspection. There were three care staff on duty during the day, two in the evening and one at night. The manager told us the service was currently trying to recruit staff to vacant positions and using agency staff in the interim. The service booked the same agency workers whenever possible to provide continuity of care. This was reflected on the rota and we spoke with and observed an agency worker on duty who clearly knew people and interacted well with them.

Staff told us the agency staff were "Really good. People know them" and that there were enough staff deployed to meet people's needs. Staff said "The team are really good at swapping shifts to ensure safety" for example to make sure there were staff on shift who had received appropriate training in the administration of emergency medicines for epileptic seizures. The service had requested that agencies providing staff send those who had this training and the agency worker we spoke with had completed this specific training.

A health and social care professional told us that before January 2017 there had been a number of incidents of medicines errors and behavioural incidents, however they had no concerns about the service at this time. Another health and social care professional said there had previously been some issues with not all staff being trained in the administration of emergency medicines for epileptic seizures. They told us the manager had been "Open and honest about this and made proactive steps to rectify the issue".

Since the last inspection the provider had notified us of a number of medicines errors that had occurred in the service. At this inspection we saw evidence that this aspect of the service had improved. Staff continued to receive training in the safe administration of medicines and this was followed by competency checks. If a member of staff was identified as making a medicines error, an incident form was completed and the member of staff was required to complete a reassessment, in order to support learning and safe practice. Medicines were checked and counted twice a day so that any potential errors would be identified quickly and action taken.

Up to date records were kept of the receipt and administration of medicines and any unused medicines were signed for and disposed of by the pharmacist. There were detailed individual support plans in relation to people's medicines, including any associated risks. Guidelines were in place for when prescribed 'as required' (PRN) medicines should be given and a member of staff demonstrated their knowledge of these. People's medicines were kept under review. One person was reported to be more settled since having their medicines reviewed and changed. Each person's bedroom was equipped with an individual medicines cabinet, which promoted their privacy and dignity.

Staff training included training in epilepsy awareness and administering medicines for the treatment of epileptic seizures. Staff showed us records for checking and signing in and out of medicines for the treatment of epileptic seizures, which staff would take with them when supporting a person in the community, or which could be signed out to relatives when the person visited them.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They were aware of the policy and procedures for protecting people from abuse or avoidable harm. Staff understood the possible signs that could indicate abuse and were confident that any issues they reported would be responded to appropriately by the organisation. There was also a policy protecting staff if they needed to report concerns to other agencies in the event of the organisation not taking appropriate action.

People were supported to take planned risks to promote their independence. We saw a range of risk assessment and management plans which provided relevant guidance for staff, for example when supporting people in the community. Staff were able to tell us about the risks associated with certain situations and people, demonstrating they knew people well. Examples of this included risks relating to mobility, choking, or behaviour that might challenge others. Falls and seizure monitoring procedures were in place for some people and staff were knowledgeable about these.

People had been assessed in relation to their mobility and risk of falls with the advice and support of an occupational therapist. One person had a condition of tunnel vision and staff were aware of this person's movements, particularly around other people as this could present a risk of falling and injury. The person knew the layout of the home and where furniture was placed and staff were aware of the importance of not making changes to the layout without due consideration. Staff told us how they provided "Reassurances and attentiveness" according to people's individual needs and known preferences. For example, one person liked "Peace and quiet and familiar faces"; another liked routine and another person responded well to "Encouragement and humour to mobilise independently".

There was a current fire risk assessment and records were kept of regular checks and tests of the fire alarm, emergency lighting and fire safety equipment. Staff fire safety instruction and drills were also recorded. Each person had a personal emergency evacuation plan, which included important information about the care and support each person required in the event they needed to evacuate the premises. Following the inspection visit the manager informed us they had met with the housing association representative, who had assigned work to be completed that included recommendations identified by the fire risk assessment.

The provider had continued to follow safe recruitment and selection processes to make sure staff were safe and suitable to work with people. We looked at the files for three staff including those most recently recruited. The staff files included evidence that pre-employment checks had been carried out, including employment histories, written references, satisfactory disclosure and barring service clearance (DBS), and evidence of the applicants' identity. The system of checks included obtaining profile records of agency staff who worked at the service. Staff confirmed the provider carried out checks before they were employed to

work in the home.

There was a cleaning schedule in place for staff to follow and regular checks and audits took place. The home environment was clean and staff were aware of infection control procedures. Staff received training in infection prevention and control and used protective clothing when carrying out cleaning and personal care tasks.

Good

Is the service effective?

Our findings

Staff had received regular training to enable them to provide effective support to people, such as moving and handling, fire safety, infection control and first aid. Additional training was provided for staff around people's specific needs such as epilepsy. The manager told us the community health team also provided support with epilepsy training, for example for new starters. A system was in place to track and record the training that each member of staff attended. The tracker showed that refresher training in first aid was due for a member of staff and we saw this was scheduled to take place the following day.

New staff completed an induction that included working alongside experienced staff as well as completing the Care Certificate, where required. The Care Certificate is a nationally recognised set of induction standards for health and social care staff. An agency care worker confirmed they had received an induction into the service and told us staff communicated effectively and encouraged them to ask any questions.

Staff received supervision and appraisals from their line manager, which provided them with formal opportunities to discuss their work performance, any training needs, ideas or concerns, and to receive feedback. Staff confirmed they were well supported and could ask for advice or guidance when they needed to.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA. Mental capacity assessments had been completed appropriately and best interest decisions made with the involvement of relevant others. A health and social care professional said "The service maintains good contact with the service user's family and any decisions are discussed with them and myself" and "The staff appear to have a good understanding of the laws and good practice surrounding mental capacity and consent".

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 application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). The provider had applied for appropriate authorisation where required. Where necessary restrictions were in place, these were documented in people's support plans.

People were supported to be able to eat and drink sufficient amounts to meet their needs. A relative told us their family member had a good appetite and "It's all good food, cooked on the premises". Staff demonstrated knowledge of people's individual support needs and associated risks in relation to eating and drinking. For example, One person required full support with eating and drinking. For another person there were speech and language therapist (SALT) guidelines in place regarding eating and choking risks and also support from a dietician in relation to nutrition and wellbeing. Staff were providing smoothies and milk

shakes to support the person who was regaining weight. Staff had noticed the person was losing weight and contacted their doctor, who had referred the person to the dietician.

Staff were proactive in requesting visits or reviews from health professionals, such as GP's or other health care professionals. Staff recorded all contacts and visits from health professionals in people's care plans and followed up any appointments where required. Health and social care professionals confirmed people were supported to maintain good health. One community professional said "The service users have a Health Action Plan and their health needs are met appropriately".

Since the last inspection new laminate flooring to better suit people's needs had been fitted in the communal areas. Environmental maintenance work by the housing provider was in progress.

Good

Is the service caring?

Our findings

Relatives said they liked the fact that it was a small home and they felt this suited their family member who lived there. A relative told us "All the staff care" and that their family member was "Always happy when I see her". They said the person "Has calmed down a lot since living at the home" and "Laughs a lot". Another relative said "Staff are very good and look after him well. He's happy there". A health and social care professional told us "All of the staff that I have met have a very caring nature".

Staff had developed positive caring relationships with people using the service. The atmosphere in the home was friendly and supportive and we observed staff knew people well and communicated effectively with them. We observed a member of staff interacting and communicating well with a person as they engaged in a ball game. The person called the staff member by name. Positive relationships were also evident among the staff team, as one member of staff told us staff "All look out for each other as well".

Each person had a key worker, a named member of staff who acted as a link with the person's relatives and participated in reviewing the person's care and support with them. The role also included liaising with community care professionals about health matters. A relative remarked that their key worker was "Very dedicated".

The relationships between staff and people receiving support demonstrated dignity and respect. Staff spoke about people in a respectful manner and demonstrated understanding of their individual needs. People's care and support plans were written in a respectful way that promoted their dignity and independence. For example, a person's support plan stated they could sometimes exhibit behaviours that could impact on their dignity. Staff therefore ensured the person's dignity was respected by closing doors, limiting interruptions to personal care and not speaking about the person's behaviours in a negative way.

Staff supported people to stay in touch with people who were important to them and to be involved in making decisions about their care and support. Review meetings were held with the involvement of the person's family, staff and external professionals. People's care and support plans included guidance to assist staff to involve the person and help them with everyday decisions. For example, how best to present information and ways to help the person understand. Staff had spent time with people, involving them in discussions about their activities, care and support.

Staff we spoke with had got to know people and learned how individual's communicated their needs and wishes. They told us how they presented options, such as what to wear or to eat, in ways the person could understand. A relative told us "Even though she doesn't speak they know what she wants. If she has an off day they go through options to find out what it is about".

Another person's support plan stated they were able to make simple choices in their life and liked to have a bath every morning, for which detailed support guidance for staff was recorded. The support plan advised staff to encourage the person to focus on what they were doing, particularly when mobilising, as they walked slowly and carefully and did not like to rush.

A hatchway had been fitted between the kitchen and dining room so that a person could watch and smell their dinner being cooked, as they liked to do. While it was not safe for the person to be in the kitchen at these times, this was an important part of the mealtime experience for them.

Good

Is the service responsive?

Our findings

One relative expressed concern that agency staff did not know people and were reliant on regular staff informing them of people's individual needs. They were also concerned that the person was "In the lounge a lot" and staff were not engaging them with activities as much as other people, particularly as the person required two staff to go outside the house. They said "Some staff have tried different things" but then those staff had moved on to different jobs. The relative said they were able to raise any issues they had with the manager or senior staff member.

We asked the manager about this person. The service had introduced new support planning recording tools, which included a section which asks the support staff 'what has worked well today, what could have gone better?' Staff used these to record any activities or other support that had gone positively, or something which did not work out. At the end of each month, a senior member of staff checked these records and used a 'summary of monthly learning log,' to highlight how the month had been in terms of support and any lessons learnt through the previous months. An example of learning was how staff had adapted the way they supported the person when out in the community. Through the monitoring of incidents it had been identified that a probable trigger for a person's behaviour was the way staff interacted with them. Following this, staff maintained a lower level of engagement with the person, who preferred to quietly observe their surroundings. Team meetings were used to discuss new ideas and alternatives for people's activities.

The person's support plans and risk assessments stated staff could not leave them unattended due to a risk of the person falling. The records also indicated the person's level of tolerance to staff or other people within the home interacting with them. Through observing and recording a particular behaviour, staff had become aware that the person used this to communicate their wish to be supported away from communal areas. Staff were therefore able to understand the behaviour and respond positively to what the person was communicating. The service was working with the community learning disability team in monitoring and reviewing the person's moods and behaviours to plan and provide on-going appropriate support.

Staff kept a record of activities they offered the person and which ones were accepted or declined. The person had a close relationship with a parent, who provided staff with guidance about what activities had worked or not worked historically.

Other comments from relatives confirmed the service was responsive to people's needs, including activities and health related matters. One relative said "They are on board regarding healthcare; they don't hesitate to respond". People's care plans contained one page profiles detailing what was important to them, what people liked and admired about them, and how best to support them. People had individual activity plans that included their personal preferences, for example shopping, walks and trips to a pub.

The service worked in partnership with multi-disciplinary community teams to support people with complex needs. A health and social care professional told us "Since the changes made to the management and staff team, the needs of the service users at The Mullion are met very well. The needs of the three service users are very complex as all three have a severe learning disability, behavioural needs and a variety of physical health

needs including epilepsy. The team seek appropriate support and advice from support services such as Learning Disability Health teams, Physiotherapist, and Occupational Therapist (OT)".

A health and social care professional said "At last year's review, it was identified that my service user does not have a large variety of activities within her week. A detailed activities plan was put in place (aided by OT) and the staff worked hard at trying new activities. However, they realised that the activities were not ones that the service user enjoyed. Therefore instead of simply giving up, or persevering to the extent that the service user became distressed, the team adapted the plan to make it more suitable and service user-led. This was highlighted at this years' review and demonstrated some innovative ideas for how to support the service user better".

The home had a complaints procedure which was also made available in an easy read picture format for people who were unable to read complex information. Relatives were aware of the complaints procedure. One relative said they had "No complaints at all" and another told us they had not had any reason to contact the provider and would feel comfortable to say if there was a problem. The manager told us they had received no complaints about the service. Staff understood people's needs well and demonstrated how they would be able to tell if a person was not happy about something, which meant that people would be supported to express any concerns.

Good

Is the service well-led?

Our findings

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The previous registered manager had not been in day to day charge of the home since March 2017. The current manager had been in post since May 2017 and had applied for registration. The manager was responsible for the day to day management of three services. We received mixed feedback from relatives about this. One relative said "One manager trying to run three places doesn't work". Another relative said "One manager to three houses worried me to start" but that now "Senior staff take on more". Another relative told us they were "Happy with the management".

A member of staff said "From March we did not have a manager or a senior. Other managers did come in to help out, which helped make it less stressful, and it did not affect people in the home. It's very good now, it has settled". Another member of staff told us "The managers are always there when you need them". They said the atmosphere was "Happier, more relaxed in the home now" and that this was due to "Greater consistency of management".

Health and social care professionals were positive about the changes. One said "We had concerns about the care provided by the staff last year; however at the beginning of 2017, there has been a change of management and a change of house senior which has made a positive impact in the service. The quality of the care provided has improved and the atmosphere in the house feels much more positive. The staff team are more proactive and willing to try new activities/strategies". Another community professional said "Since the new manager started recently, the home has felt better managed and there has been improved communication between them and I. They are also more proactive in reviewing support plans and risk assessments".

Staff team meetings were held on a bi-monthly basis and staff were encouraged to add items to the agenda for discussion. The minutes showed that any actions arising were reviewed at the following meeting. The meetings were also used to share learning and success stories, for example staff morale had improved and people were more settled in the home and enjoying more trips out. Staff told us the learning from errors in the management of medicines had been openly shared "So we learn from it". Staff were aware of the company values, which included a focus on people's safety and wellbeing, and said these were talked about during training.

The provider had introduced a new quality assurance process. There was an annual service improvement plan from June 2017 that included the introduction of a new support planning format, the further personalisation of care and support, and staff recruitment. The implementation of the improvement plan was monitored by service and regional managers and there was a monthly cycle of feedback, checks and audits. The provider also had a Quality Team who carried out monitoring visits of services. The regional

manager told us the Quality Team had visited the service recently and had not identified any additional actions to those on the annual improvement plan.

A customer satisfaction survey was carried out that included questionnaires sent to people who used services and their relatives. We saw that the results of the most recent survey were positive, with all of the people who responded saying they were either happy or very happy with aspects of care including, for example, information, support, choice and involvement. All had stated they felt safe where they lived. The provider also carried out a staff engagement survey.

The provider understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the home and on the provider's website.