Mrs Susan Kay Hardman

Luke's Place

Inspection report

The Old Estates Office
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Tel: 01582458201

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an unannounced inspection at Luke's Place on 08 August 2016.

This service provides accommodation and personal care for up to 4 people with learning disabilities, physical disabilities or mental health conditions. At the time of this inspection there were three people living at the service.

There was a registered manager in place. A registered manager was not required by law at this location because the registered provider was an individual rather than an organisation and previously managed the service themselves. However, to support improvements to the service, the provider recently employed a manager to oversee the running of the service. Registered managers, like registered providers, 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.

At our last inspection on 11 April 2016, the service was in breach of Regulations 9, 11, 16, 17 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The service received an overall quality rating of inadequate, and was placed into Special Measures. An existing condition placed on the provider's registration to restrict admissions remained imposed. We issued warning notices to tell the provider what improvements they needed to make and gave them a timescale to do this. We carried out this inspection to check on the improvements made since the last inspection.

During this inspection we found that significant improvements had been made to the service. As a result, the decision was made that the service would no longer be placed in special measures.

Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home, and these were reviewed regularly. Accidents and incidents were recorded and the causes of these analysed so that preventative action could be taken to reduce the number of occurrences.

There were sufficient numbers of staff on duty and recruitment processes were safe.

Staff had received ongoing training to equip them with the skills to support people. They understood their responsibility to ask people to consent before providing care and demonstrated an understanding of the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards.

People had enough to eat and drink and had access to health care services as appropriate.

Staff had positive interactions with people and treated them with kindness. People's dignity was upheld.

Person centred care plans had been developed and were currently out for consultation with people's

families. Key worker sessions were held to support people to be involved in planning their care. Relatives were not always as involved as they would like in the full process of assessing their family member's needs and planning their care.

There was an effective complaints system in place although some family members did not feel that complaints were always effectively resolved. Information was available to people about how they could make a complaint should they need to.

There were systems in place to support people and their relatives to share their views of the service. However, some families felt that communication between them and the service could be improved.

There were effective systems in place to assess and monitor the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff demonstrated an understanding of processes to safeguard people from harm and concerns were reported to the local authority appropriately.

Staff recruitment practices were safe and there were enough staff on duty

Personalised risk assessments were in place to reduce the risk of harm to people.

Medicines were administered and stored safely.

Is the service effective?

Good

The service was effective.

People had a good choice of nutritious food and drink

Staff and managers were trained and supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People received support to access health care services if they were unwell, and advice from health care professionals was sought as appropriate.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff engaged appropriately with people, demonstrating kindness and compassion.

People were supported with dignity and their privacy was upheld.

People's representatives were not always confident about the

information they received.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Person centred care plans had been developed. Key workers were supporting people to be more involved in planning their care. However, some relatives did not feel they were not fully involved in assessing their family member's needs and planning their care.

People's individual interests and hobbies were identified and activities were being planned with their preferences in mind.

There was an effective complaints process and a record of complaints, actions and outcomes was in place. People and their representatives were aware of how to make a complaint but some relatives did not feel that complaints were always appropriately acted upon.

Is the service well-led?

Good

The service was well led.

Although it was not a legal requirement at this service, the provider had made the decision to employ a manager to support continuous improvements at the service. The manager was registered with the Care Quality Commission.

There were systems in place to support people and their relatives to share their views about the service.

The manager provided clear visible leadership and, although some staff had found the recent changes difficult, they all said that the service was well managed and had made significant improvements.

There were systems in place to monitor the quality of the service and these were operated effectively.

Luke's Place

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 on the improvements made to the service following our inspection in April 2016 and 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 08 August and was unannounced. Two inspectors carried out the inspection.

Before the inspection we reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with two of the people who used the service but due to their complex needs they were not able to tell us in detail about their experience so we used observations to help us understand. We also spoke with the provider, the registered manager, the administrator, the senior support worker and three care staff. We reviewed the care records of all of the people that used the service. We checked medication administration processes, staff training and recruitment records and we reviewed evidence to demonstrate how the provider assessed and monitored the quality of the service provided.

After the inspection visit we spoke with three relatives of people who use the service by telephone and contacted three health and social care professionals who work with the service

Good

Is the service safe?

Our findings

People were not able to tell us whether or not they felt safe. However, they appeared cheerful and at ease in the company of staff which told us they felt safe in their presence.

The provider had up to date policies designed to protect people from abuse which included safeguarding and whistleblowing. Staff demonstrated a good understanding of abuse and their responsibility to protect people from avoidable harm. They were confident that if they reported any concerns it would be dealt with appropriately by the manager. A member of staff said, "I would report everything to [manager's name] and I know she would deal with it." Staff had an understanding of the provider's whistleblowing policy and we saw that information encouraging staff to report concerns was on display in the office and on a board in the hallway.

Personalised risk assessments were in place in relation to people's individual needs, and covered areas such as personal care, mobility, using transport, going out in the community, swimming. These assessments identified the risks and had control measures in place to support staff to care for people safely. We saw that protocols had been developed to guide staff about how to support people to manage behaviour which may impact negatively on themselves or other people. These included information about what triggered the behaviour, how the behaviour escalated and interventions that staff could use to manage the risk safely. Staff had received training in relation to challenging behaviour and we saw that robust monitoring had been introduced which could be used to reflect upon and learn from any such incidents. Since our last inspection no incidents of this nature had taken place.

General risk Assessments in relation to the environment had been completed and we saw evidence that fire alarm testing, fire equipment servicing, gas safety and portable appliance testing (PAT) had taken place. A recent sample of water from the service and from the provider's on site swimming pool had been sent off for testing for legionnaire's disease but a new certificate had not been received at the time of the inspection.

We checked recruitment records for recently appointed staff and found that all the correct checks and processes had been carried out. This included references from previous employers, proof of their identity, confirmation of the right to work in this country and a Disclosure and Barring Service (DBS) report. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. Some newly appointed staff were still waiting for a start date because their DBS check had not been received yet.

Each person's care plan contained a list of their current prescribed medicines, including the dosage, time and preferred method of administration, as well as a risk assessment in relation to the administration of medicines. People's medicines were administered safely and we saw that medicine administration records (MAR) were completed accurately. Regular audits of medicines and the associated systems and processes were carried out by the manager or the provider. Staff who administered medicines had received training to ensure they understood and were competent to do so. We noted that there were no protocols in place regarding the appropriate use of specific 'taken as required' (PRN) medicines. However, the manager was

able to show us the system she had recently been provided with by a pharmacist, which she was planning to put in place with immediate effect.

Good

Is the service effective?

Our findings

At the inspection in April 2016, although some work had commenced to develop the skills and knowledge of staff, we found that insufficient improvements had been made since the previous inspection in November 2015. The provider and staff were not working within the requirements of the Mental Capacity Act 2005 and staff understanding of this legislation was insufficient. Family members had expressed concern about the lack of training offered to staff to meet their family member's specific needs in relation to both the use of a communication aid and with moving and handling.

At this inspection we found that improvements had been made to the training and development of staff. Staff had received appropriate training and there was evidence that this was booked ahead of time and monitored to ensure that staff attended courses and refresher training where necessary. Staff received training in essential areas such as fire safety, safeguarding people from abuse and food hygiene. They also received training which was specific to the needs of the people using the service such as person centred care, epilepsy, and challenging behaviour. Since the last inspection the service had consulted a physiotherapist to advise and give support in relation to one person's moving and handling needs, and to assess whether the service had the necessary equipment. The manager had also arranged for moving and handling training to be provided by trainers recommended by the Hertfordshire Care Providers Association. We saw records that showed this training had been developed to take into account the very specific needs of the people using the service.

We spoke with the manager to identify what action had been taken to develop staff understanding of the specific communication aid. They confirmed that this matter had been raised with the local authority to establish whether or not additional funding would be provided for staff to attend training. The manager was waiting for a response and said she would be following this up with the person's social worker as soon as possible.

Due to the complex needs of the people who used the service, they were not able to tell us about whether or not staff supported them effectively. Although some relatives expressed continuing reservations about the skills of the staff, one social care professional we spoke with said, "Even after a fairly short amount of time, staff appear more confident and are able to hold a conversation with professionals about [person's name] without deferring to the manager. This is an improvement." When we spoke with staff, they demonstrated a stronger understanding of their role as enablers and were clearly more confident about their own skills and knowledge. They confirmed that training opportunities had improved and that they felt more equipped to perform their duties effectively. One member of staff said, "We've done a lot of training now. We go through things at staff meetings too." Staff confirmed that they had received supervision and an annual appraisal. Records confirmed that most supervisions had taken place, although there were some that were overdue. Appraisals were up to date.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had completed capacity assessments and made DoLS applications where it was felt to be appropriate. The manager had created a tracker to monitor the progress of these applications.

We found that all staff had received in-house training in the MCA and DoLS which was comprehensive and tested staff knowledge. Staff we spoke with demonstrated an understanding of this legislation. One member of staff said, "People have capacity to make some decisions like what they want to eat, or what clothes they want to wear and we support them to do this. Sometimes, if they have big decisions, like health ones, they might not understand enough to make the decision so we would make that decision for them with family and professionals based on what is best for them. You would still help them to understand what was happening as much as possible though." The manager said, "We'll be testing staff sporadically to make sure they have retained the knowledge." We saw that people were asked for their consent by staff during the day of our inspection and that staff were looking for non-verbal cues to establish whether or not people consented to care if they were unable to say clearly how they felt.

People's care plans contained sufficient detail in relation to their nutrition and hydration needs including any dietary aids they used, the level of support they required with eating and drinking and any professional input. For example, one person had been referred to a speech and language therapist (SALT) in relation to a risk of choking when eating and drinking. Staff were following the advice given about the support the person required and the type of foods that were safe for them to eat. Although the service did not have weighing scales suitable for people who were not able to stand independently, the manager had made arrangements with an external service to ensure people could be weighed periodically to monitor their weight. People had enough to eat and drink and we saw that food and drink was freely available to them whenever they wanted it. We looked at meal records which confirmed that people had a balanced and appropriate diet and choice over what they ate. At lunchtime we observed the mealtime experience for one person and saw that the food offered was of a good quality and nutritionally balanced. The support offered to the person was appropriate and dignified.

People's individual health conditions were listed in their care plans and there were separate protocols and risk assessments in place in relation to each of them. For example, there was a protocol in place in relation to one person using a continuous positive airway pressure machine (CPAP), which contained detailed information about its use and the risk related to the person not consenting to use it. A CPAP machine is used to treat breathing conditions and uses mildly pressurised air to keep the airways open. We saw from records that people had been assisted to seek medical support if they were unwell and referrals to health care professionals had been made as appropriate. We found that input from healthcare professionals had been sought to ensure people were supported appropriately with their ongoing healthcare needs. We also found records were kept to demonstrate that staff were following the advice given by health care professionals as well as monitoring forms which listed all the appointments each person had attended.

Requires Improvement

Is the service caring?

Our findings

People appeared relaxed and comfortable in the presence of staff. When asked about staff, one person said, "Nice." A relative told us, "[Person's name] is happy at Luke's Place, we see that. Only the other day when we were out together; on the way home I asked [them] 'Where are we going now?' and [they] said 'Home!' and cheered, throwing [their] arms up in the air."

Staff spoke to people in a respectful, but relaxed and friendly manner. We saw good humour and warmth in the way that they engaged with people during our inspection. Interactions were not all task focused and we saw that staff took opportunities to sit and chat with people throughout the day. For example, at lunch time, we saw one member of staff reminding one person of their plans for the afternoon while gently encouraging them to eat. Another member of staff was talking to a person about their time at an event the previous day and reminding them of all the things they'd done.

People's privacy and dignity were upheld. We saw that people were offered personal care discretely, and this assistance was provided behind a closed door to ensure people's privacy was respected. The manager told us that they had recently invested in some new continence aids with a view to supporting a person when they were out of the service. This measure, along with thoughtful planning of activities depending on the person's fluctuating needs in relation to continence, protected the person's dignity when out in the community. She said, "It's important to get this support right to protect (their) dignity. They want to go out and about but need to feel safe that they won't have an accident while their out too."

We found that, although the work to support people to be as independent as possible was still in development, the staff approach when supporting people was more inclusive than we had seen at previous inspections. We saw that their understanding of their role to enable people to maintain and develop their skills had improved. For example, staff told us that they supported people to be involved with basic tasks such as cutting vegetables, assisting them by putting their hand over the person's hand to help them complete the task.

People were supported to maintain relationships with people that were important to them. Friends and relatives were able to visit at any time and people were supported to go to their family home for visits if this was what they wished to do.

At our last inspection in April 2015 we became aware that some relatives and staff had some longstanding opposing views about some aspects of people's care, where both parties felt they were supporting the individual's view. In recognition of this the manager had given people information about local advocacy services. This gave them the option of making decisions about their care with the support of an independent advocate. She had also started the process of working more closely with people's social workers to review people's care.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in April 2016 we found care plans were not detailed enough to give staff clear guidance on how to support people well. Although there was some information about people's individual needs and preferences, the plans were not person centred and did not demonstrate that people or their families had been sufficiently involved in their development. Relatives reported that they had not been adequately involved in planning their family member's care. Little consideration had been given to ensuring that the format used for care plans could support people to understand the contents. Although some work had been done to improve the activities provided, peoples interests were not routinely taken into consideration. A system for recording complaints had been developed but we found that it had not been used effectively.

At this inspection we found that some improvements had been made.

Care plans were much more detailed and person-centred with some information supported by pictures to help people to understand the contents with support from staff. There was an 'about me' section which provided information on the person's background and social history as well as 'need to know' information about the person to support staff to understand each person's preferences for how their care was provided.

Objectives had been created for each person and this included details on the steps that staff could take to support them to achieve each one. For example we saw that one person had a clearly defined outcome to maintain a structured week, and as a result a clear schedule had been developed for them to follow. When we contrasted this with the daily records we saw that this was usually being adhered to.

There were individual protocols in place across different areas of each care plan, including communication, mental health, personal care and relationships. Staff were supported to understand how each person communicated and how they could build a relationship with them. For one person we saw that they used a communication aid which was important to them to be able to express their needs and wishes. The person's care plan made frequent mention of this aid and how it was used in practice, although we noted that training for staff in the use of this aid was still outstanding. We spoke with the manager about this who told us, "[Person] does use it and will say when [they] want it and is never told they can't have it. They also use other means of communicating with staff, such as using pictures and gestures, and [they] will have a good conversation with staff without the [communication aid] sometimes too." The manager acknowledged that training for staff was still outstanding and told us they would be raising this again with the local authority as a priority. In the meantime the manager had encouraged the use of the aid and had familiarised herself with how it worked.

Detailed guidance had been developed for tasks and routines that people followed which helped staff to ensure that they were following the same routines at different times of day. Because of the complexity of people's physical health these were robust to ensure that staff were able to follow each step effectively. People's changing needs were addressed in the plans. For example, we saw evidence that the action taken to involve healthcare professionals in one person's care was reflected in the care plan.

Each plan was subject to six monthly review and at the time of our inspection, families were being asked for their input and involvement. However, relatives we spoke with told us that they would like to be involved throughout the process of developing their family member's care plan. Relatives knew their family members well and, particularly where the person was only able to have very limited input themselves, the knowledge of family members was important to avoid inaccurate information being included in the plans. The family member of two people gave us examples of inaccuracies that could have been avoided if they had been involved from the outset of development rather than waiting until the plans had been written.

The manager was working to improve activities and had recently identified a member of staff who was to take the lead planning this aspect of the service. We saw that more activities had been provided and greater consideration had been given to people's interests. For example, we were told that one person, who is a keen wrestling fan, had been supported to go to a wrestling event with staff. The day before our inspection, people had gone to 'umbrella fest', which was a festival organised by 'electric umbrella', a music group that people attended during term time. We saw photographs of the event which showed people having a great time, joining in with singing and celebrations.

We saw that records from meetings people had with their key workers identified their interests and any activities they would be interested in pursuing in the future. One person had said they would like to go to a Greek restaurant with belly dancers. We were told that, although a restaurant had not been identified yet, staff were working on this to make sure it happened.

An activities tracker had been created to monitor people's engagement with activities, and this showed people were engaged in consistent routines and hobbies. We saw card-making, bingo, bowling, seaside trips, a trip to a local farm and regular day services and classes as well as swimming in the pool run by the provider. The manager had printed details of local activities that were accessible to help plan options for the future. Families told us they would welcome greater forward planning of events and activities to enable people to know in advance what was taking place in their week. This would create more structure for people and would support them to have greater control of their own lives.

Some relatives we spoke with expressed continuing dissatisfaction with how complaints were handled at the service. One relative said they had, "Given up complaining because nothing gets done." All family members we spoke said that communication with the service could be better. However, we saw that the system to record complaints had been used effectively. A log had been developed and we saw that it was used to monitor complaints and how they were progressed and resolved. A computerised system was used to document the details of every complaint that was received and to clearly identify what action was taken to resolve the issue. We saw from staff meeting minutes that complaints were discussed and used to learn from and make changes to the service. A complaints policy was in place and an easy read copy was on a notice board in the service.

Good

Is the service well-led?

Our findings

At our last inspection in April 2016, the new manager had only been in post for five weeks, and although some improvements had been made in this time, many changes were in the early stages of implementation so had not been fully embedded within the service. A quality monitoring system had been developed but was not all operational and care records were disorganised. Relatives did not feel they had the opportunity to share their views or that their views were taken on board to drive improvements to the service. The provider remained in breach of five Regulations which, despite the recent appointment of the manager, demonstrated that the service had not been supported by good leadership since the previous inspection in November 2015.

At this inspection we found that significant improvements had been made and the service was now well led.

Staff we spoke with were positive about the manager and stated that the changes made since their arrival were significant. One member of staff said, "[Manager's name] is really supportive. The changes have been good. [Manager] is supportive to staff and there is more structure now, but not too much so it stops feeling like people's home. [Provider] is happier, less stressed and it's become a lot better." Another member of staff we spoke with told us that, although they had found some aspects of the changes difficult, they recognised improvements had been necessary and the service to people was better as a result. Staff had confidence in the manager and told us they could discuss any concerns or ideas for improvement they had and that their views were listened to and acted on as appropriate. We saw the manager was engaged with the people who used the service and that they appeared comfortable and familiar with her presence.

Although relatives we spoke with continued to have some reservations about the effectiveness of communication with the service, the manager had put systems in place to support people, their families and other professionals involved with people's care to share their views. We saw that visitors to the service had been asked to complete feedback forms and of the three received back, two were very positive and one other was neutral. The manager confirmed that relatives had recently been sent feedback forms but these had not been returned yet. Monthly key worker meetings were documented which clearly supported people's views, wishes and preferences for support they wished to receive and interests they wished to pursue. We noted that a suggestions box had been placed in the entrance hall to provide an opportunity for visitors to make comments as they felt necessary. The manager also told us that relatives visited frequently and were able to speak with staff, the manager or the provider informally when they wished. Some relatives, however, told us that they did not always feel the manager was available when they visited and that communication could be better.

The manager had worked very hard to address the shortfalls in the service and was realistic about their progress so far. They told us that they had needed to concentrate on building the foundations of good care through developing staff skills and systems to support the running of the service. They were clear that improvements needed to be continuous and that, although the pace of change could be frustrating for all concerned at times, it was necessary to stay focussed on making changes in a way that could be sustained. It was clear that the manager had worked hard with staff to identify and meet their training needs and to

improve their understanding of their roles and responsibilities. Staff we spoke with were more knowledgeable about their roles and what was expected of them and were able to tell us of the values of the service. It was evident that the manager promoted a person centred culture and this was reflected in the development of the service.

There was an effective quality assurance system in place. Regular quality audits were completed by the manager and covered a wide range of areas, including audits of health and safety, medicines, and infection control. The manager and provider both completed regular general quality monitoring checks which covered observations of practice on shift, cleanliness of the premises, training records, supervisions and oversight of all care related documentation. We also noted that a recent night time spot check had been carried out to assess the quality of care provided by night staff.