Purple Care Limited

Lyndale

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

This comprehensive inspection took place on 15 and 16 November. The first day was unannounced.

Lyndale is a care home for up to nine adults who require support with their mental health. There were eight people living there when we visited. Bedrooms are situated on the ground and first floors of the building. The first floor is accessed by stairs.

The service had a registered manager, which is a condition of its registration with the Care Quality Commission (CQC). A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The deputy manager was also involved with managing the service and provided information for us during the inspection.

People were treated with dignity and respect. They received individualised care and support from staff who knew them and understood their needs and preferences. They were involved in planning and reviewing their care and support. They received the support they needed to manage their health and to eat well, including managing special dietary needs.

People's consent had been sought for their care. The management team had a working understanding of the Mental Capacity Act 2005 and when authorisation under the Deprivation of Liberty Safeguards would be necessary.

People were protected from the risk of abuse and avoidable harm. Staff understood their responsibilities in relation to safeguarding adults, and information about safeguarding was also available for people and was discussed with them. People's individual risks were assessed and managed in a way that respected people's choices.

People and staff were meaningfully involved and consulted in the running of the service. There were meetings for residents and for staff. The registered manager and deputy worked closely with people and staff and regularly spoke with people informally about what was happening.

The management team had close oversight of how the service was operating. They had commissioned outside audits of its performance and had an action plan to address areas for improvement.

Complaints and concerns were viewed as an opportunity to improve the service. Information about how to make a complaint was displayed in the hallway. However, the complaints policy was dated 2010 and referred people to CQC if they were unhappy with the way their complaint had been addressed. This was incorrect, as CQC has no powers to investigate individual complaints, although it is glad to hear about people's experiences of the services it regulates. We have made a recommendation about updating the

complaints policy.

Key property maintenance and testing, such as gas, electrical, water and fire safety was undertaken by specialist contractors. There was a property refurbishment programme under way. A new kitchen had recently been installed and people told us this was a great improvement. The outside of the building and some communal areas had also been redecorated. There were outstanding maintenance issues with two people's bedrooms that had not yet been refurbished. The management team confirmed these were programmed for refurbishment and were seeking to arrange this that minimised disruption and anxiety for the people concerned.

Medicines were stored and managed safety. The management team had close oversight of medicines and checked that staff who handled medicines were trained and competent to do so. However, they did not clearly record their competency checks. We have made a recommendation about recording competency checks.

There were sufficient staff on duty to provide the support people needed. Recruitment procedures were robust to ensure staff were suitable to work in a care setting. They had the training, skills and support they needed to be able to perform their roles effectively.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from abuse as staff were aware of their responsibilities for safeguarding people.

People were protected from avoidable harm. Risks were assessed and managed in a way that respected people's choices.

Medicines were stored and managed safely.

Is the service effective?

Good

The service was effective.

Staff had the knowledge, skills and support they needed in order to perform their roles.

People's consent was obtained for their care and support. The management team had a good working knowledge of the Mental Capacity Act 2005 and an understanding of when authorisation should be sought under the Deprivation of Liberty Safeguards.

People had the support they needed to manage their health and their diet.

Is the service caring?

Good

The service was caring.

People received care and support from staff who knew and understood them as individuals.

Staff treated people with dignity and compassion.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care, and received the care and support they needed.

People were encouraged and supported to maintain hobbies and interests, and to use facilities in the local community.

Is the service well-led?

Good

The service was well led.

The service had a positive, person-centred, inclusive culture.

Quality assurance arrangements operated to maintain and improve the quality of the service provided.

Legal obligations were understood and met.

Lyndale

Detailed findings

Background to this inspection

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

The inspection took place on 15 and 16 November. The first day was unannounced.

The inspection team comprised of an adult social care inspector for both days and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case mental health services.

Before our inspection we reviewed the information we held about the service. This included the Provider Information Return (PIR). A PIR is a form in which the provider gives some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with five people who used the service and two visiting health and social care professionals. We also talked with three members of staff, the registered manager and the deputy manager. In addition, we made observations around the building and reviewed records. The records reviewed included three people's care records, medicines administration records, two staff files, training records and other records relating to how the service was managed. Following the inspection we obtained feedback from another health and social care professional.

Good

Is the service safe?

Our findings

People were protected against the risks of potential abuse. Staff had the knowledge and confidence to identify safeguarding concerns and knew how to report these. One person had staff look after their money, by agreement, and there were procedures in place to ensure this was kept safe and accounted for properly. Safeguarding adults and how to raise concerns and complaints were discussed at residents' meetings. Information about abuse and how to deal with it was displayed for people and staff to refer to.

People were supported to take risks to promote their independence. Risks were identified and assessed, which protected people and supported them to maintain their freedom. Risk assessment and management plans covered areas relevant to each particular person, such as risks associated with physical and mental health conditions, self-medication, finances, food preparation and using household equipment.

Risks posed by environmental hazards were assessed and managed. Refurbishment had been undertaken indoors and outdoors since our last inspection. One person who lived at the service commented, "It's a hell of a lot nicer than it used to be". They remarked on the new kitchen being a great improvement; the kitchen had recently been installed following an inspection by the local environmental health team. An upstairs bathroom had cracks in the grouting around the tiles, a shower rail that was beginning to rust and a shower curtain with some small stains at the edges. The management team told us that refurbishment was ongoing and that this room was due to be refurbished. Some upstairs windows were not restricted; the registered manager advised us that this was in accordance with people's preferences and they considered this an acceptable risk.

People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. Accidents and incidents were recorded and the records signed off by the registered manager or deputy manager once they had reviewed them for any further actions that were needed to ensure people's safety.

Key maintenance and testing was undertaken by specialist contractors including: gas safety, portable appliance testing, electrical hardwiring, legionella testing and the inspection and servicing of fire equipment. There were also ongoing daily or weekly checks of matters such as security, fridge and freezer temperatures, food temperatures when cooking, kitchen cleaning, water temperatures, fire detection and fire-fighting equipment, and health and safety checks around the building.

There were outstanding maintenance issues with two people's bedrooms, including a non-functioning shower in one of the rooms. These rooms were scheduled for refurbishment, and the management team were seeking to arrange this in a way that respected the people's preferences and minimised any distress due to the upheaval. For one of the people, this entailed ongoing attempts to liaise with their commissioning authority.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. Staff knew what action to take if the fire alarm sounded and

confirmed that they had been trained about what to do in event of a suspected fire.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. Someone who lived at the service told us there was a regular team of staff working at the service. During the day there were generally two staff on duty during the day on weekdays, and one at weekends or during the evening. At night, a member of staff slept in. The service had a lone working policy, and staffing levels were reviewed and adjusted if needed, for example, if someone became mentally unwell and needed additional support at home rather than being admitted to hospital. Staff confirmed they were able to do what was expected them within existing staffing levels. They said the registered manager and deputy manager were frequently present and could also be called upon at other times if needed.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role, including criminal records checks with the Disclosure and Barring Service. Staff files included application forms, full employment history since leaving education, records of interview and appropriate references.

Peoples' medicines were managed and administered safely. Where appropriate, people were able to self-administer their medicines with support from staff. Risks associated with this were kept under review and balanced with the need to promote independence. Medicines were stored securely and were audited monthly to check they were recorded properly and that all stocks were accounted for. The service's pharmacy had last carried out an independent medicines audit in September 2016.

The management team had close oversight of medication and checked periodically that staff were competent in handling medicines. They were able to give us a clear account of how they went about this. However, these checks were not clearly recorded.

We recommend the service reviews how they record staff medicines competency checks and introduces a suitable document.

Good

Is the service effective?

Our findings

People were supported by staff who had the skills, knowledge and understanding needed to carry out their roles. Staff were developed through training, supervision and appraisal. A support worker commented, "I've really enjoyed it, learnt a lot since being here". Another support worker told us, "They have trained me and given me the opportunity to learn… I'm really enjoying it". Staff confirmed they had the training they needed when they started working at the home, and were supported to refresh their training. Training completed by staff at induction and at intervals thereafter included safeguarding adults, handling medicines, food safety and hygiene, first aid awareness, health and safety, infection control and fire safety. Staff also had training in mental health awareness. New staff were expected to obtain the Care Certificate, a nationally-recognised qualification for staff new to health and social care. Following their induction staff were encouraged to work towards diploma qualifications in health and social care.

The management team checked individual staff records to monitor when training was due, rather than maintaining a separate training matrix to provide oversight of training courses and dates for all staff. The staff team was very small and their training was up to date.

Staff said they felt supported by the management team and their colleagues. They had one-to-one supervision meetings with their line manager to discuss their work and their professional development needs. One of the management team told us that supervision meetings happened every three months, and that staff had an annual performance appraisal. Staff confirmed that supervision meetings happened regularly and enabled them to discuss any training needs or concerns they had.

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's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. People were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. The registered manager recognised when people's mental capacity might need to be assessed and a best interests decision made in relation to particular aspects of their care. For example, they had identified concerns that had called into question someone's capacity to consent to assistance with managing their finances. A mental capacity assessment had been carried out in relation to this, with involvement from the person's professionals.

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The management team understood when DoLS applications would be required. However, no-one at the service was being deprived of their liberty and so there had been no need for DoLS applications.

People told us they liked the food, were able to make choices about what they had to eat and that their dietary needs and preferences were respected. For example, someone told us, "I have my own milk, butter and cheese in the fridge…The food is very good… Have a choice of food". People prepared their own breakfast and lunch, and assisted staff on a rota basis to prepare an evening meal for everyone. Alternatives were available for those who did not want the main option, and we saw staff willingly arrange these for people. People's dietary needs and preferences were also clearly recorded in their care plans. Ideas for healthy eating snacks and meals were displayed in the kitchen, along with the menu planner for the main meal.

Health and social care professionals, including mental health professionals such as psychiatrists, community nurses and social workers, were involved with people's care. People told us they had the support they needed to manage their health, including seeing doctors, dentists and opticians. For example, someone told us staff supported them to attend hospital appointment, and that they were able to go to local appointments such as the doctor's by themselves. Staff also supported people to obtain gender and age-related health screening, and screening and reviews in relation to their other health conditions, such as diabetic eye screening and annual reviews for diabetes. Staff had recognised when someone was experiencing a relapse in their mental health condition following a change in their medication, and had liaised with mental health services to ensure the person got the professional support they needed. A visiting health professional confirmed that staff contacted them when necessary.

Good

Is the service caring?

Our findings

People told us the service had a relaxed and friendly feel and that their wishes were respected. Comments included: "It's got a relaxed atmosphere here; although eight people live here it seems a lot less", "Nice atmosphere here… I can do what I want when I want", "Pretty relaxed atmosphere" and "Easy going, can do what you want".

The relationships between staff and people receiving support demonstrated dignity and respect. All of the interactions we observed were professional and respectful. Staff supported people in a humane and unhurried way, as one adult to another. We observed people having natural and easy conversations with staff, with staff listening attentively and responding accordingly.

Staff were aware of people's need for privacy and prioritised this. For example, when staff assisted people with medication they ensured the door was closed. Some people preferred to spend time on their own and staff respected this, whilst continuing to provide any support the person needed.

People received care and support from staff who knew them well. Staff told us how one of the most enjoyable aspects of their work was getting to know people. They were knowledgeable about things people enjoyed and found difficult and how changes in daily routines affected them. This was evident during a shift handover we observed, where staff spoke about people in a way that reflected they knew and cared about what was happening in their lives. People's care records contained information about their individual abilities, interests and preferences, such as 'This is Me' documents that gave detailed information about people's lives and what was important to them. Staff were familiar with people's likes and dislikes that were reflected in their care plans. For example, a staff member explained how one person's care plan stated that staff were not to knock on this person's door as it caused distress to them.

Care records reflected how people's choices were respected. A person had smoked tobacco on and off for many years. They had tried different ways to stop or reduce their smoking, but chose to continue this. Their care plan described their smoking habit and the help they had had with this. It emphasised their right to smoke and reminded staff that they should not denigrate the person's choice.

Staff understood and responded to people's needs in a caring and compassionate way. A person told us, "If I have any problems I can go to [key worker] and he helps me". People readily approached staff with worries and concerns, and these were dealt with in a respectful manner. For example, someone who was worried was put at ease very quickly by a member of staff who encouraged them to go for a walk.

People were given the information and explanations they needed, when they needed them. People each had a key worker, which is a named member of staff who was responsible for ensuring their care and support needs were met. People we spoke with all knew who their key workers were and felt they could approach them. Key workers met people each month to discuss their care and support.

Good

Is the service responsive?

Our findings

People told us they had the support they needed. A visiting mental health professional described the service as being "very aware of the clients' needs".

People were involved in developing their care, support and treatment plans. The people whose care we reviewed had lived at the service for a long time. Their care plans included details of what people wanted to achieve and clearly explained how they would like to receive their care and support. They emphasised that staff should be respectful of people's choices and rights. For example, someone's care plan explained how their smoking habit was associated with changes in their mental health, setting out the measures the person had tried to reduce or stop smoking and the support they needed when they craved cigarettes.

Care records included people's individual indicators that they might be experiencing a relapse in their mental health condition. These described how the person presented when they were well and set out signs the person showed when they were becoming unwell, with the action staff should take when people were well and when they were showing signs of relapse. Staff were familiar with these and supported people accordingly. For example, one person when they were well needed staff to encourage them to go out and to recognise their good days and achievements; we observed that staff did this.

Care plans were kept under review and were updated when people's needs changed. The examples seen were comprehensive, covering areas such as mental health, physical health, communication, medication, personal safety and risk management, social interests and community inclusion, personal care, household tasks and money and financial management.

Staff had a good understanding of the support people needed. Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Staff recognised what people found difficult and took action to address this. For example, a staff member explained that someone had a fear of going down steps and hills, and that as a result of this, handrails had been installed by the steps to the laundry to provide safe access and help to overcome her fear.

People were supported to follow their interests and take part in outside social activities, education and work opportunities. Throughout the inspection people were involved with activities that were meaningful to them. For example, people went out to social groups, to the gym and for walks. A person told us how staff helped them do their craft work, and someone told us they were supported to go out to a café every Friday. A staff member explained how they were working with the person to build their confidence to do this alone. People were also involved in activities around the house, such as preparing food and doing personal laundry. Wireless broadband was available for people to use, should they wish.

Complaints and concerns were viewed as an opportunity to improve the service. Information about how to make a complaint was displayed in the hallway. There had not been a complaint since our last inspection from or on behalf of someone who uses the service. The most recent complaint on file was dated June 2015

and had come from a third party. This had been investigated and resolved.

The complaints policy was dated 2010 and referred people to CQC if they were unhappy with the way their complaint had been addressed. This was incorrect, as CQC has no powers to investigate individual complaints, although it is glad to hear about people's experiences of the services it regulates.

We recommend the service updates its complaints policy and procedure to include reference to the correct agencies that are able to investigate complaints.

Good

Is the service well-led?

Our findings

The service promoted a positive culture, where what people and staff had to say was listened to and acted upon. People and staff had confidence the management team would listen to their concerns, which would be received openly and dealt with appropriately. People told us they felt able to speak with the management team and we observed they did so. Staff told us their managers were supportive.

People and those important to them had opportunities to feed back their views about the home and quality of the service they received. They were routinely involved, through residents' meetings and through more informal conversations, in most aspects of the running of the service, such as deciding on weekly menus and food purchases, taking care of the house, choosing room décor, and meeting potential new residents. They had been involved in deciding how meals would be provided while the kitchen was being refurbished. Quality assurance surveys were also undertaken to obtain views from people, their families and healthcare professionals. At the time of the inspection they were due to be sent out as the most recent one had been undertaken a year before. Survey forms were available in the hallway for people to complete.

The management team valued feedback from staff and acted on their suggestions. This was done through formal and informal staff meetings and individual staff supervision. The registered manager described the staff team as 'close knit' and likened shift handovers to staff meetings, in that information was shared and staff views heard.

Equality and diversity were respected. This was illustrated by the installation of microphones and adaptations to the phone, fire alarm and nurse call system to accommodate people and staff with a hearing impairment. Staff were aware of importance of cultural needs and preferences, and these were reflected in people's care plans.

The management team were aware of the requirement to notify CQC about significant events such as serious injury, although notifications had not been required over the past year. CQC uses such information to monitor the service and ensure they respond appropriately to keep people safe.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. The registered manager and nominated individual had commissioned audits from an external consultant as part of their process for monitoring and improving the service. The registered manager and deputy manager had devised an action plan following the consultant's visits to the service in July and October 2016. The shortfalls found had been or were being addressed, for example, reviewing and updating the safeguarding policy, and the recording of appointments with healthcare professionals.