Mersey Care NHS Foundation Trust

Rufford Road

Inspection report

141 Rufford Road
Southport
Merseyside
PR9 8HT

Tel: 01704383032

Date of inspection visit:
30 January 2017
31 January 2017

Date of publication:
22 March 2017

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 unannounced inspection of Rufford Road took place on 30 and 31 January 2017. The inspection was conducted by an adult social care inspector.

Rufford Road is a four bedroomed bungalow located in a residential area of Crossens, Southport. It provides 24-hour support to four men who have a profound learning disability and complex health care needs. The home is close to local shops and near to local transport links.

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

We were unable to speak to the people living at the home, however we did observe the care and support for one person, and we spoke to the family member of another person, who told us they felt Rufford Road was a safe place for the person to live.

People received their medicines as prescribed and safe practices had been followed in the administration and recording of medicines.

External safety checks by contractors were taking place.

People had been referred to healthcare professionals when needed.

People told us there were enough suitably trained staff to meet their individual care needs. Staff were only appointed after a thorough recruitment process. Staff were available to support people to go on trips or visits within the local and wider community and attend medical appointments. People were also support to pursue hobbies and other personal interests.

The deputy manager and the staff understood the principles of the Mental Capacity Act 2005 and associated legislation and had taken appropriate steps to ensure people exercised choice where possible. Where people did not have capacity, this was documented appropriately and decisions were made in their best interest with the involvement of family members and relevant health care professionals where appropriate. This showed the provider understood and was adhering to the Mental Capacity Act 2005.This is legislation to protect and empower people who may not be able to make their own decisions.

The provider was meeting their requirements as set out in the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the Mental Capacity Act (2005).

We observed staff delivering support with kindness. They knew people well and were aware of their history, preferences and dislikes. People's privacy and dignity were upheld. Staff monitored people's health and welfare needs and acted on issues identified.

Some people were making use of advocacy services at the time of our inspection.

Care plans with regards to people's preferred routines and personal preferences were well documented and plainly written to enable staff to gain a good understanding of the person they were supporting. Care plans contained a high level of person centred information. Person centred means the service was tailored around the needs of the person, and not the organisation.

We discussed complaints with the registered manager. There had been no complaints in the home in the last 12 months.

Quality assurance procedures were robust and identified when actions needed to be implemented to drive improvements. We saw that quality assurance procedures were highly organised and processes had been implemented from another internal source to help support the service to continuously improve. We were shown these procedures by the deputy manager during our inspection.

Feedback had been gathered from people who used the service in the form of questionnaires, and telephone conversations with families.

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.

Risk assessments were accessed and reviewed as part of people's care needs, these were detailed and gave staff clear instruction of how to manage and minimise assessed risks.

Medicines were managed safely and stored appropriately in the home by staff who were trained to do so.

Staff were only offered employment once suitable pre-employment checks had been carried out which included an assessment of their suitability to work with vulnerable people.

Checks were carried at regular intervals by external contractors on the building to ensure it was safe, and internal checks such as the water temperatures and fire alarm tests were being completed by staff.

Is the service effective?

Good

The service was effective.

The service was working in accordance with the MCA and associated principles and were aware of their roles and responsibilities in relation to this.

Staff had the skills and knowledge to support people in the home. This was demonstrated in staff training records and training course certificates.

Staff were well supported and engaged in regular supervision and yearly appraisals. New staff were inducted into their roles in accordance with the providers policies and procedures.

People were supported to access healthcare which they required and which met their needs.

People ate their meals when they chose in accordance with the own plans for the day.

Is the service caring?

Good

The service was caring.

We observed people's dignity and privacy being maintained by staff.

Records we viewed showed that people or their relatives had been involved with the care planning process.

Staff knew the people they were caring for well, including their needs, choices and preferences.

Relatives were able to visit at any time.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and contained information about people's likes, dislikes and preferences.

There was a complaints procedure in place and it was accessible for people who lived at the home. People told us that they knew how to complain.

There were activities available and people could choose what they did with their time.

Is the service well-led?

Good

The service was well-led.

The registered manager was aware of their role and had reported all incidents to the commission as required.

People and staff told us they felt the home was well-run, and they liked the registered manager and the provider.

There was regular auditing taking place of care files, medication and other documentation relating to the running of the service.

There were quality assurance systems in place and people were regularly asked for feedback to help improve the service.

Rufford Road

Detailed findings

Background to this inspection

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

This inspection took place on 30 and 31 January 2017 and was unannounced.

Before our inspection we reviewed the information we held about the home. This included the Provider Information Return (PIR). A PIR 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 were not able to view the PIR for this service due to technical issues on our behalf. We also looked at the statutory notifications and other intelligence which the Care Quality Commission had received about the home.

During the inspection, we spent time with two staff who worked at the service, the service manager, the community learning disability nurse employed by the provider, the deputy manager and one of the area managers. We observed the care and support for one person living at the home, and contacted the relatives of another person to gain their views. The other people living at the home were unable to speak with us.

We looked at the care records for two people using the service, three staff personnel files and records relevant to the quality monitoring of the service.

Good

Is the service safe?

Our findings

We were unable to speak with the people who lived at the home as they were unable to communicate with us, however we did observe the interaction between one person and their staff member, and we also spoke with a relative of someone who lived at the home.

One relative told us, "I feel very safe knowing that [family member] is at the home, they never give me a cause for concern." They also said, "The staff make it feel safe to me, as they know [family member] very well and are aware of their needs."

We reviewed three files relating to staff employed at the service. Staff records demonstrated the deputy manager had robust systems in place to ensure staff recruited were suitable to work with vulnerable people. The deputy manager retained comprehensive records relating to each staff member. Full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person and ensuring each person had two references on file prior to an individual commencing work.

The deputy manager also requested a Disclosure and Barring Service (DBS) check for each member of staff prior to them commencing work. This enabled the registered manager to assess their suitability for working with vulnerable adults.

Staff were able to describe how they would raise concerns about people's wellbeing, and who they would speak to. Staff had received training in the principles of safeguarding but also the practicalities of how to raise an alert with local safeguarding teams. Their responses were in line with procedures set out in the service's safeguarding policies. Staff also explained the organisation's approach to whistleblowing, and told us they would be encouraged to report any bad practice or concerns. We saw information regarding safeguarding for people who used the service and relatives was readily available on the noticeboards in the office and the service user guide.

We looked at how medicines were managed and found appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines. There were three people in receipt of medicines at the time of our inspection. Medication was delivered pre packed which meant people's medicines had been dispensed into a monitored dosage system by the pharmacist and then checked into the home by staff on duty. Arrangements were in place for confirming people's current medicines on admission to the home. Corresponding Medication Administration Records (MAR) charts were provided and all the MAR's were checked and were complete and up to date.

Medicines were stored securely which helped to minimise the risk of mishandling and misuse. Auditing medicines reduced the risk of any errors going unnoticed and therefore enabled staff to take the necessary action to rectify these. Training records showed staff responsible for medicines had been trained and a regular audit of medicine management was being carried out. Where new medicines were prescribed, these were promptly started and arrangements were made with the supplying pharmacist to ensure that sufficient

stocks were maintained to allow continuity of treatment.

Accidents and incidents were accurately recorded and were subject to assessment to identify patterns and triggers. Records were detailed and included reference to actions taken following accidents and incidents.

Risk assessments were regularly reviewed, and contained relevant and comprehensive information to help support people safely. We saw that each risk assessment was reviewed every week by the person's keyworker and the person. We saw that risk assessments covered all aspects of people's care and support needs, and contained relevant links to staff training and protocols when needed. For example one risk assessment made reference to the fact that the person can harm themselves when being supported with personal care, so to minimise the risk staff were to give the person something to hold to stop them doing this. There was a protocol to follow if the person became anxious and continued to self-harm, which was clearly written and regularly reviewed.

We also saw there was another risk assessment in place for someone when the weather was hot, this person would be required to wear total sunblock. There was guidance in the risk assessment of how to apply the sunblock, and the risks if the person was to become sunburnt.

We checked to see if the relevant health and safety checks were regularly completed on the building. We spot checked some of the certificates, such as the gas and electric and found they were in date. The three people who lived at the home had a personal evacuation plan (PEEP) in place that was personalised to suit their needs.

Good

Is the service effective?

Our findings

We asked a relative if they felt the staff had the right skills and attributes to support their family members, they said, "Oh yes, they are all professional and there is good standard of care in the home."

We saw that training was delivered via a mixture of online methods and face to face. Mandatory training was completed in subjects such as safeguarding, health and safety, first aid the Mental Capacity Act 2005 (MCA) and fire safety. Specialist training requirements, such as manual handling and medication were delivered in the home, by a trainer who had the professional qualifications to do so. For some training subjects, such as medication, we saw this was delivered in two parts, with the second part consisting of a competency assessment completed with staff by the trainer. We asked staff about their training and if they felt it met their needs. One member of staff said, "Yes it is good quality, we have done all of the mandatory, and we get told when we are due refreshers."

New starters completed an induction over the first twelve weeks of their role which was aligned with the principles of the Care Certificate. The Care Certificate is a set of standards health and social care workers can adhere to as part of their role. We saw that the registered manager had also completed training sessions with new workers which took them over the running the service.

Staff were given regular formal supervision and appraisal which was recorded on their file every month. New staff were also given regular informal supervision and support by the registered manager and their assigned mentor every week. All staff had had an annual appraisal.

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 DoLS provide a legal framework to protect people who need to be deprived of their liberty in their own best interests.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There was one person subject to a DoLS during our inspection, and there were two conditions imposed on the DoLS authorisation. We checked to see if the service manager was complying with these conditions, and although the staff were doing this as part of the person's daily routine, we saw there was no formal documented review process. We highlighted this to the service manager and they agreed to formalise this approach.

We saw from looking at records relating to people's medical and clinical needs, that this was being well

maintained by the staff. Appointments were scheduled into people's daily activity plans and staff were allocated to support that person to attend the appointments. We saw staff completed documentation when they returned from the appointment with that person to show the outcome and additional information (such as any medication changes) which the staff would need to know.
We saw the home was well decorated with modern fixtures and fittings. People who lived at the home had helped to choose the décor of the home, and had also chosen how they wanted their rooms to be decorated.

People had access to food and drink whenever they wanted it, the kitchen was not locked and there were no restrictions or set mealtimes, people chose when they wanted food and were supported to make healthy lifestyle choices. We saw that people's likes and dislikes were documented and menus were chosen taking this into account. People took turns to complete the weekly food shop. We saw that stew was a favourite of people who lived in the home, and observed there was stew in the slow cooker for the evening meal.

Good

Is the service caring?

Our findings

We were unable to speak to the people who lived at the home as they were unable to communicate with us, however, we spoke with a person's relative who gave us positive feedback regarding the caring nature of the staff at the home. They told us, "The staff are just fantastic, they really care about [family member.]" They also said, "No matter what time you call, they always know what is going on and they keep me well informed." They also described the staff as "Caring, friendly and chirpy."

We spoke to one staff member who described how important is was for them to support people to do as much as possible and how it was important to find out what they liked. The staff member said, "I think providing dignified care and support is about getting to know people, enjoying getting to know them, and doing things that they like. Which is what we try to do here."

We observed one person interacting with their staff member using body language, vocal sounds and facial expressions. The staff member demonstrated a complex knowledge of the person, and we saw them being given kind and personalised support.

We saw photographs around the home of people engaging in various activities, and that there were photographs in people's care plans of their hobbies and how they chose to spend their days.

Care plans evidenced that people had been involved in discussions and changes to their care needs. This was because they were signed by people's family members. One relative told us, "I am always invited when the care plan needs reviewing, it is very thorough." Care plans and any changes to care needs were discussed as part of this meeting.

For people who had no family or friends to represent them contact details for a local advocacy service were available, we saw that one person was receiving advocacy support at the time of our inspection.

We saw people's records and care plans were stored securely in a lockable room, which was occupied throughout our inspection. We did not see any confidential information displayed in any of the communal areas.

We checked to see if people had information made available to them in a way, which they understood. We saw that there was some easy to read information available in the service, and the deputy manager advised us this was a working progress and they were planning on making all information in the home easy read.

Good

Is the service responsive?

Our findings

Care plans demonstrated that the service was providing care which was person centred. This means based around the needs of the person, and not the needs of the organisation. There was highly detailed information available in each person's ELP (essential lifestyle plan). This is a document which records relevant and up to date information about the person and what is important them and their life. This enabled the staff team to provide personalised support. For example we saw that one person liked rock music and would rock when they heard it. There was also an action for staff in this persons care plan to ensure their 'MP3 player was updated every three months.' Another person become extremely anxious when they heard the fire alarm sound, so there was a process in place to test this when they were out. This was included in the person's PEEP.

In addition to each person's ELP, there was also a 'top tips' document which contained personalised, bullet pointed information of how to support that person. For example, one person who experiences body temperature alterations due to medication side effects was supported to wear clothes 'in layers' to enable them to be removed or added if their temperature fluctuated.

We saw communication passports were in place for each person, which contained information about people and what their individual communication needs were. For example, we saw that one person did not like a lot people visiting them at once, and would become anxious, and how they would communicate this to staff using facial expressions and gestures. These passports were added to and used by staff as a working 'tool' when something new was found out about the person.

We looked at complaints and how the complaints procedure was managed in the home. We saw that the complaints procedure was displayed in the hallway of the home and was accessible for people to view. People and relatives we spoke with told us they were aware of the complaints procedure and knew who they would go to if they wanted to complain. The procedure clearly explained what people had a right to expect when they raised a complaint and the timescales as to when they should expect their complaint to be responded to. Relatives told us they knew how to complain, most people said they had never had a cause to complain. There were no complaints made about the home in last 12 months.

We saw that meetings for people living at the home were taking place every month and the next one was planned for the next few weeks. Due to the size of the home, and it being a small service, meetings did not always take place, as most things were discussed as and when they occurred.

Good

Is the service well-led?

Our findings

There was a registered manager in post. They had been in post for a number of years.

The service manager was mainly responsible for the day to running of the home and they supported us through our inspection.

The management structure for the home consisted of the service manager, who was responsible for the day to day running of the home and the support staff. They were being supported by the registered manager and the deputy manager, who was responsible for checking quality assurance processes, notifications to CQC, training and development. There was also a learning disability nurse (RNLD) employed by the provider who provided support to the home with care planning and risk management. The area manager provided oversight to into the running of the home, the registered manager provided detailed compliance plans to the area manager where areas of concern had been identified.

Relatives and staff we spoke with were very complimentary about the service manager. One relative said, "He is happy." A staff member told us "[Service mangers name] is a nice fella, and very supportive."

The service demonstrated good management and leadership. Staff were asked for their views about the service through team meetings and supervisions. We saw evidence of this in the team meeting minutes and the staff member we spoke with explained the supervision process. The staff member told us, "I am regularly supervised and we have team meetings."

The service manager demonstrated an ability to deliver high quality care and regular audits took place to assess the quality of the care delivered, these were completed monthly. In order to demonstrate provider oversight, the service manager was required to send all of their audits to the registered manager who would check them for any anomalies before issuing any further actions. Audits were specifically tailored to the needs of the people using the service. They demonstrated this by showing us outcomes of audits, which had been undertaken and any remedial action the manager had taken following these audits. For example, we saw various actions recorded in audits such as 'update risk assessment in file' this action was then emailed to the service manager for completion along with a timescale. This was then re-checked at the next audit. Records confirmed that audits had been conducted in areas such as health and safety, including accident reporting, manual handling, premises, food safety, medication, and risk assessments and care planning.

We saw that surveys had been sent to people and families to ask for feedback, however we also saw that feedback was gathered weekly by the staff who phoned families and updated them. Weekly meetings were also held with the people who lived at the home. These methods were appropriate for the size of the service. All feedback was documented.

The home had policies and guidance for staff to follow. For example, safeguarding, whistle blowing, compassion, dignity, independence, respect, equality and safety. Staff were aware of these policies and their roles within them.

The registered manager understood their responsibility and had sent all of the statutory notifications that were required to be submitted to us for any incidents or changes that affected the service.