Midway Care Ltd

Glebe House

Inspection report

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Date of inspection visit: 14 April 2015
Date of publication: 22/05/2015

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?	**Requires Improvement**

Overall summary

This inspection took place on the 14 April 2015 and was unannounced.

Glebe House provides care and accommodation for up to six people with a diagnosis of a learning disability or autistic spectrum disorder. The communal areas of the home are on the ground floor, together with two bedrooms. The rest of the bedrooms are on the first floor.

We last inspected the home in July 2014. After that inspection we asked the provider to take action to make improvements in the safety of the premises and their quality assurance systems. At this inspection we found improvements had been made in these areas, but further improvements were still required to the building. The service was due to close for a period of time so an intensive refurbishment programme could be completed.

There was no registered manager at the time of our inspection. 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

Summary of findings

Act 2008 and associated Regulations about how the service is run. The provider was recruiting to the position and in the meantime an interim deputy manager was providing managerial oversight of the home.

Staff had received training in keeping people safe and understood their responsibility to report any observed or suspected abuse. Where risks associated with people's health and wellbeing had been identified, there were plans to manage those risks. Risk assessments ensured people could continue to enjoy activities as safely as possible, access the community and maintain their independence.

There were sufficient numbers of staff to provide the levels of supervision each person required. Staff received a thorough induction to the service and training that supported them to effectively meet the needs of the people who lived in the home. Staff were able to explain how they had implemented the training they had received into their everyday practice.

The provider and staff understood their obligations under the Mental Capacity Act and the Deprivation of Liberty safeguards (DoLS). The provider had made appropriate applications to the local authority in accordance with the DoLS and was following legal requirements.

People were encouraged to be as independent as possible according to their abilities and staff supported people to be involved in everyday tasks around the home. Staff were kind and understood the importance of supporting people to maintain relationships with friends and family.

People were involved in making decisions about what they had to eat and drink and regularly referred to external healthcare professionals to ensure their health and wellbeing was maintained. Medicines were managed so that people received their medication as prescribed.

There had been significant changes in both management and staffing in the six months prior to our visit. It was acknowledged that this had been a challenging time for both staff and the people living in the home. An interim deputy manager had introduced improvements and stability to the service while the provider recruited to fill the managerial vacancies.

The provider had introduced a series of checks and audits to ensure the improvements in the quality of service were sustained.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

There were risk assessments and management plans to ensure people could continue to enjoy activities both inside and outside the home safely. The provider ensured there were sufficient numbers of staff to keep people safe and staff understood their responsibility for reporting any concerns about people's wellbeing. Medicines were managed according to good practice so people received them safely.

Good

Is the service effective?
The service was effective.

Staff received a comprehensive induction and training which supported them to meet people's needs effectively. Staff had received training in the Mental Capacity Act and respected the decisions people were able to make. Where restrictions on people's liberty had been identified, appropriate applications had been made to the supervisory body.

Good

Is the service caring?
The service was caring.

Staff had a good understanding of people's abilities and supported them to be as independent as possible. Staff were positive in their interactions with people and encouraged them to maintain relationships with family and friends. Staff treated people with dignity and respect.

Good

Is the service responsive?
The service was responsive.

Staff understood people's preferences and wishes so they could provide care and support that met their individual needs. People were supported to socialise and follow their interests. People were regularly reminded how they could make a complaint and asked if they had any concerns about the service they received. Complaints received had been dealt with and responded to in accordance with the provider's complaints policy.

Good

Is the service well-led?
The service was mostly well-led.

The service had been though a challenging time with significant managerial and staffing changes and did not have a registered manager at the time of our visit. An interim deputy manager had been appointed who had introduced systems and processes which had impacted positively on the culture of the service.

Requires Improvement

Glebe House

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 14 April 2015 and was unannounced. The inspection was undertaken by two inspectors.

Before our visit we asked the provider to complete a Provider Information Return (PIR). The 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 reviewed the information we held about the service. We looked at information received from relatives, from the local authority commissioners and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with one person who lived at the home and two relatives. We spoke with the area manager, four staff and a healthcare professional who visited the home. We observed how people were supported during the day. We spent time observing care in the lounge and communal areas to help us understand the experience of people who used the service.

We reviewed four people's care plans to see how their support was planned and delivered. We looked at staff files and medication records and reviewed management records of the checks made to assure people received a quality service.

Good

Is the service safe?

Our findings

When we visited Glebe House in July 2014 we found there was a breach in Regulation 15 of the Health and Social Care Act 2008 and associated Regulations because improvements needed to be made to the environment to ensure it was safe for the people who lived there. At this visit we found improvements had been made. For example, at our last visit in one person's bedroom there was a strong unpleasant odour from the carpet. Also, damage to the bedroom and en-suite bathroom meant they could not be cleaned properly and this presented a health risk. At this visit we saw the carpet had been replaced, damage had been repaired and the rooms decorated. Improvements had also been made in the kitchen, including the replacement of the chipped and damaged worktops we saw at our last visit. The provider was aware that further work needed to be carried out and a total refurbishment of the home was scheduled for later in the year to address the outstanding issues.

The provider had conducted risk assessments of the premises and carried out health and safety checks to minimise risks. External contractors undertook regular safety checks of the water, gas and electricity. A member of staff we spoke with told us the premises and equipment were repaired or replaced promptly when they reported problems. They said, "I would say it's definitely safe. The bannister broke the other day and it was fixed almost immediately." Records confirmed that maintenance issues were dealt with quickly to ensure the environment was safe.

Most people who lived at Glebe House had no or limited speech. As they were unable to tell us whether they felt safe living at the home, we spent time observing the interactions between them and the staff supporting them. We saw people were relaxed and responded positively when approached by staff and people approached staff confidently. We asked one relative if they thought their relative was safe and they responded, "There's no problem with Glebe House."

Staff told us they had received training in safeguarding people and had a good understanding of the provider's safeguarding policy and procedures. All the staff we spoke with told us they would not hesitate to report any suspected or observed abuse to senior staff or the manager. Staff had access to the information they needed to help them report any safeguarding concerns. The local authority safeguarding contact numbers were displayed in staff areas should they be required, together with the provider's dedicated whistleblowing line. One staff member told us, "You would report it to a senior or the manager or you can whistleblow at head office. They would have to report it to safeguarding." Any concerns had been referred to the local authority as required.

People who lived at the home needed support to manage their finances. The home was able to hold small amounts of personal money for people. There were robust arrangements in place to keep people's money safe and protect them against financial abuse.

There were risk assessments to identify any potential risks to people and detailed plans which informed staff how those risks should be managed to keep people, staff and others safe. Where risks had been identified when people were out, management plans enabled people to continue to enjoy activities as safely as possible. For example, some people required the support of two staff to keep them safe when outside the home. Risk assessments around the completion of domestic tasks in the home ensured that people were encouraged to maintain as much independence as they wanted. Staff we spoke with were knowledgeable about each person's risks and the support they needed to manage those risks.

We asked about the use of physical intervention techniques as a means of reducing risk of harm to people whose behaviour may present challenges. We were told that although all staff received training in non-violent crisis intervention, the provider's own behaviour specialist supported staff with behavioural strategies to minimise episodes of behaviour that could be challenging. This meant staff did not have to use physical intervention because they understood how to avoid events that could trigger anxiety and agitation.

During our visit we saw there were enough staff to meet people's care and welfare needs and provide the supervision and support people needed to keep them safe at home and in the community. One staff member told us, "Staffing levels are very good now. Before there was a lot of agency staff." When asked about staffing levels another member of staff said, "It's got better."

Records showed that staff were recruited safely, which minimised risks to people's safety and welfare. The

Good

Is the service safe?

provider carried out police checks and obtained appropriate references to ensure staff were safe to work with people who lived in the home. Staff we spoke with confirmed they were not allowed to start work until all the checks had been completed. Disciplinary policy was followed where it had been identified that staff were responsible for unsafe practice.

Medicines were stored safely and securely and there were checks in place to ensure they were kept in accordance with manufacturer's instructions and remained effective. Each person had their own medicine administration folder with a photograph on the front of their records to reduce the chances of medicines being given to the wrong person. Administration records showed people received their medicines as prescribed. Appropriate arrangements meant that people's health and welfare was protected against the risks associated with the handling of medicines. A relative told us their family member, "Gets their tablets when they should."

Some people required medicines to be administered on an "as required" basis. There were protocols for the administration of these medicines to make sure they were given safely and consistently.

Staff completed training before they were able to administer medicines and had regular checks to ensure they remained competent to do so. This ensured staff continued to manage medicines to the required standards.

The provider had taken measures to minimise the impact of unexpected events. Fire safety equipment was regularly tested and a practice fire drill had recently been undertaken. Each person had their own fire evacuation plan so staff and the emergency services would know what support people needed in the event of an emergency.

Good

Is the service effective?

Our findings

We asked a relative whether staff supported their family member in the way they needed. They responded, "I'm quite happy with the care."

New staff followed an induction programme and were subject to a six month probationary period. The induction included a week at the head office where new staff received the provider's mandatory training. There was then an induction to the home and a period when new staff shadowed experienced members of staff to become familiar with the care and support needs of people who lived there.

Staff received training in a range of subjects to meet the specific needs of people who lived in the home. This included training in managing challenging behaviour, epilepsy and autism. Staff we spoke with told us they felt training provided them with the skills and knowledge to meet people's needs effectively. One staff member told us, "I asked for epilepsy training. I requested that in my supervision and I did it next time it came round. We had autism training and I went on it but I didn't feel I benefited from it so they put me on it again and I benefited a lot more. You can reflect on your residents and it made sense more." They explained how they had put the training into their everyday practice in the home, saying, "I stopped wearing perfumes and I don't wear red because it can trigger behaviours." They also explained how the training had given them an understanding of the reasons for some of the behaviours people displayed so they were able to manage them more effectively.

Staff told us they received regular supervision to discuss their role and the provider encouraged them in their own personal development by supporting them to gain qualifications in health and social care. Several staff we spoke with were completing relevant care courses and one staff member was about to start a qualification in care management.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure, where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. Care staff we spoke with had received training and understood the requirements of the MCA and where people were able to make their own decisions, staff respected the decisions they made.

The interim manager understood their responsibility to comply with the requirements of the Mental Capacity Act if a person was not able to make a decision. For complex decisions, that involved a lot of information to consider, the interim manager had obtained the services of an advocate or arranged best interest meetings. An advocate is an independent person, who is appointed to support a person to make and communicate their decisions. For example, advocates were supporting people to understand the risks and benefits before they made a decision about where they wanted to move to while the home was being refurbished. Where people did not have capacity to make a decision, healthcare professionals and those closest to them were consulted to ensure any decisions made were in the person's best interests.

The MCA and DoLS require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. Applications had been submitted where potential restrictions on people's liberty had been identified. Where DoLS were in place, applications for their continuation had been submitted in good time to ensure the requirements of the legislation continued to be met.

We looked to see whether people received a balanced diet. People were supported to make their own decisions about their meals. People with limited communication were shown pictures to help them make their choices. Meal times were flexible with one person choosing to have a late breakfast on the day of our visit.

Where people had specific dietary needs, there were plans to meet those needs. For example, one person was diabetic and there was information for staff about how to support the person to manage their condition. A colour coded chart was displayed in the kitchen to help plan the person's meals. Another person was trying to lose some weight and a special diet plate was used so the person had an understanding about portion sizes. Where a need was identified, people had their weight monitored and food and fluid charts were in place. This ensured people had enough food and fluids to maintain their wellbeing and keep them healthy.

Good

Is the service effective?

Support workers were knowledgeable about people's individual needs, which minimised risks to people's health. Staff recorded people's appointments with health professionals, such as psychiatrists, psychologists and doctors, together with the advice provided. Each person had a 'grab sheet' to be given to medical staff in an emergency which contained important information about them. One person told us, "I had an operation, if I walk far it hurts, so sometimes they help me see the doctor." A healthcare professional spoke positively about the support one person had received to maintain their physical and mental health and said, "They have managed to ensure [person] has not gone back into hospital."

Good

Is the service caring?

Our findings

During the day we observed that staff were kind and spoke positively to people. Staff had developed friendly relationships with the people they supported. One member of staff said, "Staff are caring, people's needs are looked after." Another staff member said, "Everyone who works here pulls together because we love our job and care about the people we are supporting." A relative told us, "Staff are nice and caring."

Due to the needs of one person who lived in the home, staff had to maintain constant supervision at all times. This was done in a low-key and unobtrusive manner that enabled the person to move around the home as they wished.

Care plans provided staff with information about how people communicated non-verbally. Staff we spoke with demonstrated a good understanding of people's non-verbal communication. For example, a member of staff described how they knew when one person was anxious by their actions.

Staff used non-verbal communication to support people in making choices about their everyday care and support. One person used a picture key-ring to make their choices. Another person used Makaton which is form of sign language. Another had their daily routine on their bedroom wall so they could make a decision about whether they wanted to complete the activity or not.

Where people needed support to make major decisions, they had been referred to independent advocates to support them through the decision making process.

People were encouraged by staff to be as independent as possible according to their abilities. For example, where possible, people were supported by staff to take responsibility for small amounts of money. One person bought their own mobile phone 'top ups'. Their keyworker had looked into a direct debit as this was more cost effective, but they were discussing with the person whether to pursue this as it would take away the person's independence of 'topping' it up themselves.

Staff understood the importance of treating people with dignity and respect. Staff offered people support with everyday tasks according to their abilities and ensured people were given the opportunity to complete everyday tasks independently. One person made their own breakfast and hot drinks during our visit. People's personal rooms were decorated to reflect their tastes and interests and contained their personal belongings. Some people chose to lock their bedroom doors and kept the keys themselves and this choice was respected. Staff were observed to knock on people's doors before entering.

Staff supported people to maintain relationships with their friends and relatives. One person was supported by staff to go on regular home visits. Another person was supported to attend a family function which had been appreciated by their relatives. One relative told us they could visit when they liked and their family member phoned them regularly, saying, "There is no limit on when they can call us."

Good

Is the service responsive?

Our findings

During our visit we observed that the care and support provided by staff was responsive to people's individual needs. One person told us, "It's okay here, I like it here." They went on to tell us, "I go swimming, I like this." A relative said, "They take [person] out and about to different places."

Each person had a care plan which detailed the care and support they required and how they would prefer to receive that care and support. Care plans contained information about people's personal preferences and focussed on individual needs. The PIR submitted by the provider stated, "Each person who lives at the service has had their support plan recently updated on to a more person centred support plan. It incorporates real goals that the person wants to achieve and is clear for those supporting them what is expected. It focuses on the choices of the individual and the support to be provided in the most empowering way. These are reviewed regularly to ensure that the person is at the centre of the care they receive."

People were assigned a keyworker who acted as a focal point in developing their care plans and social opportunities. When allocating keyworkers, people's needs and who they responded to was taken into consideration. One staff member explained, "He [interim deputy manager] has changed the keyworkers around. He looked at who responds well to what staff." People had monthly meetings with their keyworker to look at whether any changes were required in how their care and support was delivered.

We saw that people were offered the opportunity to engage in a variety of activities and interests. One person was supported to attend a work placement. Another person had been enrolled on a pottery course at a local education centre. We were told about a disco three people had attended a couple of days before our visit which they had really enjoyed. People were also encouraged to be involved in the running of the home. On the day of our visit some people visited a garden centre to choose plants for the garden. People were helping to redecorate the activities room in the home where they could enjoy painting and crafts. However, we were told of one person who recently chose not to engage in their favourite activity of swimming. On the day of our visit they did not want to attend another planned activity. We found there could be more creativity and encouragement to ensure people maintained their enthusiasm to pursue their interests.

Information about how to raise a complaint was displayed in the hall. This was in an easy read format which made it accessible to the people who lived in the home. People were reminded how to raise any complaints at the monthly residents' meetings and asked if they had any concerns. We looked at the record of complaints. There had been three complaints in the last twelve months. Two of the complaints were external and a meeting had been arranged with the complainants to discuss the issues that had been raised. All the complaints had been investigated and responded to in line with the provider's policy and procedure.

Requires Improvement

Is the service well-led?

Our findings

There had been significant management and staffing changes over the six months prior to our visit. The registered manager had been absent for a long time and then resigned their position. The deputy manager had also left the home during this time. There were a significant number of staff vacancies, staff morale had been low and there had been a negative staff culture due to a lack of defined leadership within the home. The provider had taken action and placed a senior member of staff from another home within the group as interim deputy manager to provide managerial oversight.

All the staff spoke positively about the impact the interim deputy manager had made since taking up their post in November 2014 and spoke of improvements in the culture of the service. Comments included: "[Interim deputy manager] has been absolutely brilliant." "You can go to him with a problem and he will just sort it out." "It is a lot more relaxed and we are working more as a team again." The area manager explained, "[Interim deputy manager] has been a breath of fresh air. The staff just lost a bit of passion but he has brought that back."

When we last visited the home in July 2014 we found there was a breach in Regulation 10 of the Health and Social Care Act 2008 and associated Regulations because improvements needed to be made in assessing and monitoring the quality of service people received. At this visit we saw the provider and interim deputy manager had taken action to address some of the concerns we identified. Policies and procedures had been reviewed and amended to ensure they reflected the most up to date information on good practice. Staff had signed to confirm they had read and understood these documents which meant they were working in a consistent way.

A training and supervision matrix had been implemented to ensure training and supervision was delivered in a timely way. One staff member told us, "Supervisions get done a lot more now. He tries to do them every month." We saw that a system of staff observation of practice had been implemented as a form of "performance monitoring". The area manager explained an important part of the process was to "make sure everybody has clear job roles and responsibilities".

Five new staff members had been recruited to ensure a stable staff team and provide continuity of care to the people who lived in the home.

At our last visit we found there was a lack of checks and audits to identify issues with the environment. There were no cleaning schedules in place to ensure the environment was kept clean. At this visit we saw that a series of checks and audits had been implemented and a cleaning schedule meant staff knew what their domestic responsibilities were on each shift. There were a series of opening and closing checks each day to ensure tasks had been completed.

However, it was acknowledged that this was a service in transition. Although a new deputy manager had been appointed and was due to start the week after our visit, the provider was still recruiting to the registered manager position. The interim deputy manager was due to take up another managerial position within the provider group. Staff, relatives and the external healthcare professional we spoke with expressed concerns about the managerial changes and whether the improvements could be sustained. There was also concern about the planned closure of the home for refurbishment and the impact this would have on both staff and the people who lived there. The area manager explained, "I would say [interim deputy manager] has identified everything, it is just about ensuring that it is now carried forward."

Records showed there were regular staff meetings at which staff could discuss issues in depth. There were detailed discussions around individuals and at service level to improve the outcomes for everyone living and working in the home.

People, relatives, staff and external health professionals were requested to complete feedback forms about the service. Questionnaires were available in an easy read format so they were accessible to all. We saw the result of the questionnaires had been analysed and actions put in place to address any issues identified. We saw one issue was that the sofa in the lounge was too low. The interim deputy manager was taking action to raise the height of the sofa. Most of the comments about the service were positive, although one person felt the building and decoration required improving.

At the time of our visit, the interim deputy manager was on annual leave. Some of the documents we requested to look

Requires Improvement

Is the service well-led?

at were unavailable because they were locked in filing cabinets and the interim deputy manager was the only person who had the key. This included staff records and records of accidents and incidents. This meant there was no accessible information about who should be contacted if there was an emergency involving a member of staff.

The area manager carried out regular audits of the service. We saw that where issues were identified, there were clear actions with a target date for completion. Checks on completed actions were carried out to ensure the quality of service was maintained.