Dolphin Homes Limited

Myrtle Cottage

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 inspection took place on the 28 July 2018 and was unannounced

Myrtle Cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. It is registered for up to six people with learning disabilities or autistic spectrum disorder. At the time of our inspection there were four people living in the home.

The home was a two storey detached property which had an open plan lounge and dining area, a sensory room, a kitchen, one bedroom and a shared bathroom on the ground floor. On the first floor there were five further spacious bedrooms.

The care service had been developed and designed in line with the values that underpinned the Registering the Right Support and other best practice guidance. These values included choice, promotion of independence and inclusion. People with learning disabilities and autism using the service could live as ordinary a life as any citizen.

The service had not had a registered manager in post since August 2017. 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. A new manager had started at the home and had undertaken a telephone interview with our registration team five days prior to our visit.

People were not able to tell us about their experiences of life at the home so we therefore used our observations of care and our discussions with staff and other stakeholders to help form our judgements.

People were protected from avoidable harm as staff understood how to recognise signs of abuse and the actions needed if abuse was suspected. There were enough staff to provide the assessed care hours to people and recruitment checks had ensured staff were suitable to work with vulnerable adults. When people were at risk of seizures or behaviours which may challenge the service staff understood the actions needed to minimise avoidable harm. The service was responsive when things went wrong and reviewed practices in a timely manner. Medicines were administered and managed safely by trained staff.

People had been involved in assessments of their care needs where possible and had their choices and wishes respected including access to healthcare when required. Their care was provided by staff who had received an induction and on-going training that enabled them to carry out their role effectively. People had their eating and drinking needs and preferences understood and met. Opportunities to work in partnership

with other organisations took place to ensure positive outcomes for people using the service. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Families and professionals described the staff as caring, kind and friendly and the atmosphere of the home as relaxed and engaging. People were supported to express their views about their care using their preferred method of communication and were actively supported to have control of their day to day lives. People had their dignity, privacy and independence respected.

People had their care needs met by staff who were knowledgeable about how they were able to communicate their needs, their life histories and the people important to them. Equality Diversity and Human Rights (EDHR) were promoted and understood by staff. A complaints process was in place and people felt they would be listened to and actions taken if they raised concerns. People were not supported with end of life care.

The service had an open and positive culture that encouraged involvement of people, their families, staff and other professional organisations.. Leadership was visible and promoted good teamwork. Staff spoke positively about the new management changes and had a clear understanding of their roles and responsibilities. Audits and quality assurance processes were effective in driving service improvements. The service understood their legal responsibilities for reporting and sharing information with other services.

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. There were sufficient staff available to meet people's assessed care and support needs.

People were supported by staff who had completed safeguarding adults training and were able to tell us how they would recognise and report abuse.

People were protected from harm because risk assessments and emergency plans were in place and up to date.

People were at a reduced risk of harm because medicines were managed safely, securely stored, correctly recorded and only administered by staff that were trained to give medicines.

People were protected by the prevention and management of infection control. Policies, equipment and schedules were in place.

Lessons were learnt and improvements made when things went wrong.

Is the service effective?

Good

The service was effective. People's needs and choices were assessed prior to admission which form the basis of care and support plans.

People's choices were respected and staff understood the requirements of the Mental Capacity Act 2005.

Staff received training, supervision and appraisals to give them the skills and support required to carry out their roles and meet people's assessed needs.

Staff supported people to maintain healthy balanced diets. Dietary needs were assessed where appropriate.

People were supported to access health care services and local

learning disability teams.

Is the service caring?

Good

The service was caring. People were supported by staff that spent time with and treated them with kindness and compassion.

People were supported by staff that used person centred approaches to deliver the care and support they provide.

Staff had a good understanding of the people they cared for and supported them in decisions about how they liked to live their lives.

People were supported by staff that respected and promoted their independence, privacy and dignity.

Is the service responsive?

Good

The service was responsive. Care file's, guidelines and risk assessments were up to date and regularly reviewed.

People were supported by staff that recognised, responded to and understood their changing needs.

People were supported to access the community and take part in activities which were linked with their own interests and hobbies.

Information was provided to people in a variety of formats in line with the Accessible Information Standard.

A complaints procedure was in place which included an accessible easy read version. People and relatives were aware of the complaints procedure and felt able to raise concerns with staff.

Is the service well-led?

Good

The service was well led.

The management promoted and encouraged an open working environment.

The management were flexible and delivered support hours as

and when necessary.

Regular quality audits and service checks were carried out to make sure the service was safe and delivered high quality care and support to people.

The management team were aware of their responsibilities under the Health and Social Care Act 2008, Duty of Candour and demonstrated an open, honest approach.

Staff and relatives felt involved in developing the service.

The service worked in partnership with other agencies in ways which benefitted people using the service.

Myrtle Cottage

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 site visit took place on 28 July 2018 and was unannounced. The inspection was carried out by a single inspector.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We contacted the local authority quality assurance team and safeguarding team to obtain their views about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We received feedback from two relatives via the telephone. We also had telephone conversations with two health and social care professionals.

We spoke with the area manager and met with three care staff. We reviewed three people's care files, three Medicine Administration Records (MAR), policies, risk assessments, health and safety records, incident reports, consent to care and treatment and quality audits. We looked at two staff files, the recruitment process, complaints, and training and supervision records.

We walked around the building and observed care practice and interactions between care staff and people.

Good

Is the service safe?

Our findings

Relatives, professionals and staff told us that Myrtle Cottage was a safe place to live. A relative told us, "Our loved one is safe at Myrtle Cottage. Staff are friendly, the home is clean and nothing is left out". Another relative said, "I think [name] is safe. There is a locked gate. They are supported 1:1 in the home and 2:1 in the community. Staff are also aware of his needs". A professional said, "From what I know I feel the home is safe for those who live there". Staff described the service as safe and told us that safe systems in place included; clear guidelines, risk assessments, policies, audits, checks and support.

The home had safe systems and processes which meant people received their medicines in line with the providers medicine policy. The service had safe arrangements for the ordering, storage and disposal of medicines. The staff that were responsible for the administration of medicines, were all trained and had had their competency assessed.

A staff member took us through the medicine process for administering people's medicines. We observed people's medicine blister packs were cross checked with people's Medicine Administration Record (MAR) sheets to ensure the correct medicine was administered to the correct person at the right time. Medicine Administration Records (MAR) were completed and up to date. Medicines that required stricter controls by law were stored and recorded correctly in a separate cupboard. We observed one person being supported to have their medicine. The staff supported the person to sit down and explained that it was time for their medicine. The staff handed them their medicine and water. The person appeared happy. The MAR was then signed.

There were enough staff to meet people's care and support needs. A number of vacant shifts were filled with agency and bank staff. The area manager told us that the service was actively recruiting staff. We noted that the rota reflected the people's funded hours and that people's activities were not affected. The area manager told us they regularly reviewed staffing and both increased and decreased staffing levels in response to changes in need and/or behaviour. The area manager said, "We have recently reduced staffing levels for one person now they have been here for three months. We are trying to be person centred with our rota and ensure that the number of staff working are assigned at times people want to access the community or receive one to one support at home". The area manager told us that they will discuss staffing levels and the new person centred approach to rotas in the upcoming staff meeting. They also added that they will give staff the opportunity to raise any concerns they may have raised at the inspection. A relative told us, "The are enough staff for [name]. They manage to get out into the community". Another relative mentioned that although it was hard to determine if there were always enough staff they confirmed that they felt there were always enough staff when they visited.

The service had a robust recruitment procedure. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. All staff files contained appropriate checks, such as references and a Disclosure and Barring Service (DBS) check. The DBS checks people's criminal record history and their suitability to work with vulnerable people.

Staff were clear on their responsibilities with regards to infection control and keeping people safe. All areas of the home were kept clean to minimise the risks of the spread of infection. There were hand washing facilities throughout the building and staff had access to Personal Protective Equipment (PPE) such as disposable aprons and gloves. Throughout the inspection we observed staff wearing these. Staff were able to discuss their responsibilities in relation to infection control and hygiene. A relative told us, "There have never been any issues with cleanliness".

Staff were able to tell us signs of abuse and who they would report concerns to both internal and external to the home. There were effective arrangements in place for reviewing and investigating safeguarding incidents. There was a file in place which recorded all alerts, investigations and logged outcomes and learning. We found that there were no safeguarding alerts open at the time of the inspection. A professional told us, "I have no safeguarding concerns". Relatives and staff said they had no safeguarding concerns and would feel confident to use the whistleblowing policy should they need to. A relative told us, "I have no safeguarding concerns at all. I think [name] would show in their behaviour if anything made them feel uncomfortable. [Name] seems settled and is always happy to go back after he has been at home with us".

Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary. Staff told us if they had concerns the manager would listen and take suitable action. Accident and incident records were all recorded, analysed by the manager and actions taken as necessary. These had included seeking medical assistance and specialist advice. Lessons were learned, shared amongst the staff team and measures put in place to reduce the likelihood of reoccurrence. A professional said, "Incident reports are fully completed and well written".

People were supported by staff who understood the risks they faced and valued their right to live full lives. This approach helped ensure equality was considered and people were protected from discrimination. Staff described confidently individual risks and the measures that were in place to mitigate them. Risk assessments were in place for each person. For example, where people had been assessed as being epileptic assessments showed measures taken to discreetly monitor the person. The management of risks also included seeking specialist support when appropriate. Some people were at risk of choking and assessments had been completed by a Speech and Language Therapist (SALT). Safe swallowing plans were in place and implemented by the care staff. A staff member said, "Risks are known by us all. We always try to reduce and prevent risks to people. Risks are always assessed and these are available to all".

Some people presented behaviour which challenged staff and the service. We found that positive behaviour support plans were in place, up to date and in line with best practice. These plans gave staff clear guidelines on approaches to use if people displayed behaviours which may challenge the service. Behaviour charts were completed by staff; these detailed what happened before an event, during an event and what preventative actions were taken. These were then monitored and analysed by the management and internal behaviour trainer. Myrtle Cottage had good working relations with the local learning disability teams and came together with them, the person and family in response to new trends occurring and/or a set review. The support people had received by staff had had a positive impact on their lives and had meant that they could access the community more with support from staff who had a clear understanding of active and proactive strategies to support them safely. A professional told us, "The service manages behaviour well and supports people proactively".

All electrical equipment had been tested to ensure its effective operation. A fire risk assessment had been completed and was up to date. People had Personal Emergency Evacuation Plans (PEEPs) in place. These plans told staff how to support people in the event of a fire.

Good

Is the service effective?

Our findings

At our last inspection in July 2017 we found that staff had not always had support from the manager. At this inspection we found improvement had been made.

People's needs and choices were assessed and care, treatment and support was provided to achieve effective outcomes. Care records held completed pre admission assessments which formed the foundation of basic information sheets and care plans details. There were actions under each outcome of care which detailed how staff should support people to achieve their agreed goals and outcomes. As people's health and care needs changed, ways of supporting them were reviewed. Changes were recorded in people's care files which each staff member had access to.

Staff told us that they felt supported by the manager and received appropriate training and supervisions to enable them to fulfil their roles. A staff member told us, "We have enough training to our job including; NVQ 3 Health and Social Care and the Care Certificate. We also get a pay incentive to complete all of our training". Training records confirmed that staff had received training in topics such as health and safety, moving and assisting, infection control and prevention and first aid. Staff were offered training specific to the people they supported for example; challenging behaviour, epilepsy and autism awareness. In addition to general training some staff also had achieved or were working towards their level three diplomas in health and social care. A health and social care professional said, "Staff seem skilled and come across professional".

Staff told us they received regular supervision sessions and annual appraisals. This helped to monitor the skills and competencies of staff and to identify any training needs staff might have. A staff member said, "I receive regular 1:1's. I find them useful, a time to reflect and get things off my chest".

There was a clear induction programme for new staff to follow which included shadow shifts and practical competency checks in line with the care certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. The area manager told us, "New staff do two shadow shifts and have a two week induction which includes training and medicine competency. They get 12 weeks to complete the care certificate and we also offer diplomas in health and social care from levels two for care staff to five for managers and seniors".

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 at Myrtle Cottage were living with a learning disability, autism or had needs relating to their mental health, which affected their ability to make some decisions about their care and support. Staff showed a good understanding of the Mental Capacity Act 2005 (MCA) and their role in supporting people's rights to

make their own decisions. We observed staff putting their training into practice by offering people choices and respecting their decisions. Staff told us how they supported people to make decisions about their care and support.

Capacity assessments and best interest paperwork was in place which covered a number of areas of care. For example, behaviour, delivery of personal care, medicines and access to the community. Three of the four people had paperwork in place which was up to date. One person was receiving care inline with the MCA however paperwork had not been completed at the time of our inspection. The area manager told us that this would be completed with the home manager as a priority. Following our inspection we were shown that this had been completed.

People can only be deprived of their liberty to receive care and treatment when it is in their best interests and legally authorised under the MCA. 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. Applications for Deprivation of Liberty Safeguards (DoLS) had been made for each person. The area manager told us that one person was pending the outcome.

People were supported with shopping, cooking and preparation of meals in their home. We observed people being given choice of what they wanted for their breakfast. Staff got options out of cupboards and let people point to their preferred choice. For example, bread or crumpets, cereal or toast. The staff communicated with the person effectively using speech, signs and gesture. People understood these methods of communication which enabled them to make decisions. Weekly menu's were in a visual format to support people to understand options and make decisions.

We observed people eating at different times and found that there was a relaxed atmosphere. Food looked appetising, was plentiful and mealtimes were a pleasurable experience. People requiring assistance were helped in a manner which respected dignity and demonstrated knowledge of individual dietary and food consistency needs. People were able to choose where they wished to eat. We observed one person eating in the lounge dining area and two others eating in the kitchen.

People had access to health care services as and when needed. Health professional visits were recorded in people's care files which detailed the reason for the visit and outcome. The area manager told us that they were working with the local Intensive Support Team (IST) to assess a person. Recent health visits included; a community learning disability nurse and a GP.

The service worked effectively with people, professionals, families and local authorities during transition between services. The organisation employed a referral and assessment manager who coordinated people's transitions into and out of the service. At the time of our inspection a person was under assessment to move into the home. A professional told us, "The referral and admission manager has been out to the family home to meet the person and their family". We were told that the new person had been invited to the home last week and was expecting their new keyworker to be on shift however, they were unavailable and the home manager had stepped in to support them. The professional told us that this wasn't quite to plan but they were hoping the transition would still go ahead. A relative said, "The service worked really well with the other placement. Communication was good and information was shared".

The home was split across two levels and had been adapted to ensure people could access different areas of the home safely and as independently as possible. There was a sensory room on the ground floor with lights and bubble stimulation. There was an open plan lounge dining area and large enclosed garden with a trampoline and hot tub which staff told us people enjoyed.

Good

Is the service caring?

Our findings

People each had their own preferred methods of communication and this was understood, respected and used by staff. Methods of communication included, sign language, speech, written text, photos and picture exchange communication system (PECS). The area manager told us that the service was in the process of reviewing people's communication needs and creating communication passports with them and their families. We observed staff using these communication preferences throughout the inspection with people to aid and enable them to be as independent as possible and make choices and decisions for themselves.

Professionals and their relatives told us staff were kind and caring. A relative said, "Staff are kind and caring and understand our loved ones needs". Another relative mentioned, "Staff are lovely and care for [name]. they [staff] give him choice and options". A professional told us, "The staff are nice, kind and welcoming. They know the people well". Staff were able to tell us how they supported people to be independent. One staff member said, "We promote independence and support people to live positive lives". Another staff member told us, "I promote independence like when we do cleaning, a enable the person to spray the cleaner and wipe. I also encourage people to do their own tasks such as laundry. In the community I support people to take items to the checkout or point to choices on a menu".

There was a calm and welcoming atmosphere in the home with moments of laughter. We observed staff interacting with people in a caring and compassionate manner. For example, a staff member asked a person what they wanted to do. The person chose to sit at the table and the staff member sat with them. A social care professional told us, "Staff are very forthcoming with information. There is always a positive atmosphere at the home".

People were treated with respect. We observed staff knocking on people's doors before entering and not sharing personal information about people inappropriately. A family member said, "Our loved one is respected as an individual here". Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. The area manager told us that people are involved in choosing their room colours and decoration. We also noted that the homes environment was a standing agenda item on weekly resident meetings.

People were supported to maintain contacts with friends and family. This included visits from and to relatives and friends. During our inspection we noted a person contacting their relatives via their tablet. Another person was away from the home visiting their family. We were told that some people visit their families every other week. A relative told us, "We are made to feel welcome when we visit and can come as and when we wish. We have been known to turn up unexpectantly. Never an issue". Another relative said they came when they wished and were always greeted politely by staff and made to feel welcome; they went onto say, "[Name] regularly comes home to us too". Staff were aware of who was important to the people living there including family, friends and other people at the service.

People's cultural and spiritual needs were respected. Staff encouraged people to receive visitors in a way that reflected their own wishes and cultural norms, including time spent in privacy. We found that people's

cultural beliefs were recorded in their files and that they were supported to attend services and meetings of their choice if requested.

Good

Is the service responsive?

Our findings

Myrtle Cottage was responsive to people and their changing needs. Throughout the inspection we observed a positive and inclusive culture at service. Promoting independence, involving people and using creative approaches was embedded and normal practice for staff. There were clear personal care guidelines in place for staff to follow which ensured that care delivered was consistent and respected people's preferences. People's support plans included information about people's personal history, their individual interests and their ability to make decisions about their day to day lives. Support plans provided guidance as to individual goals for people to work towards to increase their independence and therefore their reliance on staff for support. A staff member said, "Care plans are detailed and give us the guidelines we need".

The registered manager alerted staff to changes and promoted open communication. Staff actively supported people as their needs and circumstances changed. For example, in response to a person's changes in behaviour the home were working closely with the behaviour trainer and intensive support team. A staff member said, "One person came here in a wheelchair. We encouraged and supported them to be mobile. He now no longer uses it. We have adapted to their needs and as the person walks slowly we are patient and walk at their pace". A relative told us, "We are always kept up to date with changes. On average we have contact with the home twice a week which is good".

Staff were able to tell us how they put people in the centre of their care and involved them and / or their relatives in the planning of their care and treatment. A relative said, "I'm involved in my loved one's care. The home keep us fully involved and up dated". The area manager told us that annual review meetings took place with the local authorities, families and people where possible.

People were supported to access the community and participate in activities which matched their hobbies and interests and reflected in individual support plans. Staff considered how barriers due to disability and complex behaviour impacted on people's ability to take part and enjoy activities open to everyone. People were supported to access the community and walk along the local sea front and enjoy lunch out at a restaurant. People had weekly timetables which enabled them to access different activities which matched their hobbies and interests. For example, one person liked to visit the local airport and watch planes, other people enjoyed swimming, trampolining, walks, restaurants, boat rides and the homes hot tub. Daily records evidenced that people had been supported to attend these activities. A health and social care professional said, "People are often out and about. We put in for activity hours which are allocated". Another professional told us, "People were engaged in activities during my recent visit. One person was enjoying the trampoline in the garden".

The service met the requirements of the Accessible information Standard. The Accessible Information Standard (AIS) is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The service had considered ways to make sure people had access to the information they needed in a way they could understand it, to comply with AIS. People's assessments made reference to people's communication needs, this information had been included in people's support plans where a need had been identified, and communication

passports were being put into place.

The area manager told us that they welcomed complaints and saw these as a positive way of improving the service. The service had a complaints system in place; this captured the nature of complaints, steps taken to resolve these and the outcome. We found that there were no live complaints at the time of our inspection. A relative told us, "I have no complaints or concerns. Any issues I will contact the manager who I am confident will act fast". Another relative mentioned, "No concerns or complaints from us. All is well. We would always be happy to raise any though". A health professional said, "I have no concerns or complaints about the home". People were supported to understand the complaints procedure which was also available in an easy read pictorial format.

Myrtle Cottage was not supporting people with end of life care.

Good

Is the service well-led?

Our findings

The service had not had a registered manager in post since August 2017. 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. A new manager had started at the home and had undertaken a telephone interview with our registration team five days prior to our visit.

Quality monitoring systems and processes were in place and up to date. These systems were robust, effective, regularly monitored and ensured improvement actions were taken promptly. Audits covered areas such as; care plans, staff files, infection control, medicines and health and safety. The area manager told us that home manager regularly worked care shifts with staff which enabled them to observe practice, make sure staff were completing records and take action to improve as and when necessary. In addition to the managers audits the area manager completed monthly audits and an internal quality team carried out six monthly audits at the home. Any outstanding corrective actions were followed up by the area manager in their audits. We found that some actions had been closed for example, storage of topical creams and staff annual medicine competency checks.

Although the home manager was new to the home staff, relative and professional feedback was positive. Staff comments included; "The manager is ok. They listen to me and the team", "Over the past few years we have instability with management. Now we have a new manager I feel it's stable again. [Managers name] always listens. They sort out any problems and respect us" and "[manager's name] seems to be a good manager. The team leader is O.K. and supportive". Relative comments included, "We like the manager, and they are good. [Manager name] has good communication and seems meticulous with paperwork which is good" and "There has been a number of management changes but the new manager seems very good. They really seem to work well with relatives and do a good job". A professional told us, "My experience of the manager is positive. They are transparent and in regular contact" The area manager told us that the provider was open and supportive. We were told that they listened to staff and the management and would fund resources required to deliver the best care to people living at Myrtle Cottage.

The service worked in partnership with other agencies to provide good care and treatment to people. Professionals fed back that they felt information was listened to and shared with staff. A professional said, "The home works well in partnership with us".

The area manager understood the requirements of duty of candour that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm. They fulfilled these obligations where necessary through contact with families and people. The area manager told us, "Duty of Candour is all about being open, honest and up front. We always address concerns and issues and would hold our hands up and apologise as and when necessary".

Relatives and staff told us that they felt engaged and involved in the service. A relative said, "We are involved

in the development of Myrtle Cottage and [manager name] keeps us up to date. I can't think of any examples now though". A staff member told us, "I feel respected within the team and listened to".