Sanctuary Home Care Limited

Park Lodge

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

We inspected Park Lodge on 10 and 12 August 2016, the inspection was unannounced. Our last inspection took place on 12 September 2013 and we found that the provider was meeting all of the regulations that we checked.

Park Lodge provides accommodation and care for 23 people with mental health needs. The home has 22 studio flats and a one bedroom flat for people who are able to live more independently. At the time of the inspection there were 22 people using the service. All the flats were furnished with en-suite bathrooms and kitchen facilities. There were comfortable communal areas, a lift and a large accessible garden.

The service had a registered manager. 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.

Staff understood how to protect people from abuse and systems were in place to inform people about how to report concerns. Risks to people's health and welfare were regularly assessed and reviewed.

People were involved in the staff recruitment process. The provider followed safe recruitment practices. There was enough staff deployed in the service to meet people's needs. Staff had access to appropriate training and were sufficiently trained on how best to support people in the service.

Staff sought people's consent before carrying out care and support. Staff understood and worked within the principles of the Mental Capacity Act 2005 (MCA).

People were given choice and control over how their healthcare needs were met. Reasonable adjustments were made for people. The provider worked in partnership with healthcare professionals to ensure arrangements were in place to meet people's healthcare needs.

Good systems were in place to ensure the safe administration, storage and disposal of medicines.

People were able to cook their own foods and were supported by staff to follow a well-balanced diet.

People were given opportunities to increase their skills and knowledge about the care and support they received. Information was co-produced by the people who used the service. People were involved in all aspects of their care and forums were available for people to express their views.

People were supported by caring and friendly staff and were comfortable approaching staff when they required support. People's privacy and dignity was maintained. The provider implemented improvements when any complaints were raised. People knew what to do if they had any complaints.

Staff were enthusiastic about people reaching their goals and told us the registered manager was supportive and approachable.

Quality assurance systems were in place and used to obtain feedback, monitor service performance and manage risks. People had a say on how the provider designed, planned and delivered 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.

People were protected from harm and had received training in how to recognise abuse. Staff understood the guidelines to follow if they had any concerns in relation to people's safety and welfare.

There were risk management plans in place to support people's safety. People had been involved in producing their own plans.

Sufficient numbers of staff were employed by the provider to meet people's care and support needs.

People received their medicines as prescribed and staff who had received medicines training managed them safely.

Is the service effective?

Good

The service was effective.

People were supported to maintain and follow a well-balanced diet.

Staff were knowledgeable and trained to meet people's needs effectively.

Consent to care and treatment was sought in line with relevant legislation and guidance on best practice.

People's health needs were monitored and they were able to access relevant healthcare services.

Is the service caring?

Good

The service was caring.

People told us they were supported by friendly and polite staff.

Opportunities and forums were available to help people express their views about the care they received.

People's privacy and dignity was respected and promoted.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

People knew how to complain and give feedback about the service.

Is the service well-led?

Good

The service was well led.

People using the service and staff were fully supported by the registered manager and felt confident that the service was well-led.

People were involved in the planning and delivery of the service.

There was a range of quality assurance systems in place to monitor the service and appropriate actions were taken to address issues of concern.

Park Lodge

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.

We visited Park Lodge on 10 and 12 August 2016 to undertake an inspection of the service. The inspection was unannounced on the first day and announced on the second day. The inspection was carried out by one inspector.

We checked information that the Care Quality Commission (CQC) held about the service which included a Provider Information Return (PIR), the previous inspection report and notifications sent to CQC by the provider before the inspection. The PIR is a form that asks the provider to give some key information about the service, including what the service does well and any improvements they plan to make. The notifications provide us with information about changes to the service and any significant concerns reported by the provider.

We spoke with four people who used the service, one relative and one health and social care professional who reported no concerns about the service. Some people were not available to speak to us during the inspection and some people chose not to speak to us. We spent time observing the care people received, toured the building and listened to a staff handover.

We spoke with three project workers, the administrator and the registered manager. We looked at the records in relation to four people's care including their medicines records. We also looked at five staff recruitment and training records, minutes of meetings with staff, quality assurance audits, staff rotas and a selection of the provider's policies and procedures.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. One person reported, "It feels good here, I feel safe" and another person said, "I do feel secure and supported."

People were safe as there were systems in place to reduce the risks of harm or potential abuse.
We spoke with staff who told us they had received appropriate training in safeguarding and understood whom they would report to, and what actions they would take if they had concerns about a person's safety. Staff completed worksheets and an evaluation that included a test after the training. In addition to safeguarding training staff and the people who used the service had completed safeguarding questionnaires. The questionnaires asked specific questions about how to identify and recognise different types of abuse. Furthermore, staff discussed the importance of protecting people from harm in meetings. This showed the provider was keen to ensure that staff understood safeguarding issues in order to help protect people from the risk of abuse.

There was an easy read safeguarding policy so the information was accessible and understood by the people who used the service. Posters displayed on communal noticeboards signposted people to who they should inform if they had any concerns. People received welcome handbooks when they moved into the service that gave clear guidance on what actions to take if they felt they were being bullied or harassed. This was to reassure people that the provider would safely support them if they had any concerns about their welfare.

Staff told us who they would raise concerns with if required to keep people safe. The whistleblowing procedure was displayed on the office notice board and gave clear guidance on who concerns should be reported to, such as the CQC, and Public Concern At Work which is a charity that aims to protect society by encouraging workplace whistleblowing about wrongdoing.

Risk assessments for people were detailed, informative, and included measures introduced to reduce the risk of harm to people. This included early warning signs for staff to observe when people's physical or emotional wellbeing may be at risk. We found that staff had a good understanding of how to manage risks in a way that promoted people's independence and did not unnecessarily restrict them from using the service. For example, there was clear guidance in place for one person whose behaviour challenged the service and required two to one support. For another person, there was an assessment on reducing the risk of the person misplacing their keys. We found information on coping strategies available for people to refer to and guidelines on how staff should manage serious incidents, such as self-harm. These were reviewed regularly so they remained reflective of people's needs and helped staff to determine the support people needed if they had a sudden change of condition or experienced an increased risk. Staff had the knowledge to deal with emergencies that may arise so that people received safe and appropriate care.

Staff consistently assessed the risks in people's environment and control measures were in place to minimise the likelihood of incidents and accidents in the service. There was guidance and instructions on how to prevent needle stick injuries, a list of staff trained to administer first aid was available, health and

safety checks carried out in people's flats, guidance on lone working was followed and an accident reporting line was available for staff to report workplace issues.

'This is our house we should be part of the recruitment process', one person had written in response to the provider's recruitment decisions. We saw records and photographs to show that two people who used the service had completed recruitment and selection training and agreed to be part of the interview panel for future staff interviews. This demonstrated that people were actively encouraged to take part in the decisions about their home and the services they received. We found that the provider carried out thorough staff recruitment checks, such as obtaining references from previous employers and verifying people's identity and right to work in the UK. Criminal records checks were completed for all the staff and the provider had systems in place to confirm if staff were suitable to work with the people who used the service.

A concierge worked during the night as a main point of contact to maintain a safe and secure environment and there were sufficient numbers of staff on duty to safely meet people's care and support needs. Staff were available to assist people as and when required and people did not have to wait for support. We observed that people were comfortable in the presence of staff and they looked relaxed when approaching staff for assistance. The registered manager told us how they worked out staffing levels and made sure that there were appropriate levels of management support available to staff. We looked at the staffing rota for the service and saw that appropriate numbers of staff were allocated to work both during the daytime and throughout the night. The provider employed bank staff to cover staff absences, and the deputy manager covered for the registered manager when they were away from the service.

Staff supported people to take their medicines safely and in a way that was right for them. We looked at the systems in place for the storage, administration and disposal of medicines. We found that medicines were stored safely and that regular checks were taking place to ensure that medicines were stored at an appropriate temperature. Medicines were held in a lockable cabinet, which contained individual blister pack boxes; these were clearly marked with the correct dosage and correlated with the individual medicines administration records (MAR). People's medicines records contained a photograph of the person, their date of birth, room number, GP details and any allergies or reactions they may experience. Where people had refused medicines this was recorded accurately in the MARs and staff told us that this was reported to health professionals immediately to ensure that people were supported with any adverse effects of this. The returns medicines book demonstrated that any surplus medicines were disposed of safely.

Some people were able to take their own medicines and their risk assessments contained clear guidelines about how staff should manage this. Staff told us they observed people's 'relapse triggers' such as changes to people's emotions, mood or behaviour and knew what action to take in the event of this. We found that staff helped people to take their medicines independently, for example, there were discussions with the GP to dispense a person's medicines in blister packs rather than boxes to help the person to take their medicines safely. This showed that the provider took into account people's ability to self-administer medicines and the level of support they required to ensure that people maintained their independence whilst managing their medicines safely. We saw that there were records to instruct staff in what circumstances to give medicines prescribed as 'when required' to ensure these were only administered as needed. Records confirmed that staff were trained to administer medicines safely and their competency was regularly checked.

People's safety was maintained through the maintenance and monitoring of systems and equipment. Certified external contractors carried out regular servicing on fire, gas, water and electrical equipment. Fire practice evacuation drills were regularly held involving both people who lived in the home and staff, and people had specific written plans on how they should be supported when leaving the home in the event of a

fire.

Good

Is the service effective?

Our findings

People were supported to develop and maintain daily living skills. Cooking facilities were available in people's flats and they were able to cook and prepare their own foods. During our inspection, we saw staff escorting people to do their weekly shopping and this was recorded in their daily records. The staff team also held a regular cooking group to show people how to follow a well-balanced diet. During our tour of the building, we saw there was a newly refurbished kitchen, located on the first floor that was used for this purpose. The group was formed as a result of people's feedback and a request for the cooking group to take place. The aim was to promote healthy living, develop budgeting skills and support people to cook healthy and nutritious meals to prepare them for moving into their own homes. People using the service and staff were trained in safe food hygiene practices before they could attend the cooking session and records confirmed this. One person who participated said, "I cooked steamed vegetables and a smoothie, it's not every day you can have chips." People told us they had cooked foods they liked from their national and cultural backgrounds, such as Eritrean, Algerian and British dishes so other people could sample their cuisines. The registered manager told us "There is a local market that sells a variety of different food at good prices, they are learning how to manage their budget and how to cook foods from different cultures, I also learn from them."

People were supported by staff who had access to the training and support they needed to carry out their roles and responsibilities. This comprised of specific training to enable them to meet the needs of people using the service, for example, dual diagnosis training. The registered manager showed us a training evaluation tool used to plan further training that was required, particularly in response to any individual needs of the people staff supported. The registered manager worked in partnership with the Community Mental Health Team (CMHT) to deliver essential training to staff. For example, a health professional from the CMHT was booked to deliver training on personality disorders and self-harm.

Staff told us they had received a good induction to the service which included an introduction to the people who used the service. The training records we viewed confirmed that staff had attended training to ensure that they could meet people's assessed needs. This included training on professional boundaries, mental health awareness, managing aggression, health and safety, first aid and fire awareness. We noted that an awareness of the way people communicated, such as body language, tone of voice and gestures was highlighted as an area staff needed to improve upon. One staff member said, "Training is vital, every day is a learning process and we have to adjust to people's needs, you must be prepared to admit and learn from your mistakes." Staff received regular supervisions and an appraisal each year and used this time to identify and address any learning and development needs to support them in their role.

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 are called

the Deprivation of Liberty Safeguards (DoLS).

The registered manager confirmed that no one in the service was subject to a DoLS authorisation and we did not observe any restrictions on people during the inspection. Our conversations with staff demonstrated that they understood their responsibilities under the MCA 2005 and staff had received appropriate training.

Care plans recorded if people were able to oversee their own financial affairs and appropriate support and advice had been sought where required. We found for one person that there was a recorded discussion and decision to seek an appointee to help manage their finances with the support of an Independent Mental Capacity Advocate (IMCA). IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. Care plans had been signed by the person, or their representative, to indicate their consent to the care as outlined in their care plan. For one person, we saw written records to inform staff that the person may become anxious before signing any documents.

Staff asked people for their consent before carrying out any aspect of care and support. For example, staff asked if the inspector could view a person's room and, people had signed third party consent forms to agree that their information could be shared with health and social care professionals if deemed appropriate. Additionally, people had signed consent forms for staff to provide a 'duty of care'. The agreement was to make sure people made contact with the staff every two to three days to ensure they were safe.

People were involved in making decisions about the way their healthcare needs were met. We saw that staff had discussions with people about how they wanted staff to support them. For example, one person had a medical condition that they were able to manage independently. They had been appropriately assessed by healthcare professionals and staff were able to provide support in an emergency situation. There was a clear risk management plan that was co-produced by the person and staff regarding how they wished to be supported.

Records highlighted that staff worked closely with a wider multi-disciplinary team of healthcare professionals to provide effective support to people. Held on file for each person was an 'interagency communication sheet' that held clear and concise information on where and when people had attended trauma clinic groups, smoking cessation clinics and screenings for diabetes. It also listed appointments with their GP, community psychiatric nurses, psychiatrists, the home treatment team and dentists. Where people had not attended appointments, staff recorded the reasons for this. We observed a staff handover during which the registered manager informed staff that they had received positive feedback from the hospital regarding a person's health and wellbeing. They commented that since the person had used the service there had been a reduction in their hospital admissions. The provider had a good working relationship with the GP and we were told they would visit the service if staff had any concerns about a person's health and wellbeing.

Good

Is the service caring?

Our findings

Positive relationships were observed between staff and people using the service. All the people we spoke with told us that staff were friendly and caring. One person said, "The staff, yes I would say they are friendly and they care." Another person told us, "They listen, I really like the staff and they always help me when I need something." Staff we spoke with took an active interest in people's well-being and understood what was important to people. During the day, we heard staff speaking to people in a friendly and polite way. We saw that staff greeted people when they arrived and left the service and that they exchanged warm pleasantries. Staff had patience with people and took time to listen to what people said to them, which made the service appear welcoming and relaxed. People told us they felt comfortable and we observed that they had the freedom to make their own choices on their preferred daily routines. Support was offered in a calm and considerate way and people were open and trusting of staff that supported them.

We saw written compliments from people using the service and their relatives commenting on the service and the support they had received. These included, 'Everyone is warm, friendly and smiley', 'At the cooking club residents decided who wanted to be the chef so they could cook Jollof rice' and 'I just wanted to reassure staff on the excellent level of support during his/her stay at Park Lodge.'

People were supported to express their views and were involved in making decisions about their care. Staff explained that they encouraged people to "speak up" at Care Programme Approach (CPA) meetings and challenge any decisions about their medicines and physical and health matters if they had any concerns. CPA meetings are used to ensure that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. The provider facilitated events for people to attend such as the 'getting involved forum' where people could take an active part in improving the service, such as, reviewing the providers' policies and procedures. One person had attended a networking meeting on mental health matters and we found people had access to the easy read version of the Mental Health Act 1983. The Mental Health Act is a law that sets out when people can be admitted, detained and treated for mental health conditions against their wishes if they are putting themselves or someone else at risk of harm. Advocacy services were available to people to use and we found clear information on advocacy for people's specific cultural needs. Daily contact records showed that a person had been offered a befriender to help reduce social isolation and form friendships; however, the person had declined the support. This demonstrated that people were empowered to make informed decisions and offered choices about how their individual needs were met.

People had staff called keyworkers who worked specifically with them on a one to one basis to make sure their care and support needs were met and to ensure continuity. The registered manager explained the importance of person centred care that allowed people to express their views in key work meetings by focusing on what was important to them at that particular time. However, we found that the outcome of these meetings were not always recorded to demonstrate how people's views were listened to. We spoke to registered manager, who agreed and showed us how she had addressed this with the staff in their meetings. We saw records to show that the registered manager consistently reviewed these sessions to ensure that positive recovery was the key focus and a holistic approach used to support people's overall wellbeing.

Effective key working was discussed in handover meetings, such as the importance of praising people for their achievements. The registered manager sought creative ways to engage people in their key work sessions. For example, staff were encouraged to explore different environments for key work meetings based on people's hobbies, interests and recreational pursuits such as cafes, local parks, during dominoes or card games and meals to meet people's preferences. Friends and family were also welcomed to participate in activities if people wished. This was to help strengthen positive and trusting relationships with people. One staff member commented, "The registered manager is very proactive and gives us strategies and ideas on how best to support people."

People were treated with respect and dignity, for example, staff knocked on their doors and did not enter without permission. People were offered support in private when it was considered appropriate. For example, there were private rooms in the service where people could attend meetings with multi-disciplinary teams or receive support to take their medicines.

Good

Is the service responsive?

Our findings

People told us they had been asked about their individual preferences and interests and whether any improvements could be made to the delivery of care. One person said, "I love music, I have musical instruments in my room, I also like to sing, but mostly to myself" and another commented, "I attend the meetings every week and like to go to the gym."

There was a thorough assessment of people's needs carried out by the CMHT. The registered manager had then reviewed the information to ascertain if the service could fully support people's assessed needs. We saw that the provider had included in their care plans the information from the assessments after discussions with people when they had moved into the service. Care plans contained details about the person, which included information such as the next of kin contact, their GP or other health and social care professionals, medical conditions and special/cultural needs. There was clear information on people's preferences, communication needs, mobility and personal care needs. Staff regularly reviewed and updated plans to reflect any changes in the care and support given.

People received support to access specialist services if they experienced periods of emotional distress or to help with their physical health. We saw that people had been referred to talking therapy and hearing voices groups. These services provide a safe space for people to share their experiences and support one another. This demonstrated that intervention was sought from specialist mental health groups to support people with their mental health needs.

Staff supported people to engage in meaningful occupations and the things that mattered to them. One person was due to embark on a two-day training course as they had volunteered to lead a reading therapy class for people that used the service. The person had written a book called 'a little book of poems', which had recently been published and the provider had organised a press release. The person had prepared a statement on what they would like to say. This explained how they were inspired to write the book because they found that some people with mental health issues found it difficult to understand poetry. The person had written 'without Park Lodge this book would not be here'. On the second day of our inspection, a member of staff from the head office visited the service to take photographs of the person along with the staff team. The administrator had kindly supported the person to do their hair for photographs taken outside the service proudly showing their newly published book. This showed how staff supported and motivated people to achieve their goals, aspirations and wishes.

Coffee mornings were held weekly for people to socialise and form friendships with other people who used the service. We observed that the staff provided a selection of assorted pastries, biscuits and drinks for the occasion. Located in the service was a computer room where people could access the internet to browse for college courses or update their CVs to increase their skills and employability. Two people had received support to enrol in college and another person had expressed an interest in catering and had obtained a voluntary placement at a local bakery. Staff supported people with their welfare rights and we found that staff had helped people with financial matters such as appealing decisions.

People had access to a full range of activities, which suited their individual interests. People attended the gym, went on shopping trips for clothes and had holidays abroad. Located in the communal area was an activity chart to show people the events that were available to them in the service and the community. These included, movies, walking groups, discussions on current affairs, knitting groups and board games.

Reasonable adjustments were in place for people in order to respond to their diverse needs. There were facilities for people with mobility needs such as a wet room and appropriate aids and adaptations. Additionally, there was a lift for people to use. Information was available for people in various formats on request, for example, braille, large print, tape and different languages. One person had refused this support and the registered manager explained it was within their "rights to have choice and control" about their communication needs. The person using the service also confirmed this.

There was a commitment to ensuring a phased move on strategy for people using the service. The staff and the registered manager strived to ensure people were well equipped to remain independent after they moved into their own homes. The welcome handbooks given to people outlined that their resettlement needs were assessed from the time they began using the service. On person kindly allowed us to look at the independent flat they had have moved into that was attached to the home, it was personalised to their liking and they told us, "I'm very happy here, no concerns here." The registered manager told us the person also worked part-time in health and social care. Exit surveys were completed by people who had moved into their own homes to assess the level of support they had received whilst living in the service. One person had written, 'The project is good and the staff are encouraging and communicate well. They always say hello to me. I felt like I was in the right project.'

At the time of our inspection, people told us they knew how to make a complaint and they had no concerns. Information about how to make a complaint was available in the welcome packs people received when they began using the service and displayed on notice boards. Records showed that complaints were responded to appropriately and in a timely manner. It was evident that staff took action to address issues raised and reflected on lessons learned to improve the service.

Good

Is the service well-led?

Our findings

People using the service and staff expressed confidence in the registered manager's ability to run the service well. Staff told us they were supported by a "brilliant", "supportive" and "approachable" registered manager. There was a consensus about all the staff being open, honest and communicating effectively. On the second day of our inspection, one member of staff was on leave and the registered manager stepped in to assist. We observed that the staff confidently referred to the registered manager with any questions they had. On several occasions, the registered manager broke off conversations with us and calmly assisted people with their support needs. Throughout the day, we saw she dealt with several requests from people, visitors' and staff in a patient, discrete and skilled manner.

The provider strived for continuous improvement by sharing lessons learned. The registered manager attended the monthly managers meetings to discuss best practice and shared learning across the organisation. There was a commitment from the staff and the registered manager to ensure people were well equipped to remain independent.

Staff told us they were given the opportunity to address any areas of concerns or make suggestions at regular staff meetings that were held. They said they were well supported particularly when they required assistance when dealing with challenging situations. One staff member explained, "We receive excellent support and there is a 24 hour counselling service, if we require any extra support." Staff were enthusiastic about providing good quality care for people and told us they were motivated by seeing people achieving their goals and wishes.

People were involved in the planning and delivery of the providers' services. We saw there was a co-production toolkit developed by people who used the services, the operational staff and the heads of service. The toolkit was designed to ensure all the services were working effectively and aligned with the Care Quality Commission and the local authorities' expectations. This included seven key areas where people should be involved and influence how the provider made decisions, for example, with relevance to diversity and culture, house meetings and forming links with the wider community. We saw that staff acted on this, for example, residents meetings were held for people to express their ideas and suggestions on how the provider could improve the service. Welcome handbooks and the visitor's rules were co-produced by the people who used the service and staff. This included people's rights and responsibilities when using the service. We saw that one person had drafted the minutes of a meeting and we found people were consulted on any new and recent developments in the service. The registered manager told us, "We empower clients to give their feedback at residents meetings and get their views on what they would like us to do better."

The registered manager was open with us about areas where improvements were needed. They shared with us things that had gone well and not gone well in the past and were honest about what needed to change. We saw that there was analysis of incidents and accidents in the home and the provider used this tool to monitor trends, address any shortfalls and implement change, for example, sourcing specific training for staff. The home operated a range of quality audits on care plans, health and safety checks and staffing levels. We saw recorded that a pharmacist had completed a medicines audit. Surveys were sent to people in

2015 and 2016 and an action plan had been produced as a result of this. Overall, the results were positive.

The registered manager was aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been promptly notified of these events when they occurred. Benchmarking was used by the provider to set new standards of practice such as the National Minimum Data Set for Social Care (NMDS-SC). NMDS-SC is an online system which collects information on the adult social care workforce in England.