S.M.S. Care Limited

Dixon House

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

Overall summary

We carried out this inspection on 09 December 2014 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The service is registered to provide nursing or personal care for 11 people who have a learning disability. On the day of the inspection 08 people resided at the home.

We last inspected this service in January 2014 when the service met all the standards we inspected.

This inspection took place on 09 December 2014 and was unannounced. During the inspection we spoke with six people who used the service, two care staff and the registered manager.

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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

People who used the service told us they felt safe and felt able to voice any concerns to the manager, staff or their families.

The Mental Capacity Act 2005 (MCA 2005) sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need, where there is no less restrictive way of achieving this. Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). We found action had been taken where necessary to ensure people's capacity to make their own decisions had been assessed. Where any restrictions were in place we found these were legally authorised under the Mental Health Act 1983 or with people's consent. One person had a best interest decision about not being able to go out unattended. We found this had been approached using the correct procedures and personnel. This person had an independent person acting to protect their rights and review the decision on a regular basis.

Staff were recruited using current guidelines to help minimise the risk of abuse to people who used the service.

People had signed their consent to agree to their care, treatment, the administration of medication if required and their agreement to be photographed.

People were encouraged to be independent. We saw that people were mostly self-caring and kept their rooms as they wished. They also cooked and shopped for themselves. Staff intervened only when they had to or at the request of people who used the service.

Activities, hobbies and interests were provided. This included two people who worked for part of the week.

The activities were suitable for the age group and included going out to clubs, on holidays, ten pin bowling, to cinemas or shows and to music and dance sessions. There were also activities held indoors and on the day of the inspection several people were involved in making Christmas decorations or doing arts and crafts sessions. People told us they were happy with the activities they could join in. People who used the service also told us they could go out independently if they wished.

The environment was well maintained and people were able to help choose their décor or furnishings to make the environment more homely to them.

Staff told us they received a recognised induction, completed enough training to feel confident in their roles and were supervised. Staff felt supported at this care home.

People's needs were regularly assessed and updated. Staff were updated at each shift at their handover sessions. Staff responsible for writing care plans did so regularly which were audited for accuracy by the registered manager.

The administration of medication was safe, staff competencies were checked and the system audited for any errors by the registered manager and the local pharmacy.

People who used the service, staff and other agencies were asked for their views about how the service was performing. We saw that the registered manager had taken action to provide a better service from the views such as attending new activities and changing the menus.

The registered manager audited systems at the home, including infection control and the environment. Gas and electrical equipment was maintained to help keep people safe.

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?

Good

The service was safe. The service had previously notified the authorities of any possible safeguarding incidents. There were systems in place for staff to protect people. Staff had been trained in safeguarding issues and were aware of their responsibilities to report any possible abuse. Staff used the Blackburn with Darwen adult safeguarding procedures to follow a local protocol.

Arrangements were in place to ensure medicines were safely administered. Staff who administered medicines had been trained to do so. We observed a medicines round and noted staff followed their procedures.

Staff had been recruited robustly and there were sufficient staff to meet the needs of people who used the service.

Is the service effective?

Good

The service was effective. This was because staff were suitably trained and supported to provide effective care.

Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People were not restricted in the home unless this was legally authorised.

People were given a choice of food to help ensure they received a nutritious diet. All the people we spoke with said food was good.

People were able to access professionals and specialists to ensure their health needs were met. Care plans were amended regularly if there were any changes to a person's medical conditions.

Is the service caring?

Good

The service was caring. People who used the service thought staff were helpful and kind. A visitor we spoke to thought staff were welcoming.

We observed staff during the day. Care was given privately and people were treated with dignity. Staff talked to people in a professional and friendly manner. People who required help were given assistance quickly.

Is the service responsive?

Good

The service was responsive. People who used the service, or where appropriate a family member were involved in their care and care plans. Plans of care contained sufficient personal information for staff to meet people's health and social needs.

There was a suitable complaints procedure for people to voice their concerns. The manager responded to any concerns or incidents in a timely manner and analysed them to try to improve the service.

Is the service well-led?

Good

The service was well-led. There were systems in place to monitor the quality of care and service provision at this care home.

Summary of findings

During meetings and by sending out questionnaires the service obtained and acted upon the views of stakeholders, families and people who used the service.

Healthwatch Blackburn with Darwen and the local authority contracts and safeguarding team did not have any concerns about this service.

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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 checked 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 unannounced inspection took place on the 19th December 2014.

The membership of the team consisted of one inspector and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert was experienced with people who had a learning disability.

Before this inspection we reviewed previous inspection reports and notifications that we had received from the service. We did not request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. This was because the provider would not have had sufficient time to complete the PIR. We asked Blackburn with Darwen Healthwatch and the local authority safeguarding and contracts departments for their views of the home. The views were positive.

During the inspection we observed care and support in the communal areas of the home. We looked at the care records for three people who used the service and medication records for three people. We also looked at a range of records relating to how the service was managed; these included training records, quality assurance audits and policies and procedures.

Is the service safe?

Our findings

We found the service was safe. The six people we spoke with said they felt safe. People commented, "We've got fire alarms and other alarms" and "I would go to a staff member if I did not feel safe."

One staff member we spoke with was new and going through her induction at college and the home. The other member of staff had undertaken safeguarding training. The staff training matrix showed all staff had undertaken safeguarding training. The staff member we spoke with and the registered manager were able to tell us how they would respond to allegations or incidents of abuse; they were also aware of the lines of reporting concerns in the home. The staff member told us, "I would report any instances of abuse using the whistle blowing policy and if it was a manager I would report it to social services." There was a whistle blowing policy for staff to feel confident they would not be penalised for reporting concerns and a safeguarding policy. The safeguarding policy told staff what constituted abuse and how to respond and report any concerns. The service also had a copy of the Blackburn with Darwen safeguarding procedures to follow local protocols. Information we reviewed prior to the inspection provided evidence that the registered manager had reported safeguarding incidents to all relevant authorities including the CQC.

People we spoke with said there was no bullying by other service users or staff.

People who used the service told us there were enough staff to meet their needs. We observed staff responding promptly to people when they required help. People were also encouraged to do things for themselves such as make their own drinks to help them retain their life skills. The registered manager told us, "There are no 'clients' who require two care staff to assist them. We are currently recruiting two staff to fill the vacancies. Staff are very good and cover for each other." The member of staff we spoke with said, "Except for emergencies we have enough staff to meet people's needs and enough time to spend with service users and join in activities."

One care staff member we spoke with was able to tell us how they supported people to make their own decisions, wherever possible and offered choices for people to remain as independent as possible. The staff member said, "Most people who live here are quite independent and we encourage this. Nobody requires assistance with their mobility." One part of the plan of care showed us people were encouraged to do things for themselves such as keeping their rooms clean, go out on their own, cook and maintain their personal hygiene. Staff were there to support people if they required help. There were also directions on the wall for people to access the advocacy service. An advocate is someone who will act upon a person's behalf. This is usually a person with limited mental capacity who does not have the support of family or friends. Nobody at the present time required an advocate although one person had an independent mental capacity assessor.

There was a medicines policy which informed staff of the correct procedures for ordering, storing, administration and disposal of medicines. We looked at the policy and saw it matched the process staff followed. All staff who administered medicines had been trained. The registered manager and pharmacy who supplied the home audited the system to check staff competency.

Each person who used the service had a medication profile and had signed an agreement for staff to administer their medicines.

Medication was stored in a locked cabinet in a lockable room. We looked at six medicines records and saw that staff had completed the forms correctly and signed them. Hand written prescriptions, usually for people who were admitted on respite care had hand written instructions in the medicines records. Two staff had signed the form to minimise possible errors. The temperature of the medication room was checked and recorded to ensure medicines were stored safely. Some medication needed to be kept cool and this was stored in the fridge and the temperature was also recorded. We noted not many people required medication and that medicines were presented in a blister pack system. This system showed staff what the pills should look like and what they were used for. Staff retained the supplied advice sheets to check for possible side effects. No person currently used controlled drugs although there was a cabinet and ledger should they be needed.

The district nurse who visited one person brought with her and disposed of the needles she used.

Is the service safe?

There were risk assessments which covered many aspects of people's lives to be a risk. This included personal care and activities inside and outside of the home. The assessments were regularly reviewed.

There was an infection control policy and the registered manager conducted regular inspections to check for cleanliness and faults. The staff training matrix showed staff had completed infection control training. The laundry was separate from any food handling areas and contained sufficient equipment to provide a good service. The service also had a copy of the current health authority infection control guidelines for care homes for staff to follow good practice. There were hand washing facilities for staff to prevent the spread of infection. Staff had to complete a cleaning rota to ensure the home was kept clean. We saw staff wearing protective clothing, for example, gloves and aprons to help prevent cross infection of bacteria.

We saw that all the gas and electrical equipment had been serviced and checked. This included the fire alarm, electrical installation, gas appliances, portable electric appliances, fire extinguishers and emergency lighting.

There was a contract for the disposal of contaminated waste and the water outlets were treated to prevent Legionnaires disease. The fire system and procedures were checked regularly to make sure they were working and each person had an emergency evacuation plan.

There were regular checks to the fire alarm system to check the break points were working. People who used the service were included in fire evacuation practices to help them understand the need to evacuate safely and quickly.

We looked at two staff files. The staff had been checked for their suitability to work with vulnerable people. The checks included a criminal records check (now called disclosure and barring), two written references, an application form where the manager could explore any gaps in employment and a person's proof of address and identity.

We found the service was safe. The six people we spoke with said they felt safe. People commented, "We've got fire alarms and other alarms" and "I would go to a staff member if I did not feel safe."

Is the service effective?

Our findings

On the day of the inspection we saw that the home was warm, clean and did not have any offensive odours. We observed people who used the service were involved in cleaning their rooms and communal areas. This was part of their agreed plan of care. We observed staff stepping in to help when they were needed to.

People who used the service told us food was good. We saw that people were able to assist or make their own meals, drinks and snacks. People sat at the table to eat their meals as a social occasion. People chose what they wanted to eat and helped shop from time to time. The registered manager told us, "Some of our clients live quite independently and eat what they want. We would give advice if people were not taking a suitable diet and if necessary contact their GP or a dietician." People flavoured their food to taste and cleared up after themselves. Some of the people who used the service liked to eat out and staff accompanied them to provide support. Plans of care contained a section on food likes and dislikes.

We saw that people had a good range of fresh fruit and vegetables. Meals were sometimes discussed during meetings to ensure people were getting what they liked.

The kitchen had been given a 5 star very good rating at the last environmental health visit which meant the storage, serving and delivery of food was effective. The kitchen was clean and tidy on the day of the inspection.

The Mental Capacity Act 2005 (MCA 2005) sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need, where there is no less restrictive way of achieving this. Staff had been trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

The people we spoke with were able to make their own decisions. One person had a best interest decision for being escorted when outside the home for safety reasons. This was reviewed regularly and had been obtained using the appropriate authorities. The registered manager said she would contact the local authority safeguarding team for advice if someone lacked the capacity to make safe decisions. Care plans we looked at included an assessment of a person's capacity to administer their own medicines or people had signed their agreement for staff to administer medicines. We saw this assessment had been completed in accordance with the principles of the Mental Capacity Act. The registered manager told us, "I have arranged a best interest meeting using the current guidelines with help from professionals and family to make sure the person was protected". This meant the person's rights had been protected as unnecessary restrictions had not been placed on them.

Before people were admitted to the home staff met them and conducted an assessment. This was backed up with a social services assessment to make sure the person was suitable to be admitted. People were invited to the home to view the services and facilities. The registered manager told us people were encouraged to visit prior to admission, meet other people who used the service and staff and view any bedrooms available. They could take a meal if they wished or were able to. Some people who were admitted knew about the home because they had stayed several times for respite care. People were also supplied at this time with information about the home. One document called the service user guide told people what the service provided, such as staffing qualifications, facilities, services and other items like how to complain. The assessment process ensured the home could meet people's needs.

We asked people if they had been involved in writing their plans of care and most thought they had been involved and knew where they were located. It was unclear as to how much they were involved due to their condition. However, people had signed their care plans and the right for staff to take photographs for outings and to be placed in documents for identification purposes. The plans of care were individual to each person and showed staff had recorded people's likes and dislikes. The plans also contained a life history which told us about a person's past work and social life. The plans were detailed and looked at each person's health and social needs. This included in who people wished to see or visit to keep in touch with family and friends. A lot of the details were supported by the use of pictures to help people understand their plans. The plans followed the preferred daily routine of a person such as the time they liked to get up and what they liked to

Is the service effective?

do. The plans were regularly reviewed and updated as required. There was a comprehensive daily record of what people did, if they needed to see anyone or where they went.

We saw that people had access to specialists and professionals. They included mental health specialists, opticians, chiropodists, dentists and nurses. Each person had their own GP. The people we spoke with told us, "We are given appointments when needed and are supported to each appointment." One person said "My Dad takes me to appointments because I don't go to the same as everyone else. I prefer my own doctor." This demonstrated people were able to have a GP of their choice.

Risk assessments in the plans of care for health needs and social activities were developed to keep people safe and not place unnecessary restrictions on people.

New staff had to undertake an induction program. We spoke with a new staff member who was currently undergoing her induction at the home supported by the local college. She told us, "I have been here four weeks now and I am doing a recognised induction. I have completed fire awareness and safeguarding training here. The rest of my training is arranged through college. The staff here are supporting me. I feel comfortable and safe working here. I think I want to work with people with learning disabilities and I like the work. I can talk to anyone if I need any help." The induction process was in a recognised format following the skills for health and care workers guidelines. New care staff were shadowed until senior staff thought they had the skills and confidence to work on their own.

We looked at the staff training matrix. Staff had been trained in topics such as moving and handling, safeguarding, first aid, fire safety, infection control, medicines administration and health and safety. Certificates were available for inspection in the two staff files we looked at. Other training staff undertook included epilepsy awareness, the mental capacity act, deprivation of liberties safeguards, diabetes and autistic spectrum disorders. Most staff had achieved a recognised health and social care qualification. Staff we spoke with confirmed they had access to a lot of training and felt sufficiently well trained to perform their roles.

Staff were also supervised regularly and one staff member said, "The manager is very supportive. There is a good staff team. We have supervision on a regular basis and you can bring up training or any topic you wish. The manager is always here to talk to There is always an experienced member of staff on duty."

We toured the building during the inspection and several people invited us to look at their rooms. We saw that people had chosen the décor and one person had chosen all his own furniture. The rooms were personalised to people's tastes and they had equipped their rooms with televisions, music systems and other items which showed they followed their interests such as pop stars.

Most of the people who lived at this home were mobile and quite independent. People who lived at the home on a permanent basis tended to live upstairs with room for people who required short term or respite breaks on the ground floor. Some of the rooms had en-suite facilities. There was sufficient communal space for people to use when full. There were 8 people in the home on the day of the inspection. We saw that people were able to come and go from their rooms as they wished and two people we spoke with were proud of the way they kept their rooms clean and tidy.

People were mobile and did not require the use of a lift. No person required two people to assist them or mobility aids. People were able to go up and down stairs where there were rails to assist them. The communal space was homely and people told us they helped to choose the décor and furnishings.

There was sufficient accessible outside space and seating for people to use in good weather.

Is the service caring?

Our findings

All six people we spoke with said staff were kind. One person said, “They are more than kind. They are all nice.” The people who used the service said staff listened to them and helped them when necessary. We observed staff encouraging people who used the service to be independent. People also told us they could go out independently from staff and all six told us they could, “Come and go as we please.” Both staff members we spoke with were able to tell us how they gave support when needed but helped people retain their independence. This covered all aspects of the home such as with food, choice of getting up and going to bed and what people wore or wanted to do. We observed that staff had a good rapport with the people they supported. We saw that members of staff knew the people well and how best to support them.

We saw that staff had time to sit and talk to people who used the service. Staff also helped people pass the time by assisting them with activities.

We saw that meaningful work was undertaken by at least two people who used the service. Both the people attending work were proud to tell us what they did and were appreciative of staff efforts to help them.

We observed that both people who used the service and staff were aware of privacy issues and any assistance given was discreet. Staff were also trained in confidentiality issues to help keep care and treatment private.

People were able to follow the religion of their choice and besides going to church attended social events held by religious groups. Most were able to attend on their own but staff would support them if they wished.

There was information about the local advocacy service on the wall mural for any person who felt they needed one. An advocate is an independent person who will act on a person’s behalf to help protect their rights and let their wishes be known. One person had an independent mental capacity assessor. This assessor acted for this person to make sure any decisions which may limit the person’s freedom were the least restrictive.

During special occasions such as Christmas we saw that people were included in decorating the home. The Christmas tree was partly decorated with handmade baubles which contained the names of the people who used the service to help them feel included in the festivities.

Is the service responsive?

Our findings

We saw that people were able to join in activities within the home or go out independently. On the day of the inspection people were enjoying an arts and crafts session. Other people who used the service came and went as they liked. One person went shopping for his lunch and other were out at work or for social activities. Activities were individual to each person and they could join in group activities if they wished. Some people liked listening to their favourite music or reading. Activities included arts and crafts, board games, going out to places of interest or for a meal, youth clubs, visiting the cinema or shows, music classes, motivation classes and going home to visit families, sometimes with an overnight stay. People also had the chance to go on holiday and several residents had just returned from a holiday in Blackpool.

Visiting was not restricted although the people we spoke with preferred to go home to see their family and friends.

Part of people's care and treatment was to try to remain as independent as possible. We saw that people were involved in keeping their rooms clean and tidy, cooking and went shopping for their own food (one person went for a sandwich at lunchtime) dependent upon what they wanted to do. We saw that staff did not intervene unless requested to do so. People were risk assessed for going out on their own and any possible safety issues recorded. This did not stop people going out independently, just minimised any risks.

Each person had a 'hospital passport'. This would give other organisations the basic details they would need in an emergency. This document also told staff what items the person wanted to take with them to help reduce the stress of any moves.

There was a maintenance book for staff to record any faults or broken equipment and a person employed to replace or fix the equipment.

There was a complaints procedure which was produced as a written format and as a simplified picture aid on a wall. This told people who they could complain to. On the day of the inspection nobody had any concerns and felt able to talk to staff or the manager if they did. The pictures on the wall demonstrated a sad or happy person and what people could do if they were sad. The registered manager and staff were aware of their responsibilities to help people voice their concerns and who to contact, including social services if the complaint was about a senior member of staff or management.

We saw records of 'residents' meetings which were held regularly. All people who attended were able to have their say and the manager acted upon their suggestions. This included updating the menus and activities people wanted to attend. People told us and showed us that they had a say in decorating their rooms and choosing furniture. People were also taken shopping to choose their own clothes.

Is the service well-led?

Our findings

There was a registered manager at the home. People who used the service told us they felt able to talk to the registered manager or other members of staff if they needed to. On the day of the inspection people told us they thought the manager was approachable and involved in the daily running of the home. No-one had made any complaints formally but all felt sure that management would listen to them should they need to.

The registered manager held regular formal meetings with people who used the service and people told us staff also chatted to them to see if things were going well.

The registered manager conducted satisfaction surveys. We looked at the results of the last survey which had been designed with the use of pictures and simple questions to help people who used the service understand them. The results were positive. Questions were asked around staff response and attitude, the food, activities (including a tick box section for what people preferred with an associated picture at the side), could they talk to someone if they felt hurt or threatened (some said staff and some family), did they know what to do in the event of a fire (fire practices included people who used the service as a result) and did people like the environment.

There were regular staff meetings. One staff member we spoke with told us, “We have handover at the start of each shift and staff meetings. We have a staff meeting tomorrow and this is part of the process to keep up to date with people’s needs.” Other topics included night duty advice, support plans, medication, cleaning, fridge and freezer temperature recording, key worker roles, parties and social events for staff and residents, training and any other business staff wanted to bring up. Staff sign to say they have attended the meeting and the records are passed to staff who were not able to attend. Staff were able to bring up ways they thought might improve the service and were kept up to date with people’s needs.

There was a recognised management system which staff understood and meant there was always someone senior to take charge. The staff we spoke to were aware that there was always someone they could rely upon.

The registered manager was aware of and had sent prompt notifications to the Care Quality Commission.

There were policies and procedures which the registered manager updated on a regular or as needed basis. We looked at many policies and procedures including challenging behaviour, confidentiality, whistle blowing, safeguarding, health and safety, infection control and equality and diversity. The policies we looked at were fit for purpose.

The registered manager conducted audits to ensure the service ran well. The audits included records of water temperatures, cleaning, fire drills, medication, people’s finances, activities, the environment and care plans. The environmental check included infection control and repairs. The registered manager undertook such audits as were necessary to check that systems were working satisfactorily.

We asked the registered manager on what was working well. She said, “People who live here say the care is personal to them, they do what they want to do and they are happy. We work well with all the other agencies and families to get the best care we can for people.” She told us things that hindered good care included, “The cutbacks to finances are a challenge. Fees remain the same but everything else goes up”. The registered manager also told us, “I like working here. I like the client group and seeing people develop into more independent people.”

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.