New Generation Care Limited

New Generation Care Limited - 13 Manor Crescent

Inspection report

13 Manor Crescent
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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 was an unannounced inspection that took place on 8 June 2016.

13 Manor Crescent provides accommodation for up to four people with learning disabilities and who may also have a physical disability. The accommodation is on one level and consists of four bedrooms with ensuite bathrooms. The home is owned and operated by New Generation Care Limited. There is also a care home for people with learning disabilities next door that is run by the same organisation and shares the same staff team and manager.

The home 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 and associated Regulations about how the service is run.

In June 2013, our inspection found that the service met the regulations we inspected against. At this inspection the home met the regulations.

People were happy living at the home and most relatives with the service provided. Some relatives and a healthcare professional expressed concerns about staff turnover and the level of support received by the manager, from the organisation. During our visit there was a welcoming, friendly atmosphere with people out doing activities and interacting positively with staff. People chose their activities with staff support and, attended them within a risk assessed environment. The house also provided a safe environment to live in. The activities were varied and took place at home and within the community.

The records were kept up to date, covered all aspects of the care and support people received, their choices, activities and safety. People's care plans were fully completed and the information contained was regularly reviewed. This supported staff to perform their duties efficiently and professionally. People were encouraged to discuss their health needs with staff and had access to GP's and other community based health professionals, as required. People were supported to choose healthy and balanced diets that also met their likes, dislikes and preferences. This enabled them to be protected from nutrition and hydration associated risks. They said they were happy with the choice and quality of meals they ate.

The person who was at home, knew who the staff that supported them was and the staff knew them, their likes and dislikes. They were well supported and they liked the way their care was delivered. Relatives also said staff worked well as a team and provided them with updated information. They had appropriate skills and provided care and support in a professional, friendly and supportive way that was focussed on people as individuals. The staff were trained and accessible to people using the service and their relatives. Staff said they enjoyed working at the home. They received good training and support from the manager.

Relatives said the manager was approachable, responsive, encouraged feedback from people and

consistently monitored and assessed the quality of the service provided.

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 told us that they felt safe. There were effective safeguarding procedures that staff used and, understood. The home was risk assessed.

There was evidence the home had improved its practice by learning from incidents that had previously occurred and there were enough staff to meet people's needs.

Medicine was safely administered. People's medicine records were completed and up to date. Medicine was regularly audited, safely stored and disposed of.

Is the service effective?

Good

The service was effective.

People's support needs were assessed and agreed with them and their relatives. Staff were well trained.

Food and fluid intake and balanced diets were monitored within their care plans and people had access to community based health services.

The home had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures. Training was provided for staff and people underwent mental capacity assessments and 'best interests' meetings were arranged as required.

Is the service caring?

Good

The service was caring.

People said they felt valued, respected and were involved in planning and decision making about their care. People's preferences for the way in which they wished to be supported were clearly recorded.

Staff provided good support, care and encouragement. They

listened to, acknowledged and acted upon people's opinions, preferences and choices. People's privacy and dignity was also respected and promoted by staff. Care was centred on people's individual needs. Staff knew people's background, interests and personal preferences well and understood their cultural needs.

Is the service responsive?

Good

The service was responsive.

People chose and joined in with a range of recreational and educational activities at home and within the local community during our visit. Their care plans identified the support they needed to be involved in their chosen activities and daily notes confirmed they had taken part.

The home had a complaints procedure and system and people said that any concerns raised were discussed and addressed as a matter of urgency.

Is the service well-led?

Good

The service was well-led.

The home had a positive and enabling culture at all staff levels of seniority. The manager enabled people to make decisions and staff to take lead responsibility for specific areas of the running of the home.

Staff said they were well supported by the manager and organisation.

The quality assurance, feedback and recording systems covered all aspects of the service constantly monitoring standards and driving improvement.

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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 was an unannounced inspection and took place on 8 June 2016.

The inspection was carried out by one inspector.

During the visit, we spoke with one person using the service, three relatives, two care staff, two healthcare professionals and the registered manager. There were four people living at the home, three of whom were attending activities during the inspection.

Before the inspection, the provider completed 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 improvements they plan to make. We also checked notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed care and support, was shown around the home and checked records, policies and procedures and maintenance and quality assurance systems. We also looked at the personal care and support plans for two people using the service and two staff files.

Good

Is the service safe?

Our findings

People thought the home was safe and did not feel any pressure from the staff to do things. One person said, "I like living here." A relative told us, "The home dealt with a safeguarding issue appropriately and kept us informed."

Staff understood what abuse was and the course of action to follow should they encounter it. They had access to abuse policies, procedures and induction and refresher training that enabled them to protect people from abuse and harm in a safe way. Their responses to our questions reflected the provider's policies and procedures.

There was no current safeguarding activity. Previous safeguarding alerts had been suitably reported, investigated and recorded. Staff knew how to raise a safeguarding alert and when this should happen. They had received appropriate training that included safeguarding adults at risk of abuse, the local alert procedure, the whistle blowing procedure and the (skills for care) code of conduct. There was also information about keeping safe made accessible to people using the service.
The staff recruitment process was thorough and records showed us it was followed. The interview process included scenario based questions that identified if prospective staff had the skills and knowledge to provide care for people with learning disabilities. If there were gaps in their knowledge the organisation decided if they could be filled and the person employed. References were taken up, work history checked for gaps and Disclosure and Barring Service (DBS) clearance obtained before starting in post. If there was work history gaps people were asked to explain the reasons for them. Staff were provided with a handbook that contained the organisation's disciplinary policies and procedures. The staff rota reflected that staffing levels were flexible to meet people's needs. The staffing levels during our visit enabled people's needs to be met and the activities they had chosen to be pursued safely. A healthcare professional raised some concerns about the level of staff cover available regarding the opportunity for one person to access activities within the community due to their mobility, although they were attending an activity during the inspection. There were three staff vacancies that were being recruited to.They were also concerned about the way some staff addressed one person using the service. The person was attending an activity and not present during the inspection. The body language of the person using the service, who was present indicated that they were safe and comfortable in the environment they were living in.

There were risk assessments that enabled people to take acceptable risks and enjoy their lives safely. The risk assessments covered all aspects of people's daily living, including activities at home, within the community and when on holiday. There were also health related risk assessments for areas such as difficulty swallowing. The risks were reviewed regularly and updated if people's needs and interests changed. There was also general risk assessments for the home and equipment used that were reviewed and updated. Equipment was regularly serviced and maintained. Care plan information gave staff the means to accurately risk assess activities that people had chosen. They were able to evaluate and compare risks with and for people against the benefits they would gain. Examples of this were the way people were able to access facilities in the community such as shops, college and day centres. The risk assessments were reviewed quarterly or as required, adjusted when needs and interests changed and contributed to by people, their

relatives and staff.

The staff said they shared information within the team regarding risks to individuals. This included passing on any incidents that were discussed at shift handovers and during staff meetings. There were also accident and incident records kept. Staff told us they knew people living at the home very well, was able to identify situations where people may be at risk and take action to minimise the risk.

Medicine was safely administered during our visit. A signature list was kept of staff who administered medicine and there was a medicine profile for each person using the service. There were no controlled drugs kept on the premises. We checked the medicine records for all people using the service and found that all the records were fully completed and up to date. Medicine was regularly audited, safely stored and disposed of, as required. Staff were trained to administer medicine and this training was regularly updated. There were no people currently self-medicating.

Good

Is the service effective?

Our findings

One person and people's relatives said that people using the service decided about the care and support they received, when it was provided and who provided it. They made decisions with support, advice and guidance from staff. We were told that the care and support provided by staff was what people required and delivered in a friendly, enabling and appropriate way that they liked. One person told us, "I'm going to the day centre tomorrow. I do gardening."

There was comprehensive induction and annual mandatory training provided for staff. The induction was on line or group based depending on the nature of the training being provided. Training encompassed the 'Care Certificate Common Standards' and included infection control, manual handling, end of life, food safety, equality and diversity and health and safety. Staff were required to complete modules as part of the induction. New staff were also required to shadow experienced staff to increase their knowledge of the people who lived at the home. There was also access to more specialist training to meet people's individual needs and syndromes specific to them such as autism; epilepsy, Tourette's and intensive interactions. Relatives were invited to attend training sessions to share their experiences of caring for people who use the service with staff. This gave staff an opportunity to ask questions and gain further insight to people as individuals. The training matrix identified when mandatory training was required.

Regular staff meetings, bi-monthly supervision sessions and annual appraisals were used to identify any further individual or group training needed. There were staff training and development plans in place.

The home carried out a pre-admission assessment, with people and their relatives that formed the initial basis for care plans. The care plans contained sections for health, nutrition and diet. These included completed and regularly updated nutritional assessments. Weight charts were kept if required and staff monitored the type of meals and how much people ate to encourage a healthy diet. There was also information regarding the type of support people required at meal times. Staff said any concerns were raised and discussed with the person and their GP if necessary. Nutritional advice and guidance was provided by staff and there were regular visits by a local authority health care team who reviewed nutrition and hydration. Other community based health care professionals, such as speech and language therapists visited as required. People also had annual health checks. The records demonstrated that referrals were made to relevant health services as required and they were regularly liaised with. People using the service were all registered with a GP, had health action plans and hospital passports.

People chose the meals they wanted using pictures if needed, decided on a menu and participated in food shopping. One person told us, "I like the meals; we get to choose them." Meals were timed to coincide with people's preferences and activities they were attending. They were monitored to ensure they were provided at the correct temperature and people's preferred portion sizes.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted and the provider was complying with the conditions applied to the authorisation. Best interests meetings were arranged as required. Best interests meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The capacity assessments were carried out by staff that had received appropriate training and recorded in people's care plans. Staff received mandatory training in The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood their responsibilities regarding the Mental Capacity Act 2005 and Deprivation of liberty safeguarding. Staff continually checked that people were happy with what they were doing and activities they had chosen throughout our visit. People's consent to treatment was regularly monitored by the home and recorded in their care plans.

The organisation had a restraint policy and procedure that was de-escalation based and staff had received training in de-escalation procedures. They were also aware of what constituted lawful and unlawful restraint. Individual de-escalation guidance was contained in people's care plans as appropriate and any behavioural issues were discussed during shift handovers and staff meetings.

The home worked closely with the local authority and had contact with organisations that provided service specific guidance and informed of local events taking place. During the inspection two people were attending sensory sessions at a local Mencap facility.

Good

Is the service caring?

Our findings

People and their relatives told us that staff treated them with dignity, respect and compassion. This was confirmed by the staff care practices we saw. Staff listened to what people had to say. They valued people's opinions and acted on them if required, rather than just meeting people's basic needs. They also provided support in a friendly, caring and helpful way. One person told us, "Staff are nice."

The body language of the person at home and those who lived next door was positive throughout our visit. This indicated that they were happy with the way staff delivered care.

During our visit staff demonstrated skill, patience and knew the people, their needs and preferences well. People's needs were well met and they were encouraged to make decisions about their lives. Staff communicated with people in a way that made sure people understood. They asked what people wanted to do, where they wanted to go and who with. This included the type of activities they liked. These were also discussed with staff during keyworker sessions and at staff meetings.

The home provided care focussed on the individual and we saw staff put into practice training to promote a person centred approach. People and their relatives were enabled to discuss their choices, options and contribute to their care and care plans. The care plans were developed with them and had been signed by people or their representatives where practicable. Staff were warm, encouraging and approachable. Where people had difficulty expressing themselves staff listened carefully and made sure they understood what the person was saying. One person said, "I like living here, everyone will be back soon."

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of the person using the service.

Staff had received training about respecting people's rights, dignity and treating them with respect. This was reflected in the caring, compassionate and respectful support staff provided. There was a relaxed, inclusive and fun atmosphere that people enjoyed due to the approach of the staff. The home had a confidentiality policy and procedure that staff said they understood, were made aware of and followed. Confidentiality was included in induction and ongoing training and contained in the staff handbook.

Good

Is the service responsive?

Our findings

People and their relatives said they were enabled to make decisions about their care and the activities they wanted to do. Staff understood people's needs and wishes and met them. Their needs were met in a way that people enjoyed and were comfortable with. They were asked for their views by the home's management team and staff. During our visit people were encouraged to give their views, opinions and make choices by staff and the manager. Staff enabled people to decide things for themselves, listened to them and took action if needed. Staff were available to people to discuss any wishes or concerns they might have and to support them. Needs were met and support provided promptly and appropriately. One person said, "I get to do what I want." A relative said, "The care and support is what (Person using the service) needs." A relative said, "The home engages well with parents, they hold meetings and encourage our involvement in the care and value our contribution." Another relative told us, "We have social gatherings such as the Christmas party and summer barbecue."

We saw that staff met peoples' needs in an appropriate and timely way. People were given the opportunity to decide what support they wanted and when. The appropriateness of the support was reflected in the positive responses of people using the service. If people had a problem, it was resolved quickly and in an appropriate way. Any concerns or discomfort displayed by people using the service were resolved during our visit.

People and their relatives were consulted and involved in the decision-making process before moving in. They were invited to visit as many times as they wished before deciding if they wanted to live at the home. Staff told us about the importance of recognising the views of people using the service as well as relatives so that care and support could be focussed on the individual. They said it was also important to get the views of people already living at the home. During the course of people visiting the manager and staff added to the assessment information.

People were referred by the local authority who provided assessment information. Information from any previous placements was also requested if available. This information was shared with the home's staff by the management team to identify if people's needs could initially be met. The home then carried out its own pre-admission needs assessments with the person and their relatives.

Written information about the home and organisation was provided and regular reviews took place to check that the placement was working, once people had moved in. If the placement was not working alternatives were discussed and information provided about prospective services where needs might be better met.

People's care plans were part pictorial to make them easier for people to understand. Where possible pictures of themselves were used so they could better identify the meaning of the information and this gave them a 'starring role.' The care plans recorded people's interests, hobbies, health and life skill needs and the support required for them to be fulfilled. They were focussed on the individual and contained people's 'social and life histories'. These were live documents that were added to by people using the service and staff when new information became available. The information gave the home, staff and people using the

service the opportunity to identify activities they may wish to do. People's needs were regularly reviewed, re-assessed with them and their relatives and re-structured to meet their changing needs. The plans were individualised, person focused and developed by identified lead keyworker staff. The reviews took place between people and their keyworkers three monthly. People were encouraged to take ownership of the plans and contribute to them as much or as little as they wished. They agreed goals with staff that were reviewed, underpinned by risk assessments and daily notes confirmed that identified activities had taken place.

Activities were a combination of individual and group with a balance between home and the community. Each person had their own weekly activity planner. One person said, "I like Rocky, they had a CD of Rocky music and was dressed in a Rocky boxing robe. The person also told us that they had been to the park with their mum" The home made use of local community based activities wherever possible and people chose if they wanted to do them individually or as a group. There were also group and individual holidays with people having chosen a holiday in Somerset this year. Activities included college where people did line dancing, gardening and sign and speak and day centres where sensory and music therapy sessions took place. Other activities included going out with relatives, massage, 1-2-1 club and outings. The outings included trips to Virginia Water, airports and Guildford for lunch. There were also barbecues that relatives were invited to. The home also had its own transport.

People and their relatives knew about the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon, learnt from by the home with care and support being adjusted accordingly. There was a whistle-blowing procedure that staff said they would be comfortable using. They were also aware of their duty to enable people using the service to make complaints or raise concerns.

The home and organisation used different methods to provide information and listen and respond to people and their relatives. There were monthly house forums and weekly menu planning meetings where people could express their views. A menu planning meeting took place during the inspection. There were ten weekly relatives meetings and six monthly telephone and written surveys.

Good

Is the service well-led?

Our findings

People and their relatives told us that they were made to feel comfortable by the manager and staff and were happy to approach them if they had any concerns. One relative said, "I'm really happy with the manager and deputy, they are committed and outstanding." Another relative told us, "There is an open door policy which is very good." During our visit, we found that the home had an open culture with staff and the manager listening to people's views and acting upon them.

The organisation's vision and values were clearly set out. Staff we spoke with understood them and said they were explained during induction training and revisited during staff meetings. The management and staff practices we saw reflected the organisation's stated vision and values as they went about their duties. There was a culture of supportive, clear, honest and enabling leadership.

There were clear lines of communication within the home and specific areas of responsibility. Staff told us the support they received from the manager was good, they did not comment on the support that the organisation provided. They felt suggestions they made to improve the service were listened to and given serious consideration. One member of staff said, "The manager is an amazing person, very good." Another staff member told us, "I really enjoy working here." The management was honest, transparent and there was a whistle-blowing procedure that staff felt confident in.

There were regular minuted home and staff meetings that enabled everyone to voice their opinion. The records demonstrated that regular staff supervision and appraisals took place and this was confirmed by staff.

There was a policy and procedure in place to inform other services, such as district nurses, of relevant information should services within the community or elsewhere be required. The records showed that safeguarding alerts, accidents and incidents were fully investigated, documented and procedures followed correctly including hospital admissions. Our records told us that appropriate notifications were made to the Care Quality Commission in a timely way.

There was a robust quality assurance system that contained performance indicators that identified how the home was performing, any areas that required improvement and areas where the home was performing well. This enabled required improvements to be made. Areas of particular good practice were also recognised by the provider.

The home used a range of methods to identify service quality. There were compliance audits that included, files maintenance, care plans, night reports, risk assessments, infection control, the building, equipment and medicine. There was also health and safety checks were carried out to ensure safety with regard to premises, food hygiene, equipment, infection control and clinical waste. There were weekly and monthly medicine audits in place, to ensure that staff were following the procedures for administration, recording, storing and disposal of medication. All lifting equipment had the require checks every six months. Electrical equipment was safety tested and Legionella testing was done annually. Fire alarm systems and emergency

lighting were serviced every six months and the fire equipment was checked annually by an external agency. An annual health and safety audit of the premises took place. Shift handovers included information about each person that enabled staff coming on duty to be aware of anything they needed to know.