Pathways Care Group Limited

Northleigh

Inspection report

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Tel: 01536312138

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on 11 May 2016. This residential care service is registered to provide accommodation and personal care support for up to twelve people with learning disabilities. At the time of the inspection there were three people living at the home.

There was a registered manager in post at the time of our inspection; however they were not available on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's privacy and dignity was not always protected and promoted. There were many occasions when people's confidential information was discussed in front of other people who used the service.

The systems in place for monitoring the quality of the service delivery were not always effective. There were issues relating to records which were out of date and inaccurate.

People felt safe in their own home. Staff understood the need to protect people from harm and abuse and knew what action they should take if they had any concerns.

Staffing levels ensured that people received the support they required at the times they needed. There were sufficient staff to meet the needs of the people and recruitment procedures protected people from receiving unsafe care from care staff unsuited to the job.

People received care from staff that were supported to carry out their roles to meet the assessed needs of people living at the home. Staff received training in areas that enabled them to understand and meet the care needs of each person.

Care records contained risk assessments and risk management plans to protect people from identified risks and helped to keep them safe but also enabled positive risk taking. They gave information for staff on the identified risk and informed staff on the measures to take to minimise any risks.

People were supported to take their medicines as prescribed. Records showed that medicines were obtained, stored, administered and disposed of safely. People were supported to maintain good health and had access to healthcare services when needed.

People were actively involved in decisions about their care and support needs. There were formal systems in place to assess people's capacity for decision making under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Care plans were written in a person centred approach and focussed on empowering people; personal choice, ownership for decisions and people being in control of their life. They detailed how people wished to be supported and people were fully involved in making decisions about their care. People participated in a range of activities both in the home and in the community and received the support they needed to help them do this. People were able to choose where they spent their time and what they did.

People had caring relationships with the staff that supported them. Complaints were appropriately investigated and action was taken to make improvements to the service when this was found to be necessary. Staff and people were confident that issues would be addressed and that any concerns they had would be listened to.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 felt safe and comfortable in the home and staff were clear on their roles and responsibilities to safeguard them.

Risk assessments were in place and were continually reviewed and managed in a way which enabled people to safely pursue their independence and receive safe support.

Safe recruitment practices were in place and staffing levels ensured that people's care and support needs were safely met.

There were systems in place to manage medicines in a safe way and people were supported to take their prescribed medicines.

Is the service effective?

Good

The service was effective.

People were actively involved in decisions about their care and support needs and how they spent their day. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People received personalised care and support. Staff received training to
ensure they had the skills and knowledge to support people appropriately and in the way that they preferred.

Peoples physical and mental health needs were kept under regular review.
People were supported to access relevant health and social care professionals to ensure they received the care, support and treatment that they needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always protected and promoted.

There were positive interactions between people living at the home and staff.

Staff had a good understanding of people's needs and preferences and enabled people's communication through the use of pictorial aids.

Staff promoted people's independence to ensure people were as involved as possible in the daily running of the home.

Is the service responsive?

Good

This service was responsive.

People were listened to, their views were acknowledged and acted upon and care and support was delivered in the way that people chose and preferred.

People were supported to engage in activities that reflected their interests and supported their physical and mental well-being.

People using the service and their relatives knew how to raise a concern or
make a complaint. There was a complaints system in place and complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

This service was not always well-led.

The systems in place to monitor the quality and safety of the service were not effective. There was lack of managerial oversight of the service.

A registered manager was in post and they were active and visible in the home. They worked alongside staff and offered regular support and guidance.

People living in the home, their relatives and staff were confident in the management of the home. They were supported and encouraged to provide feedback about the 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11th May 2016 and was unannounced and undertaken by one inspector.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

During this inspection we spoke with three people who lived in the home, six care staff and the visiting manager from another service operated by the same provider.

We reviewed the care records of three people who used the service. We looked at six records in relation to staff recruitment and training, as well as records related to the quality monitoring of the service.

Good

Is the service safe?

Our findings

People felt safe where they lived. One person said "I'm happy living here, I like all the staff; everything about them." It was clear through observation and general interaction that people felt safe and comfortable in the home.

Staff were aware of their roles and responsibilities in protecting people from harm and had access to appropriate policies and procedures. Staff had received training in safeguarding and were aware of the various forms of abuse and the action they would take if they had any concerns. One care staff said "I would have no concerns reporting anything that I didn't feel was right; including to the local authority" We saw from records on staff training that all staff had undertaken training in safeguarding. Staff said they had not needed to report any concerns but would not hesitate to report abuse if they saw or heard anything that put people at risk.

People were enabled to take risks and staff ensured that they understood what measures needed to be taken to help them remain safe. A range of risks were assessed to minimise the likelihood of people receiving unsafe care, for example supporting people who may have high anxiety levels when in the community. Individual plans of care were reviewed on a regular basis to ensure that risk assessments and care plans were updated regularly or as changes occurred. One member of staff said "Risk assessments help you recognise the potential risks for people and if we know them we can act upon them."

When accidents had occurred the manager and staff had taken appropriate timely action to ensure that people received prompt and safe treatment. Training records confirmed that all staff were trained in emergency first aid. Accidents and incidents were regularly reviewed to observe for any incident trends and control measures were put in place to minimise the risks.

There were sufficient staff available to provide people's care and support. We looked at the staff rota for the week and saw there was enough staff to support people with their planned activities. One care staff said "I think the staffing levels here are good; we also cover for each other if other staff are on holiday." We observed that there were enough staff to attend to people's needs and to be relaxed with them during our inspection visit.

People's medicines were safely managed. Staff had received training in the safe administration, storage and disposal of medicines. One person said "I get my tablets on time and my inhalers." Staff had arranged for people to receive liquid medicines where they found swallowing tablets difficult. Staff followed guidelines for medicines that were only given at times when they were needed for example Paracetamol for when people were in pain. There were regular medicines audits, where actions had been taken to improve practice and staff were required to undertake regular competency assessments.

The provider had effective recruitment systems in place to protect people from the risks associated with the appointment of new staff. Staff told us that required checks and references had been obtained before they were allowed to start working in the home. Staff files were in good order and contained all of the required

information.

Good

Is the service effective?

Our findings

People received care from staff who had the knowledge and skills needed to carry out their roles and responsibilities effectively.

New staff received a thorough induction which included classroom based learning and shadowing experienced members of the staff team. The induction was comprehensive and included key topics on Autism, managing behaviour that may challenge and epilepsy. The induction was focussed on the whole team approach to support people to achieve the best outcomes for them. One staff member told us "My induction was a long while ago but I know we went through lots of information and policies and procedures."

Training was delivered using face to face and e-learning modules and the provider's mandatory training was refreshed annually. Staff we spoke with were positive about the training they received and confirmed that the training was a combination of online and classroom based training. One staff member said "We have the normal training (provider's mandatory training) but we also have specialist training for example; dementia training specific to learning disabilities." Training was also available from the Community Team for People with Learning Disabilities (CTPLD) for individual needs specific to learning disabilities. Staff were provided with the opportunity to obtain a recognised care qualification through the Qualifications and Credit Framework (QCF).

People's needs were met by staff who received supervision and received an annual appraisal. We saw that supervision meetings were available to all staff employed at the home, including permanent and 'bank' members of staff; however, the timing of these meetings were not in line with the providers own policy. The meetings were used to assess staff performance and identify ongoing support and training needs. One care staff said "I have regular supervision; we go through any on-line training questions, talk about any issues and general updates about the people we support." Another care staff said "I haven't had formal supervision for 6 months but I can ask the manager anything at any time."

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 saw that the service was working within the principles of the MCA. The management team and staff were aware of their responsibilities under the MCA and the DoLS Code of Practice. Best interest decisions had been recorded in care plans and people had been included in these decisions. We saw that applications had been made for people who required a DoLS to be in place and they were waiting for the formal assessments to take place.

People were supported to eat a balanced diet that promoted healthy eating. Meals and mealtimes were arranged so that people had time and space to eat in comfort and at their own speed and liking. People were relaxed at shared mealtimes and had made choices about their menu using picture cards. One person said "I like the food and I can have something different if I want."

The staff team were knowledgeable about people's food preferences and dietary needs, they were aware of good practice in relation to food hygiene and this was promoted by signage around the kitchen. All the people living in the house had nutritional plans which were detailed and gave staff information on how to support people. Staff were aware of how to refer people to the Speech and Language Therapy Team if they had difficulties with swallowing food and if required referrals were made to the NHS Dietician.

People's healthcare needs were carefully monitored and detailed care planning ensured staff had information on how care should be delivered effectively. Care records showed that people had access to community nurses, condition specific nurses and GP's; referrals had been made to specialist services when required. People received a full annual health check-up and had 'helping me in hospital' booklets in place which identified clearly for hospital staff what support a person required. Care files contained detailed information on visits to health professionals and outcomes of these visits including any follow up appointments.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity was not always protected and promoted. There were many occasions when people's confidential information was discussed in front of other people who used the service. The main dining room and seating area was the 'hub' of the home and people sat in this area throughout the day. This was also the area where staff received and made phone calls. On one occasion a member of care staff telephoned the hospital to enquire on the wellbeing of a person who had been admitted a couple of days previously and openly discussed the persons ill health and other confidential information in front of other people who were sitting in this area. Another person had a pre booked GP appointment and the care staff talked about the details of the appointment and the reasons why the person was attending in front of another person who used the service. On other occasions care staff spoke about people's personal care needs and other people's behaviour that may be challenging in front of other people who used the service.

This was a breach of Regulation 10 (1) Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were happy with the care and support they received. They told us they liked the staff and one person said "The staff are really kind to me and they take me out shopping and we go to a coffee shop." Staff demonstrated a good knowledge and understanding about the people they cared for. The staff were able to tell us about each person's individual choices and preferences. People had developed positive relationships with staff and they felt supported by them. One person said "I like it when [staff member] is working with me because she helps me with my jigsaw's; I really like her."

People were involved in personalising their own bedroom and living areas so that they had items around them that they treasured and had meaning to them. One person took us to the main lounge and showed us pictures of outings that they had been on that were proudly on display in the wall and over the fireplace.

People were encouraged to express their views and to make their own choices. People were supported to wear clothes they liked and staff explained that if people were unable to verbally communicate they presented them with the physical options to support them to make their choices. There was information in people's care plans about what they liked to do for themselves. This included how they wanted to spend their time or if they had preferences about how to receive their care, for example by male or female members of staff. Staff had a good knowledge of people's preferences and these were respected and accommodated by the staff team.

Each person had an identified key worker, a named member of staff. They were responsible for ensuring information in the person's care plan was current and up to date and they spent time with them individually.

There was information on advocacy services which was available for people and their relatives to view. People had easy read guides on advocacy and how to access the services in their care plans. No one currently living at the home used an independent advocate but staff were knowledgeable about how to refer

people to advocacy services and what advocacy services could offer people.

Visitors, such as relatives and people's friends, were encouraged and made welcome. People told us that their families could visit when they want and they could speak with them in the lounge area or their bedrooms.

Good

Is the service responsive?

Our findings

People's care and treatment was planned and delivered in line with people's individual preferences and choices. Information about people's past history, where they lived when they were younger and what interested them, featured in the care plans. The care staff used the care plans to guide them when providing person centred care. People living in the home had one page profiles which detailed a summary of information of what interests they had and how they liked to be supported. This information enabled care staff to personalise the care they provided to each individual, particularly for those people who were less able to say how they preferred to receive the care they needed. For example; what people's preferred name was and if people had a certain routine.

People had person centred plans which detailed things that were important to know about each person, who was important to people in their life and goals and wishes they wanted to achieve. This information enabled care staff to deliver personalised support individual to each person. Care plans contained information in an easy read format. For example: how to support people with their finances, information on people's right to vote.

Care plans were detailed and comprehensive and contained lots of information on how to support people, their preferred way of being cared for and lots of easy read information. However they were not always up to date or accurately reflected peoples care and support needs. The care staff we spoke with confirmed the information held in the care plan was inaccurate but did reassure us that they knew peoples care needs well. For example; care staff knew that one person was not able to go out independently because of their lack of road safety awareness.

The risk of people becoming withdrawn and lonely within the home was minimised. People were encouraged to join in regular activities such as cooking, DVD nights, board games, cake baking, beauty treatments, jigsaw's, listening to the radio and various games. Care staff made efforts to engage people's interest in what was happening in the wider world and local community by talking about topics in the local and national media and supporting people to local events.

Staff were responsive to people's needs. They spent time with people and responded quickly if people needed any support. Staff were always on hand to speak and interact with people and we observed staff checking with people that they were comfortable and asking them if they wanted any assistance. Staff knew people well and were able to understand people's needs from their body language and from their own communication style; this was also documented really clearly in peoples individual care plans.

People participated in a range of activities including attending a day service for adults with learning disabilities, day trips to the coast, meals out, swimming, local club, bowling, disco's, holidays and spending time on overnight stays with family members. One person said "I love going to the Kaleidoscope club; I meet my friends there." People had the option of having a day at home each week to receive support on a one to one basis to attend appointments, visit the shops and anything else they had planned to do.

When people came to live in the home they and their representatives were provided with the information they needed about what do if they had a complaint. The complaints information was written in an easy read format so people who used the service were able to access it. Where people could not speak for themselves, staff were aware they needed to be vigilant in observing changes in behaviours and body language that would indicate that a person was unhappy with their care. There were arrangements in place to record complaints that had been raised and what action had been taken about resolving the issues of concern. We saw that complaints that had been raised were responded to appropriately and in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

The systems in place for monitoring the quality of the service delivery were not always used effectively. Records relating to fire safety had not been completed for some time. The fire escape routes had not been signed to evidence they had been checked for eight months and the last recorded fire drill was over twelve months ago. Care staff told us the checks had taken place but because the book that records this information had run out they hadn't been recording it. This had not been identified on any of the registered managers quality audits of the service.

Care plans and risk assessments did not always contain accurate information. For example: one person's care plan stated they were aware of the dangers involved with road safety, but their risk assessment stated they were not aware of road safety. Another person's care plan stated they were not prescribed any medication from their GP; however this person had always taken prescribed medicine since they moved in to the home. On both occasions the care staff knew what information was accurate and supported the person appropriately and it was confirmed the care plans and risk assessments were inaccurate.

Although staff felt supported, there was a big variance in how often the providers policy stated supervision should take place and what actually happened in practice. One care staff had not received supervision that was recorded for eleven months, another staff for ten months and another staff for nine months. The provider's policy states supervision should take place every other month.

People were supported by named keyworkers who had planned one to one time with the person to talk about changes to their care plan, planning activities and what was going well. This keyworker time was called 'monthly keyworker meeting' and should have happened on a monthly basis. However we saw that this did not happen in practice. One person only had two meetings in 2015. Another person had one meeting in January 2016 and none since that time. Care staff told us that people had received this quality time but this had failed to be recorded.

The providers own systems for monitoring the quality and safety of the service were not effective, there was poor managerial oversight of the service and none of these issues had been identified by the registered manager in their own audits.

This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff spoke positively about the registered manager and said they were supportive and approachable and any concerns about the people who used the service could be talked through straight away and proactive steps were taken to address any issues raised.

People using the service and their relatives were encouraged and enabled to provide feedback about their experience of care and about how the service could be improved. Feedback was very positive. All the people who used the service said they knew who they could talk to if they were not happy about something and

everyone said they felt treated with kindness and respect.

The culture within the service focused upon supporting people's health and well-being and for people to participate in activities that they chose and to enhance people's overall quality of life. All of the staff we spoke with were committed to providing a good standard of personalised care and support and they were always focussed on the outcomes for the people who used the service.

Staff meetings took place on a regular basis and minutes of these meetings were kept. Staff said the meetings enabled them to discuss issues openly and was also used as an information sharing session with the manager and the rest of the staff team. The registered manager worked alongside staff so they were able to observe their practice and monitor their attitudes, values and behaviour.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not always protected and promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers own systems for monitoring the quality and safety of the service were not effective, there was poor managerial oversight of the service.