The Regard Partnership Limited

Inglewood House

Inspection report

Inglewood House
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 18 and 19 October 2016. The first day of the inspection was unannounced. Inglewood House provides accommodation for up to 12 people with a learning disability who may have an additional health diagnosis.

The service had a registered manager in post. 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 living in Inglewood House were safe. Staff working in the service had received safeguarding training and understood the provider's procedures for protecting people from abuse. People's risks of avoidable harm were reduced as a result of risk assessments. The provider's recruitment procedures were robust and there were sufficient numbers of staff to support people safely. People received their medicines safely and staff protected people by employing effective infection control measures.

People received effective care delivered by trained and supervised staff. Staff received training to meet people's specific needs and met regularly with the manager to discuss their delivery of care and support. People consented to their care and their rights under legislation were upheld. People ate well and those who required support to eat had assessments and care plans to ensure they swallowed food and drink safely. People were supported to access health and social care professionals in a timely manner.

People were supported by kind and caring staff. People were treated with dignity and respect and their privacy was protected. People who were approaching the end of their lives were cared for in a compassionate and person centred way.

People's needs were assessed and care plans were written to guide staff how to meet them. People had person centred plans which detailed their individual preferences. People chose the activities they participated in understood how to make a complaint if they had any concerns.

The manager demonstrated an open management style and staff felt supported. The quality of care being delivered to people was robustly audited. There were systems in place to monitor, review, and make improvements to the service. The service worked in partnership with health and social care professionals.

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. Staff received safeguarding training and knew what to do if they suspected abuse.

People were protected from avoidable harm because assessments were in place to reduce known risks.

There were enough safely recruited staff to meet people's needs.

People received their medicines safely and as prescribed.

The home was clean and the appropriate infection control practices were evident.

Is the service effective?

Good

The service was effective. People were supported by trained and knowledgeable staff.

Staff received supervision and support from the registered manager.

People were treated in line with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported to eat nutritious meals and were given the support they required to eat.

People accessed healthcare services and professionals as their needs required.

Is the service caring?

Good

The service was caring. People and their relatives told us the staff were caring.

People's privacy and dignity were protected.

People were supported compassionately as they approached the end of their lives.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and reassessed when their needs changed.

People were involved in developing their care plans and person centred plans.

People were supported to participate in activities of their choosing.

The service actively sought feedback from people and their relatives.

Is the service well-led?

Good

The service was well-led. People and staff felt the management team were open and approachable.

Robust quality assurance processes were in place.

The staff understood their roles and the management arrangements within the service.

The service worked alongside and in partnership with local agencies to ensure the best outcomes for people.

Inglewood House

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 unannounced inspection took place on 18 and 19 October 2016. It was undertaken by one inspector.

Prior to the inspection we reviewed the information we held about Inglewood House including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used this information in the planning of the inspection.

During the inspection we spoke with four people, one relative, three staff, the deputy manager, registered manager, locality manager and the provider's quality assurance manager. We reviewed nine people's care records, risk assessments and medicines administration records. We reviewed 11 staff files which included pre-employment checks, training records and supervision notes. We read the provider's quality assurance information and audits. We looked at complaints and compliments from people and their relatives.

Following the inspection we spoke with a second relative and contacted six health and social care professionals to gather their views about the service people were receiving.

Good

Is the service safe?

Our findings

People living at the service felt safe. One person told us, "I feel safe here." Another person said, "I have lived here all these years and I've never had any problems. I would tell staff if I had any and they would sort them out." One relative told us, "I have great confidence in the staff that they will keep my [relative] safe. Another relative said, "I used to worry at first, which you do because of the things you here about care homes. But the staff are lovely and caring and the manager runs a tight ship. I am so pleased."

The risk of people being abused was reduced because staff received training to identify signs of abuse and knew what actions to take if they suspected it. One member of staff told us, "I would make sure they [the person] were ok and inform my manager immediately." Another member of staff said, "Straight away I would tell my manager or locality manager and I would be ready to give evidence to the police and social workers."

People were protected from the risk of avoidable harm. Staff assessed people's risks and care plans were written to manage risks. Risk management plans were periodically reviewed or when people's risks changed. People at risk of pressure ulcers were supported with assessment and risk management plans. These guided staff as to the actions to be taken throughout the day to prevent pressure sores. This included regularly supporting people to stand and to change positions when seated. People at risk of malnutrition had their weight monitored. If people lost half a stone within a three month period a referral would be made to the GP and dietetic services. This meant people's risks were identified and plans were in place to mitigate them.

People were supported by suitable care staff. Staff were recruited using procedures that were safe. These included, interviewing candidates and taking up two references for those who were successful. Before staff began their employment their identities, addresses and fitness to work were confirmed and their details were checked against criminal records and barring list data bases. New staff were subject to a six month probation period which was extended if their suitability to deliver care and support had not been demonstrated.

There were enough staff available throughout the day to keep people safe and meet their needs. At night there were two waking staff. Staff had access to management for guidance outside of office hours. An on-call service with two tiers of management operated overnight and at weekends. This meant people were supported by staff with continuous management support.

People received their medicines safely and as prescribed. All staff received training to administer medicines to people however, only senior staff administered medicines to people. Medicine Administration Records (MAR) charts were signed by staff to record people had received the right medicines at the right time. Junior staff signed witness sheets to confirm they had observed their colleagues administering medicines to people in line with the provider's procedures. Medicines were stored safely in a locked cabinet and the manager audited them weekly. GP's supported people with regular medicines reviews to ensure prescribed medicines continued to meet people's needs.

People's safety was enhanced by the plans to protect them in the event of an emergency. People had individualised Personal Emergency Evacuation Plans (PEEPs). These noted people's ability to independently respond to an emergency and the support they required to be safe. For example, one person required staff to support them in their wheelchair to the nearest exit. Staff supported people to regularly rehearse building evacuations. Additionally staff undertook regular visual checks of the service's fire doors, fire fighting equipment and emergency lighting. They also tested fire alarm call points and the fire alarm panel. This meant people were safe as a result of the service's preparedness to respond to an emergency.

People were protected from avoidable infection. Staff followed appropriate hygiene practices when delivering care and support. Staff used personal protective equipment (PPE) when providing personal care. For example, staff wore single use gloves when supporting people to shower. In the kitchen staff used colour coded chopping boards for separate food types to avoid cross contamination. The home was free of unpleasant smells. One relative told us, "It's immaculately clean all the time". There was hand wash and paper towels in each of the bathrooms and toilets we viewed.

Good

Is the service effective?

Our findings

People received care and support from staff trained to meet their specific needs. Staff received on-going mandatory training in topics that included diet and nutrition, mental capacity, first aid and safeguarding. The registered manager also ensured staff received training relating to people's individual needs. For example, staff undertook epilepsy, diabetes, autism, dementia and end of life care training. This meant people were supported by staff with up to date knowledge.

New staff joining the team progressed through an induction programme. This included shadowing experienced staff and observing good practice in delivering support as well as new staff familiarising themselves with people's needs and care records.

People gave consent to the care and support they received. One person told us, "Staff always ask me what do I think about things and do I agree." Another person told us, "They [staff] say '[person's name] shall we get ready and go into town' and I say yes to them." People that were able to signed their care records. Were people had been unable to give consent they had been supported with best interest meetings.

People's rights were upheld in line with legislation. We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These aim to make sure that people in care homes are looked after in a way that does not deprive them of their liberty and ensures that people are supported to make decisions relating to the care they receive. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and lawful manner. We found that were DoLS authorisations had been approved by the local authority the service had ensured the appropriate assessment processes had been undertaken and documented.

People's communication needs were assessed, identified and met. Staff supported people to develop individual communication passports. These person-centred documents informed staff about people's preferences for expressing themselves. For example, one person's communication passport noted that, "[The person] will take you by the hand to the kitchen if [they] want a drink". A member of staff told us, "It is particularly important to write down and review the way non-verbal people communicate so that all the staff, particularly the new ones understand." People's individual activity timetables were produced in a pictorial format to make them more readily understood.

People told us they chose the food they ate and enjoyed it. One person told us, "Breakfast, lunches and dinners are great. I like them lots." Another person said, "We choose the dinners and the menus at the residents meetings." People were supported to eat a varied and balanced diet. People who needed assistance to eat were supported by staff in line with their care plans.

People were supported to access health and social care professionals as their needs required. We found people had been supported with referrals to a range of therapeutic disciplines when their needs changed. For example, when staff observed people having difficulty eating they were supported with referrals to

speech and language therapists (SALT) who undertook swallow safety assessments. We observed at mealtimes that staff implemented SALT recommendations by serving people food of the appropriate consistency and adding thickening agents to liquids.

The environment created by staff within the home met people's mobility needs. The service had a number of aids and adaptations to support people's mobility. For example, there was a seated stair lift from the ground floor to the first floor, walk in showers within wet rooms, a hoist for assisting people to transfer to and from their beds and grab rails in toilets.

Good

Is the service caring?

Our findings

People, their relatives and healthcare professionals told us the staff were kind and caring. One person told us, "The staff are very nice and lovely." Another person said, "The staff are kind and good to me. I like them very much." A relative told us, "I couldn't be happier with the staff. I'd praise them to the hilt. They've really looked out for [person's name] all these years." A healthcare professional told us, "I have noted that they appear to know [person] well and genuinely care about [their] needs and preferences."

People and their relatives told us that staff knew people well. Staff were able to tell us about people's interests, hobbies and backgrounds and the information in care records. Care records contained information which gave staff insight into people's feelings and views. People were supported with person centred plans (PCPs). Sections within PCPs informed staff about people's preferences. These included, "Important people in my life", "Things that I would like you to know about me" and "Things I am good at." This meant people's strengths were highlighted.

People were supported to maintain relationships that were important to them. Relatives told us staff kept them abreast of events and developments involving their relative and the care home and said they were made to feel welcome when they visited.

Over both days of the inspection we observed warm and respectful interactions between people and staff. We saw staff talking with people about issues that were important to them, dancing with people during a disco session, supporting people to eat, sharing jokes and laughing together.

Staff promoted people's privacy. People told us that staff knocked their doors before entering their bedrooms. People and their relatives were given space to meet when they wanted privacy. A relative told us, "I have only ever seen the staff being respectful to [people] and me." Staff referred to by their preferred names and these were stated in care records.

People chose how their bedrooms were decorated. One person told us," I have my room just as I want it. I have the photographs I want and it looks like I want it to." Another person said, "My room is good. I decided how it should look. My favourite things are my tele and my mini fridge." Another person chose butterfly designs for their bedroom wall. This meant people were supported to feel ownership of their bedrooms and to personalise them as they chose.

People told us they made decisions about how they were supported. One person told us, "I don't have a bedtime or a getting up time or anything like that." One person's care records stated, "[person] will usually wake between 5 and 6am. Another person's noted that they, " Wake independently between 8 and 10am." Whilst a third person's care records noted they liked to have their breakfast in bed. This meant support was delivered when people wanted it.

People approaching the end of their life were supported sensitively. People who were dying had end of life care plans. These stated people's preferences for care under headings which included, "How I would like to

be remembered". Within a section entitled "What a good day looks like" one person's end of life care plan noted, "no pain, interacting with peers…eating and drinking well". Staff made referrals to healthcare professionals to ensure people received specialist support.
People benefited from the involvement of their GP, district nurse and a local hospice. The manager and district nurse ensured plans were in place for the administration of anticipatory medicines to ensure people entering the final phase of palliative care were free of pain. This meant people were supported with dignity and compassion.

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their individual needs. People's needs were assessed prior to receiving a service and at regular intervals thereafter and when people's needs changed. People, their relatives and health and social care professionals participated in assessments and reassessments. One person told us, "I love it here and I never want to leave. The staff look after us super and I do lots." A relative told us, "My [relative] was in and out of so many places before settling down here. It's such a relief. I'm so thankful".

People were supported to participate in the activities they enjoyed. Care records noted people's hobbies and interests. One person told us, "I like the disco and karaoke here. I like to get up and sing." A third person told us, "I am very good at golf [on Wii]. I like the things we do here and I like it at college. Another person said, "I am good with animals so I have a pet rabbit and I have been good at looking after our dog for 11 years." Other activities people engaged in included, bowling, swimming , walking, going to the cinema and Gateway club. Six people attended college where they participated in activities including crafts, sports, pottery and cooking. While five people attended a day centre where activities included, crafts and horse riding. This meant people's activities were person centred.

People were supported to engage in therapeutic activities whilst at home. People received visits and treatments from a reflexologist. People told us they enjoyed using the service's sensory room. This room contained tactile, audio and visual equipment including lighting and bubble effect machines. One person told us, "Vibrating cushions are really good." Another person said, "The big bean bags in [the sensory room] are even better than armchairs."

Staff supported people to develop their independence. One person told us, "Staff always say 'can you do it [person's name] or would you like a little help?' I like to do as much as I can for myself." People's abilities and support needs were noted in care records. For example, one person's care records noted that they preferred to keep their money on their person when in the community but required staff assistance to complete transactions. This meant the person was supported to maintain independence whilst being protected against financial abuse.

People told us they were involved in planning their day to day support. The service used a keyworking system. Keyworkers are members of staff with specific responsibilities for ensuring that individual people's needs are met. For example, keyworkers coordinated healthcare appointments, planned activities and personal shopping with people and liaised with their families. One person told us, "I talk with my keyworker about what I'm going to do. We talk about going on holiday. That's good. We talk about it for a long, long time before I go." Keyworkers met with people each month and recorded their discussion and agreements in care records and collated information for review meetings and reassessments with health and social care professionals.

The provider actively sought the views of people and their relatives through surveys which were circulated every three months. The registered manager reviewed the results and took action to improve the service

based upon the findings. People were supported to hold monthly residents meetings to discuss service delivery. Residents meetings were chaired by a person living in the service and minutes were taken for future reference by staff. This meant a record was maintained of people's views and decisions.

People told us they knew how to raise a concern or to make a complaint. One person told us, "I would tell the manager if I had a complaint." Another person said, "I would tell my mum and dad and we would tell the staff and the manager." People had information in a booklet entitled, "Speaking Out!" The pictorial document was produced in large print with short sentences and gave people clear advice. For example, with the booklet it said, "When can I make a complaint? – Anytime!" This meant people had accessible information and a clear understanding about how to make a complaint. Complaints raised had been dealt with appropriately and in line with the provider's complaints policy.

Good

Is the service well-led?

Our findings

People and their relatives told us the service was well-led. One person told us, "[The registered manager] is a lovely lady. I always tell her what's on my mind because she will talk to me. About it." Another person said, "I can dance better than her but she is fun and she cares about me." One relative told us, "I have complete confidence in [the manager and deputy] they are really caring, they're open. They have really got to know [relatives name] and I'm so happy and grateful. [Relative's] life has been all the better for them being here."

Staff expressed confidence in the registered manager and deputy. One member of staff told us, "[The registered manager leads by example. She never asks us to do anything she wouldn't do. She is a role model." Another member of staff said, "[The registered manager] is really good. She's open. She listens and she's hands on. She doesn't shirk work. For example, she gives people personal care each morning." A third member of staff told us, "[the registered manager] has good management skills. They are the reason I have worked here so long."

Management arrangements in the service were clear. The service was led by a registered manager assisted by a deputy. They were supported by three senior staff. The manager and deputy had worked in the service for 15 and 14 years respectively. This meant people were supported in a service led by managers who knew them well.

The registered manager promoted a learning culture. Staff received mandatory, refresher and specialist training. We read the manager and staff discussed training for personal development during supervision and appraisal. In the staff office the manager had collated information into resource packs for staff. These packs included material about dementia, Alzheimer's, autism and epilepsy along with the locations of sources of further information.This meant staff had information about the specific health needs of people.

The registered manager and provider monitored quality at the service. The manager and deputy ensured that regular checks were made. For example, checks were made of medicine administration and health and safety. The manager regularly reviewed care records including, assessments, care plans, guidelines and risk assessments to ensure they were accurate and up to date. In addition the provider coordinated further quality assurance checks including quarterly audits by an external agency and checks undertaken by the locality manager. On the first day of our inspection the provider's quality assurance manager was carrying out an audit. From each of the quality audits action plans were created to ensure shortfalls were addressed. This meant that people received care and support delivered by a robustly audited service.

The registered manager understood the legal responsibilities of the registration with CQC and the requirement to keep us informed of important events through notifications when required.

The service worked in partnership with health and social care providers. Records showed staff worked in collaboration with social workers, speech and language therapists, palliative care specialists, occupational therapists, general practitioners and district nurses to support people's changing needs. This meant people received the timely input they required from health and social care professionals to ensure their needs were

met.