The Papworth Trust

Block B, Flats 15 to 28

Inspection report

Macfarlane Grieve House
Church Lane
Papworth Everard, Cambridge
Cambridgeshire
CB23 3QW

Tel: 01480357253

Date of inspection visit:
01 December 2016

Date of publication:
29 December 2016

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

Block B, Units 15-28 is a service that supports people to be more independent with their living. It provides accommodation for up to 14 adults who require support with their personal care. It does not provide nursing. At the time of this inspection two people were using the service.

This comprehensive inspection took place on 1 December 2016 and was unannounced.

A registered manager was in post at the time of the inspection and had been registered since September 2015. At the time of our inspection the registered manager was on leave. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 needs were assessed and a sufficient number of skilled and competent staff were in place to meet these. An effective recruitment process was in place to ensure that staff were suitable to look after people who used the service.

Staff had the skills they needed to keep people safe and they were aware of those organisations they could report any incident of harm to. People's medicines were administered and managed safely. Risk assessments had been completed and measures were in place to manage people's risks.

Staff were provided with training and they had the right skills to meet people's assessed care needs. People's nutritional needs were met. People were supported with their health care needs by the most appropriate health professional and the services they provided.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. People were able to make decisions with staff support. Staff respected people's choices and independent living skills. The registered manager had procedures in place to help determine if any person was deemed to lack the mental capacity to make decisions about their care. Staff had a good understanding of the guidance related to the MCA.

Staff provided people's care with compassion, respect and dignity. People, their relatives or representatives were involved in determining people's care needs. Information about advocacy was available if this was required.

People were provided various pastimes and activities they could take part in as well as opportunities to help reduce the risk of social isolation. People were supported by staff to be as independent as possible. Regular reviews of people's care plans were undertaken to help ensure people's care needs were up-to-date.

People were provided with the means to raise any concerns they may have had about the quality of their care. Corrective action was taken promptly to reduce the risk for any potential recurrence. People's concerns were recorded and acted upon promptly.

The registered manager was supported by a business manager, senior care staff and care staff. Staff had the support they needed to do their jobs effectively.

Quality assurance procedures and spot checks were in place and these helped to drive improvements in the care that was provided. People's and their relatives' views about the quality of the service had been sought.

The registered manager and provider had notified the CQC about events that, by law, they had to tell us about.

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 were knowledgeable about safeguarding people from harm and they knew who to contact should they suspect any harm had occurred.

A sufficient number of safely recruited staff were in place to meet people's needs.

People's medicines were administered and managed safely.

Is the service effective?

Good

The service was effective.

Staff received regularly training and this helped them to meet people's needs.

Staff were aware of the decisions people could make and these were respected.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People received care in a compassionate manner. Staff respected people's dignity.

Staff valued people's rights to privacy.

Relatives were able to visit when people wanted them to.

Is the service responsive?

Good

The service was responsive.

People's individual needs were assessed and these were provided in a way which supported people to be independent.

People were supported to have care plans that reflected the person's preferences.

People's concerns were used as a way to improve the service that was provided.

Is the service well-led?

Good

The service was well-led.

Audits and quality assurance processes helped drive improvements in the quality of care provided.

Staff were positively supported in their roles and as a result of this they were open and honest.

People's views and compliments were used as a way of recognising what worked well and if any improvements were needed.

Block B, Flats 15 to 28

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 1 December 2016 and was undertaken by one inspector.

Before the inspection we looked at all the information that we had about the service and used this to inform our planning. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also 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.

Prior to the inspection we made contact with the local health care professionals and the local authority who commission care at the service. This was to help with the planning of the inspection and to gain their views about how people's care was being provided.

During the inspection we spoke with two people. We also spoke with the business manager, a visiting manager from another of the provider's services, one supervisor and three care staff.

We observed how people were being looked after.

We looked at two people's care records, medicines administration records and records in relation to the management of staff and the service.

Good

Is the service safe?

Our findings

People told us they felt safe because their requests for assistance with their care needs were responded to promptly. One person responded positively when asked if staff came to help them within a few minutes. They also confirmed that if two staff were required to help them with their mobility that this assistance was only provided with both staff present. Records we looked at also confirmed this to be the case. We observed staff during the day being attentive to each person's requests for assistance in a timely manner. Where people required one to one support this was also in place. All staff we spoke with told us that there was always sufficient staff to meet people's needs. We saw that people who required equipment to help keep them safe, had this close at hand. One person told us, "They [staff] tell me I have to use it [walking aid]." They also told us that they "have a lifeline" and that staff made sure they wore it or that it was within reach. A lifeline is a device that people can use to summon assistance.

We found that not all risk assessments were in place. This was for subjects such as the equipment people used. The supervisor told us that as this was the person's own wheelchair a risk assessment had not been completed. We found that the use of this equipment had been infrequent. The supervisor immediately acted upon this and put a suitable risk assessment in place. Staff were able to tell us the checks they needed to undertake to make sure people were safe when using any such mobility equipment. We did however find that other risk assessments had been completed and regularly reviewed. For example, for people accessing the community, use of moving and handling equipment and measures to prevent people's skin integrity being affected.
Information about what safeguarding was and how to report abuse was clearly displayed on a large notice board. In addition, should any person require information in an alternative format such as easy read then this was also available. Other information was provided in a service user booklet with details of the organisations people could contact should they need to.

Staff had been trained in safeguarding people from harm. In conjunction with this, refresher training and discussing safeguarding at staff meetings had aided staff's knowledge about recognising and reporting any instance of harm should it occur. One staff member told us. "I would not hesitate to contact the [registered] manager, the local authority and if required, the police." Another staff member said, "If a person was withdrawn, quieter than normal or had [unexplained] bruises I would tell [name of registered manager] straight away. I wouldn't hesitate if I thought a person was at risk, to contact social services." One person confirmed to us that staff treated them well. The provider told us in their PIR, "[People] are informed on arrival of how the care call system [how people requested assistance by using an electronic device] works and we assess the [person's] ability to use the system. [People] can choose to wear the alarm button either as a pendant or wrist band. We found that the positioning of these pendants was within people's reach.

We found that people's needs had been assessed. This was through a combination of people's care needs such as moving and handling, one to one support, independence, mobility and the equipment people required. We found that as a result of these assessments, a sufficient number of staff were in place to meet people's care needs. One staff member told us, "We can always cover any absences such as staff who rang in sick or were delayed due to traffic." They said that this was through a combination of using off duty staff,

working extra shifts, using [bank] agency staff or on rare occasions the [registered] manager helping out. One person agreed that the staff they required to keep them safe were there whenever needed.

We found from records we viewed that staff had only been recruited once all necessary checks had been completed. One staff member told us, "I had a DBS [Disclosure and Barring Service] check." This was for any unacceptable criminal records. The staff went on to say, "I had to provide my passport, proof of address, full employment history. I had to explain any gaps [in employment] and the reasons for these." A supervisor told us that when recruiting new staff the attributes they looked for were staff's attitude. They said, "We can train staff but the most important thing is that their heart is in the job." Another staff member told us, "I had to provide [evidence of] my qualifications and confirm that I was [in good health]. I have worked in care before but I still had all of the checks done before I started."

Accidents and incidents had been acted upon. For example, where incidents of poor medicines administration had occurred we found that improvements had been made. This was for situations involving the accurate recording of when people had had their prescribed medicines. Medicines administration records (MARs) now clearly identified the dosage, time and quantities that had been administered. It was also much easier for staff to determine the quantities of medicines held and when reordering was due. Each person had a personal emergency evacuation plan (PEEP). This was for circumstances such as a need to leave the building in an emergency if this ever occurred including, flooding or fire. Staff also told us the support each person needed such as two staff, equipment or emotional support to keep the person safe was in place.

People could be as independent as they wanted to be with their prescribed medicines such as taking them by themselves, with a drink or from a container. The storage and disposal of people's medicines was undertaken in a safe way. Records of staff training showed us that staff had been trained, and subsequently deemed as competent to safely administer medicines. We observed that staff gave people the time they needed to take their medicines as well as explaining what they were for. Staff adhered to good infection control practice by the use of protective clothing and the washing of their hands prior to each person's medicines being administered. One staff member said, "We have regular training and observations of our medicines administration. I had to complete a booklet to demonstrate my understanding." We heard how staff asked people if they would like the pain relief that was prescribed to be given when they required it. People were administered their medicines as prescribed.

Good

Is the service effective?

Our findings

The provider told us in their PIR, "We create and review individualised care plans for all of our [people]. We take a person centred approach in delivery and production of care plans and involve the individual and their support network when creating them. Staff work to our organisational values of seeing people for what they can do and creating opportunities for people to maximise their independence where possible." We found that as a result of the comprehensive assessment of people's care and support needs, the necessary, appropriate and skilled staff were in place to meet people's individual needs. Other information in the provider's PIR that we found had been embedded was that staffing rotas had enabled people to be cared for and supported by their preferred member of staff. New staff joining the service had been supported to build a working relationship with each person they cared for.

Staff were trained, supported by managers and worked with experienced staff. These support mechanisms were in place to help make sure that staff were confident and competent to undertake their role. The subjects that staff were trained on included food hygiene, the Mental Capacity Act 2005 (MCA), moving and handling, nutrition and safeguarding people from harm. Other subjects staff had been trained on included dementia care, autism and diabetes. This was so that staff had the knowledge and skills to care for people effectively. One person confirmed to us that they felt staff knew what they were doing and met their needs well.

The business manager also confirmed that all new staff were to undertake the Care Certificate. This is a nationally recognised qualification in care. Records showed us that staff's training had been provided regularly including any updates staff required. For example, infection prevention and control, equality and diversity, fire safety procedures and health and safety.

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.

We checked whether the service was working within the principles of the MCA. One staff member told us, "The MCA is about helping people to make day to day decisions." They said, "This could be about offering a choice of bread, milk or porridge to help them [people] choose what to eat. This could also be by holding up a selection of clothes to wear." Staff told us that if people made unwise decisions such as not taking a medicine they would record and report this straight away. Another staff member said, "Sometimes people make the same choices but we respect them. Any changes [in choice] are documented so that we can recognise if a person's capacity [to make a choice] is reducing." We were told and we found that no person using the service lacked the capacity to make an informed choice either with or without support from staff. A supervisor told us that any best interest decision would involve a social worker, a GP, staff, relatives and where possible, the person.

A visiting manager from one of the provider's other services told us, "I have been supporting staff whilst [name of registered manager] is on leave." They said that this was to make sure that the provider's values in the provision of care were adhered to as well as implementing improvements identified by the local authority's visits. Examples of this had been in improving the audits. They also told us, "Recruiting staff who are matched to the people we care for is important and sharing the person's interests such as accessing the community."

Staff were also supported with formal supervisions. One member of staff told us, "I have one [supervision] every four to six weeks. They are always about me, people I support and if I need any help with any aspect of my job." Another staff member said that following the support they had been given, "I now see things from a different point of view for people living with autism and how this affects them. I can help them much better now as a result of the training." All staff confirmed to us that they were always made to feel valued. This was by the support the registered manager and other management provided. Staff told us that if any additional training needs were identified during supervision or at any time, this training was provided. The supervisor told us that examples of where this had occurred had been for sign language to aid communication between people and staff.

People told us that that they had a variety of foods and drinks they could choose from. One person said, "I always have a drink." They also confirmed that they could eat the foods they preferred but staff helped encourage the person to eat healthily. People were encouraged to drink sufficient quantities of fluids. Records were in place and these were used to help identify people's eating and drinking patterns as well as making sure that sufficient quantities had been taken. Where people needed to avoid certain foods, or they were required to eat a pureed or soft food diet to maintain their health and wellbeing, nutritional guidance was adhered to. One staff member told us, "For people who require a specific diet such as low sugar or gluten free content we make sure that the food that people have is safe and suitable."

We saw that where people had an allergy that meant they could be affected by certain foods, those foods were avoided. Members of care staff were knowledgeable about assisting people to maintain their nutritional health. For example, with the assistance people needed to maintain an adequate nutritional intake. A community health professional told us, "They [people] get a good choice of meals." The visiting manager told us that a "fish and chip evening" was offered as well as other takeaway meals if requested. People's nutritional needs were met.

People's healthcare needs were met and supported by staff's prompt requests for health care professional interventions. A visiting health professional told us, "Giving people prompt support makes such a difference. Where people have experienced [health condition] it is essential that they regain their independence and that's what I help them to do." Records showed how referrals for people's health needs had led to the introduction of equipment to assist in maintaining the person's independence as much as practicable.

On the day of our inspection we found that when people had not been well a GP had been called. At the shift handover we sat in on, staff had explained the reason for this and changes which had been made to the person's health support. We found that people's care plans contained detailed and relevant guidance for staff including that for people whose skin condition meant that they needed to move the person in a certain way. This was as well as the application of topical creams to maintain good skin integrity. A health care professional said, "By maintaining an exercise programme for strength people keep more of their independence." People were assured that their healthcare needs would be responded to.

Good

Is the service caring?

Our findings

People we spoke with described the care they received as being caring, homely, dignified and respectful. One person said that staff were "always nice to me" and they "help me with everything" [to do with the person's care]. The provider told us in their PIR, "When producing a care plan we work with the [person] and their circle of support, family members, advocates and friends to produce a care plan that encourages progression and support at the point of hospital discharge." We found that wherever possible people's preferences for male or female care staff were respected. One person told us that they "don't mind but prefer a female." People's care plans recorded people's needs in a person centred and respectful manner. These care plans also included pictorial guidance for staff on how to move a person from their bed to a chair and vice versa whilst doing this with kindness, dignity and compassion.

Our observations showed us that staff shared people's sense of humour. Staff knew what the important things in people's lives were such as seeing relatives, being enabled to return home or maintaining independent living skills. One person told us that they could "have a laugh" as well as staff being "very kind". One staff member told us the ways they would respect people's privacy and dignity by, "Giving people privacy to do as much [personal care] as they could for themselves." Another told us, "We have a system which tells us when someone has finished a shower so we know when the person has finished. We then ask, is it alright if I come in now?" Another person told us how they liked to have their door locked and staff respected this.

We found that people's care plans were detailed and gave staff the guidance they needed as well as being held securely to protect people's privacy. Care plans stated, "Read this it will help you to get to know me" about the person the plan referred to, We saw that an "all about me page" gave staff an overview of the person and some key points such as the foods they liked as well as their circle of friends and family. One staff member told us, "I find the care plans quite easy to follow. Following my induction where each person's needs were explained to me it was easy to be able to continue supporting the person in a way the person preferred." We saw in people's care records the level of detail in describing individual needs such as "I like a wet shave with a [type of razor] and please make sure you ask me if I need cream on my face". Records of the care that people were provided with confirmed that people's individual needs were met.

People confirmed to us that they, or their relative, had been involved in developing their care plan. We found that information the provider told us in their PIR about how they would "work with [people] to help them to build and maintain their personal relationships to help with interaction with their social circle by helping [people] to form meaningful relationships", had been effectively implemented. This was because the registered manager and provider were aware of the impact to someone's health and wellbeing that isolation and loneliness could cause.

We viewed compliments relatives had provided about the service and care provided. These included, "Everything [about the care] has been satisfactory, making me feel comfortable and at home." One staff member told us that the reason they liked working at the service was, "I like helping people to make a difference to their lives and getting to know them." Another staff member said, "People have rights. If they

don't want their care I respect this as well as giving people the space and privacy they needed." During the staff shift handover we heard how people were referred to with respect and concern. This was to ensure each person was as comfortable as possible.

We found and people told us that their friends and relatives were able to visit at any time. Records we viewed showed that people could have as much family time as they wanted as long as this had a positive impact on the person's wellbeing. This was to ensure that people received the care they needed. We found that advocacy services (this is a service for people who needed someone to speak up for them or on their behalf) were available. Information was provided to people and their relatives on how to access this.

Good

Is the service responsive?

Our findings

Prior to using the service a comprehensive assessment of people's needs was undertaken. This was to make sure the service and its staff could meet people's needs as wells as ensuring care could be provided on an individualised basis. Information was gathered from various sources such as the person, hospital discharge records, relatives and any associated [health and social care] professionals. We found from records we looked at that people, their relatives or representative had been consulted and involved in determining the person's care needs.

A detailed account and record of each person's life history helped staff to determine those aspects of the person's life they liked the most. One person told us that they "knew about" their care plan and had contributed towards making it. One staff member said, "It's nice to be able to have a chat with people. They tell us lots of interesting stories [about life]." We found that as a result of these conversations and how well staff knew people that each person's individual needs were met. We also saw how the input from relatives had been used to influence care plans in a personal way. For example, the person's preferred time to go to bed, any allergies, favourite film and pastimes such as ceramics classes and keep fit. Another staff member said, "Sometimes we may need to discuss life issues with people to help provide [reassurance] such as shopping on line, making a shopping list and getting the shop to deliver the items."

We saw that the review of people's care plans had been completed on a regular basis. The visiting manager told us that one of the reasons they were helping at the service was to make sure that any shortfalls identified by the local authority contracts team were corrected as quickly as possible. This included examples such as mental capacity assessment where this was applicable. Care plans were reviewed following any changes to the person's needs such as following a GP visit or staff handover meeting. This was for areas of care including people's prescribed medicines as well as the provision of any new equipment such as a wheelchair. We found that the care plan matched the needs of the person it described. The record of people's involvement in their care and their level of independence was in line with what we saw.

We saw that staff responded promptly where people required assistance such as with their medicines and personal care as well as with help preparing meals. People told us that they were satisfied with how their individual needs were met. Where 'one to one' support had been identified we saw that this was being provided. This was to make sure that staff were able to respond to the person's needs. A supervisor told us that some people liked to go out shopping, golfing, to a café, out for Sunday lunch at a pub or just going out in the fresh air. One person told us that whenever they wanted to go out for social stimulation or leisure staff would "always take them". Records viewed and staff we spoke with confirmed that people's needs were responded to promptly.

People and relatives told us they would speak with the registered manager or representatives of the provider if they ever had any concerns about their care. Information was provided to people on the complaints process as well as this being displayed on notice boards. We found however that the Local Government Ombudsman had not been included in the information that people were given. The business manager told us that they would add this information as part of their review of the easy read and complaints

policies. Concerns were identified during day to day care as well as care records. This helped the registered manager be proactive in responding to concerns before they became a more formal complaint. All staff told us that they would always acknowledge the person's concern, report it to a manager and make sure that any changes implemented were sustained.

Good

Is the service well-led?

Our findings

Various ways were used as a means of identifying areas for improvement including meetings with people and their relatives as well as multi-disciplinary team (MDT) meetings. These meetings were part of people's reablement (rehabilitation) and to help ensure the most appropriate actions were taken to achieve this. For example, with the right number of staff, the right equipment and being cared for in an environment that supported people to achieve their goals.

Other staff and managers' meetings were held to inform staff of the required standards of care they were expected to provide. This was as well as other information about the provider's plans in recruiting and retaining staff with a reablement role in addition to care. A visiting health professional told us, "I trained the staff on using some new equipment and they were quick to learn. They always adhere to my advice and guidance and get the best out of each person."

All staff commented favourably to us about the registered manager and provider and about the support they gave staff. One staff member said, "[Registered manager] is always there, I sometimes think she lives here. She is always saying to us that if we are not sure about anything at all to ring her." Another staff member told us, "I'd much rather ask the [registered] manager what may appear to be a silly question than something serious happen. I can't fault their commitment to us." A third staff member said, "We [staff] all work so well as a team. Yes it [work] can be a challenge sometimes with a new person but [registered manager] is there to make sure we have everything we need." We were told by staff that the registered manager spent time around the service observing them, talking with people and relatives as well as visiting health professionals. This was to help ensure that each person's care was as good as it possibly could be. One person said that the registered manager was "always popping in" to say hello and asking after their wellbeing and if they had any suggestions.

We found that various checks and quality assurance procedures were in place. These were planned to identify any problems before they became an issue. We found that audits of care plans, medicines administration, and spot checks by management on staff's performance had helped drive improvements. This was as well as maintaining the provider's values in the provision of care in being supportive, responsive and caring.

The business manager told us that these values and standards were also based on the MDTs recommendations including exercise therapies. They also told us that the main aims of the service were to provide a neurological rehabilitation service for people with a brain injury. We found that through a combination of skilled staff and health professionals that this was providing the quality of care that people expected. This was also confirmed in the provider's recent quality satisfaction survey. People were asked for their views on what had worked well whilst they had used the service.

One person told us that they could access the community "whenever I want to". Other community links were supported through occupational therapies such as going out in a wheelchair or being visited by relatives who could help with preparing meals as part of people's reablement.

Staff were aware of, and if the need arose confident to use, the provider's whistle blowing procedures. This was to report any poor standards of care. One staff member said, "If my mum used the service and staff did something wrong; how would they feel if it was their mum. I'd have no hesitation to tell [registered manager]." A visiting manager told us that as part of their spot checks they made sure that staff adhered to their training, support and the way they had been taught to care properly for people. This was planned to help make sure that circumstances that could lead to a whistleblowing situation were avoided.

People, staff and health professionals all praised the registered manager for their openness, integrity and being such an approachable person. We received positive comments from a health professional who told us that the registered manager was "always willing to listen to suggestions, took on board advice and implemented this with the staff team effectively". One staff member said, "The support I got during my induction didn't stop there. I have had shadowing support, supervisions, regular staff meetings as well as a daily handover." The staff told us that this had meant a lot to them to be "part of a team" and working well together.

The registered manager and provider had notified the CQC about events that, by law, they had to tell us about. They were supported by a team of staff, which included a supervisor, senior care staff and care staff. The business manager and visiting manager told us that the main challenge in maintaining the right standards of care were based upon the quality of the staff that had now been recruited. The business manager said, "Now that we have a more complex and interesting job role we can hopefully attract staff for the right reasons." The visiting manager told us that recruiting staff with no previous care skills was sometimes better so that the provider's values could be instilled at an early stage. A staff member said, "[Registered manager] is always contactable. I feel personally that they are a very good manager because they care about people and us. They have been fantastic supporting me. We are very lucky with the [registered] manager we have."