The Wilf Ward Family Trust

Sherburn House

Inspection report

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Date of inspection visit:
26 May 2017

Date of publication:
28 June 2017

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 26 May 2017 and was unannounced.

The service registered with the Care Quality Commission (CQC) on 29 January 2016 and this was the first inspection since registration.

Sherburn House is registered to offer accommodation and residential support for up to 12 people over the age of 18, who have a learning disability or autistic spectrum disorder. At the time of this inspection there were 10 people using the service.

The registered provider is required to have a registered manager, but at the time of our inspection the manager in post was not registered with the Commission. For this report we have referred to this person as 'the acting manager' throughout the text. 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.

We found that the care staff had a good knowledge of how to keep people safe from harm and the staff had been employed following robust recruitment and selection processes. We found that the administration of medication was safely carried out, but some aspects of recording practices, for example, 'as and when required' (PRN) medicine protocols and topical medicine charts (for external medicines) could be better.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community. People had risk assessments in their care files to help minimise risks whilst still supporting people to make choices and decisions.

People that used the service were cared for and supported by qualified and competent staff that were regularly supervised and received appraisal regarding their personal performance. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain their levels of health and wellbeing. However, the quality of recording of food and fluids consumed on a daily basis needed to improve.

People were able to see their families as they wanted. There were no restrictions on when people could visit the service. We saw that staff were caring and people were happy with the care they received. People had access to community facilities and most participated in the activities provided in the service.

We observed good interactions between people who lived in the service and staff on the day of the

inspection. We found that people received compassionate care from kind staff and staff knew about people's needs and preferences. People were supplied with the information they needed at the right time, were involved in all aspects of their care and were always asked for their consent before staff undertook support tasks.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that the acting manager met with people on a regular basis to discuss their care and any concerns they might have. This meant people were consulted about their care and treatment and were able to make their own choices and decisions.

People's wellbeing, privacy, dignity and independence were monitored and respected and staff worked to maintain these wherever possible.

The staff and one relative told us that the service was well managed. The registered provider and acting manager monitored the quality of the service, supported the members of staff and ensured that there were effective communication and response systems in place for people who used the service.

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.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

Assessments were undertaken of risks to people who used the service and staff. Written plans were in place to manage these risks. There were processes for recording accidents and incidents.

There were sufficient numbers of staff on duty to meet people's needs. Medicines were managed safely so that people received them as prescribed, but some aspects of recording practice could be better.

Is the service effective?

Good

The service was effective.

Staff received relevant training, supervision and appraisal to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

People had a choice of quality food and were provided with appropriate assistance and support. Staff understood people's nutritional needs, however, the recording on food and fluid charts needed to improve.

We found the registered provider to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

The people who used the service had a good relationship with the staff who showed patience and gave encouragement when supporting individuals with their daily routines.

We saw that people's privacy and dignity was respected by the staff.

People who used the service were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day-to-day needs.

Is the service responsive?

Good

The service was responsive.

Care plans were in place outlining people's care and support needs and people who used the service were able to make choices and decisions about their lives.

People and their relatives were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The service was without a registered manager; this is a requirement of their registration.

The acting manager and registered provider carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked there.

Sherburn 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 registered 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 26 May 2017 and was unannounced. The inspection team consisted of an adult social care inspector.

We looked at information we held about the service, which included notifications sent to us since the service registered in 2016. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We also contacted North Yorkshire County Council (NYCC) safeguarding and commissioning teams. We asked the registered provider to submit a provider information return (PIR) and this was returned within the agreed timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection we spoke with one of the registered provider's head of operations, the acting manager, interviewed two members of staff and chatted to four other staff. We met six of the ten people using the service, but they were not able to speak with us directly. We used the Short Observational Framework Tool for inspection (SOFI). SOFI is a way of observing care to help understand the experience of people who could not talk with us. We spoke with one relative and we observed staff interacting with people who used the service and looked at the level of support provided to people throughout the day.

We spent time looking at records, which included the care records for two people who used the service, the recruitment, induction, training and supervision records for three members of staff and other records relating to the management of the service. We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

Good

Is the service safe?

Our findings

Our observations showed that there were sufficient staff on duty to meet people's needs and have time to carry out activities, housework and sit and talk with people who used the service. On the day of our inspection there were ten people who used the service and we saw the levels of staff on duty included the acting manager, one assistant manager and six care staff during the day shift and three care staff at night.

Staff told us, "On the whole the staffing levels are okay. There are a number of different shift patterns we can work to ensure we have flexibility in the service to meet people's needs both in the service and out in the community. This is a good service and the staff team do their best for the people who live here."

The acting manager told us that the registered provider did not use a dependency tool to work out the staffing levels for the service. However, it was understood by the management team that each person was given a set amount of care hours a week plus additional hours as required. For example, discussion with the acting manager indicated that three people who used the service received one-to-one care during the day when in the service and two-to-one care when out in the community. The amount of additional care hours for each person was identified on their funding agreement form and documented on the rotas. We saw that the numbers of staff on duty were sufficient to cover the additional care hours for each person.

We looked at the recruitment files of three members of staff and saw that safe recruitment practices had been followed. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them.

Staff received training on making a safeguarding alert so that they would know how to follow local safeguarding protocols. Staff told us they would have no problem discussing any concerns with the acting manager and were confident any issues they raised would be dealt with immediately. There was written information around the home about safeguarding and how people could report any safeguarding concerns.

The registered provider had policies and procedures in place to guide staff in safeguarding adults. The acting manager described the local authority safeguarding procedures and our checks of the safeguarding file showed that there had been six alerts raised by the management team in the last twelve months. Five alerts were around medication errors and one was about care; the management team had worked with the local authority safeguarding team to keep people safe and improve practices. The information we hold about the service showed that CQC had been notified of the alerts. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

There were care notes and risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the risk assessments had been

updated on a regular basis to ensure that the information available to staff was correct. Accidents and incidents were recorded, analysed each month and were audited to identify any patterns that might be emerging or improvements that needed to be made.

We saw that staff worked well with individuals using the service and were able to effectively manage the agitated and distressed behaviours of some individuals. We saw there were behaviour management plans and risk assessments in some of the care files we looked at. These detailed the types of behaviour exhibited by individuals and what impact this had on them and others around them. Staff had identified trigger points and patterns of behaviours and care plans gave staff clear instruction on how to diffuse situations and keep people safe from harm.

We spoke with one visiting health care professional who told us, "I am here to see people who use the service. I have seen improvements within the service around documentation and record keeping over the past few months. Our team did have some concerns around medicines and safeguarding, but we are aware that staff are being very supportive of people and their work practices are changing and getting better."

There were contingency arrangements in place so that staff knew what to do and who to contact in the event of an emergency. Copies of the fire procedure were on display around the service and a fire risk assessment was in place. People who used the service had a personal emergency evacuation plan (PEEP) in place; a PEEP records what equipment and assistance a person would require when leaving the premises in the event of an emergency. We discussed with the acting manager that these could be improved by having the date of completion on them and when they were reviewed. They said they would do this straight away.

We looked at documents relating to the servicing of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. Clear records were maintained of daily, weekly, monthly and annual health and safety checks carried out by the staff, maintenance team and nominated contractors. These environmental checks helped to ensure the safety of people who used the service.

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. The care staff informed us that they had received training on the handling of medicines. This was confirmed by our checks of the staff training plan and staff training files.

We saw that the PIR indicated there had been six medicine errors in the last year; these were around missed or incorrect medicine doses. In response to this the registered provider had changed the medicine supply system and the new system used medicines supplied in their original containers. Each person had a medicine cabinet in their own bedroom, which enabled staff to administer medicines in a more private and person-centred way. This demonstrated that the provider viewed all errors as potentially serious and we noted the acting manager had taken action to speak with staff through meetings and supervisions to ensure practice was improved.

There were a couple of minor medication issues that were of low risk to people using the service and of low impact on their safety. The topical medicine charts to record the application of external creams and lotions all said for staff to 'use as required'. However, all medicines including topical medicines should have clear labels and prescriptions which say how, when and where they are to be used. Some medicines were prescribed by a GP for 'as and when required' use (PRN). We found that PRN protocols were in place for some of these medicines but not all, which meant staff did not have clear guidance on when to use the PRN

medicines. We saw no evidence to indicate people did not receive their medicines as prescribed, but there were some recording errors. These were discussed with acting manager who said medicine errors would be followed up by giving staff supervision and additional training.

We looked at the communal areas and a sample of bedrooms (with people's permission). We saw that the service was clean, warm, and welcoming. Sanitising hand gel and personal protective equipment such as gloves and aprons were available at appropriate points throughout the service for staff to use to prevent the spread of infection.

Good

Is the service effective?

Our findings

We looked at induction and training records for three members of staff. There was a robust induction and training programme in place for all staff. Staff who were new to the caring profession were required to complete the Care Certificate; this ensured that new staff received a standardised induction in line with national standards.

New staff were mentored by more experienced workers until their induction was completed and they received additional supervision during their probationary period. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. There was a staff supervision plan in place and staff files showed that staff received regular supervisions and yearly appraisals had been completed.

One member of staff told us, "We get lots of support from the management team. There is an open door policy in that we can go talk to them if we have any issues or problems. We have regular supervision and support meetings – about every six to eight weeks. We work well as a team and our views are listened to by the provider." Another member of staff said, "I have completed the behaviour management and awareness training, but rarely have to use it. We have sufficient equipment to make sure we can meet people's needs including a mobile hoist and overhead hoists. Training is provided on all of that so you can be confident you know what you are doing when you use the equipment."

The staff training programme covered subjects that the registered provider deemed as essential, and more specialist training. Each member of staff had their own training record. We saw that staff had access to a range of training deemed by the registered provider as both essential and service specific. Staff told us they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling. Records showed staff participated in additional training including topics such as Deprivation of Liberty Safeguards, Mental Capacity Act 2005 and equality and diversity.

The staff we spoke with displayed an in-depth knowledge about each person's care needs, choices and decisions. Staff told us that they kept up to date with people's changing needs through handovers at the start of each shift and reading the care plans. Observations of people who used the service showed how and when staff used their knowledge to make people's lives better. For example, one person had known behaviours when anxious or distressed but staff had found that by using a distractive technique they stopped these behaviours. We saw this person happily engaged during our inspection.

Staff who we spoke with told us that they only carried out tasks or provided assistance with personal care when they had obtained consent or 'implied' consent, and that they encouraged people to make decisions about their care. We saw that the care plans we looked at had been discussed and agreed with people, but staff had written where a person lacked the ability to sign for themselves.

One visitor confirmed to us that they had input to their relative's care and support and told us, "My relative

lacks capacity to consent to care. Therefore, the decision for a do not attempt cardiopulmonary resuscitation (DNACPR) has been discussed with us and we have also had the opportunity to discuss their care and support needs. [Name of relative] has a key worker who is very good with them. We have seen them communicate well with [Name of relative] and staff understand their needs and wishes very well."

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 services 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. We found that people had been assessed for capacity, and where appropriate DoLS had been sought.

There was recording of Best Interests decisions and the service also ensured that families provided copies of Lasting Powers of Attorney's where they had been registered with the Office of the Public Guardian (OPG). For example, two people who lacked capacity received medicines covertly, meaning they were hidden in food or drink. We saw that the decisions to administer their medicines in this way had been made with input from their GP and families.

Some people living at the service used Makaton and adapted sign language/gestures to make sure their wishes and choices were heard. We observed them communicating effectively with the staff throughout out inspection. The staff were able to tell us how the use of facial expressions, body language, laughs/smiles and even shouting out was each person's way of communicating. We observed staff to be kind, patient and intuitive with people who could not directly say what they wanted or needed.

Information in the care files indicated people received input from health care professionals such as their GP, physiotherapists, speech and language therapists (SALT), dentist, optician and chiropodist. We saw that people had their medicines reviewed regularly and blood tests were carried out where necessary. Each person had a health 'passport', which was taken with them to hospital or medical appointments; they gave clear information to other health care professionals about the health and welfare abilities and needs of the person where the person had difficulty communicating with others.

Staff recorded food and drink intake to ensure people who used the service received enough nutrients in the day, but we found the records such as food and fluid charts needed more detailed information. For example, we noted that in the two care files we looked at care plans for nutrition and hydration did not describe how much fluid the person should be consuming each day, the daily charts were not totalled to see how much fluid the person had drunk and there was no written information to indicate if staff took appropriate action when the fluid level intake dropped. Both people looked well and hydrated indicating this was more a recording issue than a lack of care. We discussed our concerns with the acting manager who said they would review the care plans and charts immediately with the senior staff to ensure accurate records were kept.

Observation of the midday meal showed that people were having a selection of hot and cold meals including fish fingers and beans or sandwiches and cake. Where people required a specific diet such as food cut into small pieces/finely chopped they had an appropriate meal prepared for them. The meal time was

organised and people were quickly provided with a drink and their choice of food. We saw that the meal time experience offered people a social and stimulating activity that promoted their independence. People enjoyed their meals and were able to ask for second helpings if they wished. If they did not like something then there was another choice offered to them.

We observed that staff made hot and cold drinks for people throughout the day, both on request and at regular intervals. Each person had a favourite cup or mug, some with lids and spouts for safety. We noted that staff also offered individuals regular snacks between meals.

Good

Is the service caring?

Our findings

We observed kind and caring practices during our inspection. Staff knew the people using the service very well and understood what people needed or asked for. We saw staff used verbal and non verbal communication skills effectively to ensure people's requests and needs were met. For example, people were supported in everyday activities of daily living. We saw staff offer gentle verbal prompts to assist people to eat and drink well. We also observed people being encouraged to socialise and take part in activities.

One visitor told us, "The service has good facilities and I have no issues with the environment. I am able to visit my relative when I like and I know they are kept safe and well here. They do not get out very often, but enjoy the occasional walk. They enjoy listening to music and often have it playing in their bedroom when I visit. [Name of relative] enjoys company and their clothes are always clean and comfortable for them. Their privacy and dignity are always respected by the staff. Their weight has been maintained since having a feeding tube into their stomach fitted." We saw that their relative who used the service was settled and happy during our inspection. Staff had received training from the equipment and liquid feed supplier to be able to support this person with their feeding tube. The dietician visited this person every two months to check on their weight and ensure their nutritional needs continued to be met.

Discussion with one relative, the staff and the acting manager indicated that the care being provided was person-centred and focused on providing people with practical support and assistance to help them maintain their independence wherever possible. We were told that regular discussions about care and support were held with relatives and people who used the service. Each person had a key worker and staff wrote in their care notes to show where the person had been, activities they had attended and what issues had been discussed.

Observations of the interactions between people and staff showed there was a good level of trust and friendship between them. We observed one person who received one-to-one support during our inspection. They were at ease in the service and the conversations being held between them and staff were friendly and relevant to the person's interests. The person had limited communication skills, but was able to express what they wanted. For example, they asked staff for a drink and snacks and these were quickly provided for them.

Care plans included information about the person's lifestyle, including their hobbies and interests and the people who were important to them. This showed that the person and their relatives had been involved in assessments and plans of care. For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was on display in the service. An advocate is someone who supports a person so that their views are heard and their rights are upheld. We saw that one person whose care records we looked at had an advocate from an external company who visited them on a regular basis.

We observed that staff displayed kindness and empathy towards people who used the service. Staff spoke to them using their first names and they were not excluded from conversations. We saw that staff took time to

explain to people what was happening, when they carried out tasks and daily routines within the service. Staff spoke with them in a tone and manner demonstrating kindness and respect and people responded positively towards staff.

One visitor told us that staff were friendly and they felt staff really cared about the people who used the service. They told us, "The staff are kind and they listen to people."

We observed how staff promoted people's privacy and dignity during the day by knocking on their bedroom door prior to entering, ensuring toilet and bathroom doors were closed when in use and holding discussions with people in private when required. Each person had their own private bedroom and en-suite facility and staff respected their wishes to be alone at times during the day and night, wherever this did not present a risk to their safety or that of others.

Good

Is the service responsive?

Our findings

A needs assessment had been carried out to identify each person's support needs, and care plans had been developed outlining how these needs were to be met. Risk assessments had been completed and behaviour management plans were in place to make sure people stayed safe and well. The acting manager told us that the care files were in the process of being rewritten to ensure these were up to date and person-centred. At the time of our inspection they had re-written seven care files and there remained a further three to complete.

Families were encouraged to have input to the care files where people were unable to contribute. Each of the care plans included details of the person's care needs, their wishes and aspirations in the area and any risks related to the need. This meant that people's care profiles included a wide range of information designed to assist staff to support them effectively. When people's needs changed this was clearly recorded.

We were not able to talk with people who used the service about their care plans. However, staff were knowledgeable about people who used the service and displayed a good understanding of their preferences and interests, as well as their health and support needs, which enabled them to provide personalised care. People were invited to attend reviews of their care and treatment each year with the funding authority and other people involved in their care. Families and advocates were also invited.

People who used the service had their own weekly activity timetable devised by them and the staff team, which detailed the things the person liked to do. For one person whose care records we looked at this included activities such as, games and puzzles, baking, watching movies, making music and arts and crafts. We observed that activities on a one-to-one basis were taking place. We observed people listening to music in their bedrooms, watching appropriate television shows which they were engaged in and completing jigsaws and puzzles with the staff.

The service was a single storey building and we saw bedrooms that had French doors leading out onto the outdoor space. As it was a lovely day a number of people had their bedroom doors open and were enjoying the warmth and sunshine. There was a selection of seats and tables with parasols for shade for people to sit out on and people took advantage of the good weather to have a walk about with staff in close attendance.

Some people who used the service had motorbility vehicles, which were adapted for wheelchair use. Staff told us they often took people out and about in the community and on holiday as they wished.

There was a copy of the provider's complaint policy and procedure in the service. We looked at the complaints folder and saw that two complaints had been made in the last year. Both had been responded to appropriately.

We saw evidence during our inspection that the acting manager was in regular contact with people who used the service and their relatives. They were available to discuss people's care and any concerns they might have. One relative who spoke with us said, "I can talk to the staff or the manager if I have a problem,

they listen to me and things are usually quickly resolved."

Requires Improvement

Is the service well-led?

Our findings

It is a requirement of the registered provider's registration that there is a registered manager for this service. We found that the registered manager had left the registered provider's employment the week before we inspected and an acting manager was in place. We discussed the lack of a registered manager with one of the registered provider's head of operations. They told us that an interim manager from an external agency would start in the service the week after our inspection and there was an active recruitment campaign for a permanent manager.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The acting manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

We found the service had a welcoming and friendly atmosphere. Staff said the culture of the service was open, transparent and the acting manager sought ideas and suggestions on how care and practice could be improved. The acting manager was described as being open and friendly and there was an open door policy as far as they were concerned.

Our observation of the service was that people who used the service were treated with respect and in a professional manner. During this inspection we received positive feedback about staffing, the environment and positive comments about the acting manager. One member of staff told us, "I absolutely love this place. The acting manager is very good and offers me a lot of support when I need it." One professional healthcare visitor told us, "We can see that the service is improving."

Feedback from people who used the service, relatives, health care professionals and staff was obtained through the use of satisfaction questionnaires, meetings and staff supervision sessions. This information was analysed by the registered provider and acting manager and where necessary action was taken to make changes or improvements to the service.

One relative told us, "It would be nice to have closer links and communication with the manager." When we spoke to the acting manager about this they said relatives were sent satisfaction surveys to enable them to express any views on the service and feedback was given face-to-face. Recent comments from the February 2017 relative surveys included, "Very pleasant home. No complaints and we are made welcome", "Wonderful care home, very up to date" and "Our relative is very happy here."

We found an engaged, friendly and experienced staff team in place. All staff were encouraged to share ideas and reflect on their performance through team meetings and supervisions, which were used to inform the annual appraisals.

The provider information return (PIR) contained information that indicated the registered provider

monitored and reviewed the quality of care and support provided within the service on a regular basis.

We saw that quality audits were undertaken to check that the systems in place at the service were being followed by staff. The acting manager carried out monthly audits of the systems and practice to assess the quality of the service, which were then used to make improvements. We saw that the audits highlighted shortfalls in the service, which were then followed up at the next audit. This was so any patterns or areas requiring improvement were identified and known risks were mitigated.

During the inspection we found some minor issues with records in relation to medicine protocols and topical medicine administration sheets and food/fluid charts. The acting manager and head of operations who we spoke with said they would address these issues straight away and carry out more frequent audits to monitor staff practice.