Community Homes of Intensive Care and Education Limited

Meylan House

Inspection report

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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

The inspection took place on 5 October 2017 and was unannounced. Meylan House supports up to seven adults with a learning disability and complex behavioural needs, as well as autism.

Meylan House is required to have a registered manager. A registered manager is a person who has registered with the 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. The new manager was present and assisted us during this inspection. The registered manager for the service left in May 2017. Another manager had applied for the registered manager post; however, left their post in August 2017 before registration was completed. At the time of the inspection a new manager was in place who had applied to be registered with the Care Quality Commission (CQC). Their CQC application is currently being processed. The manager is being supported by the assistant area director.

People were kept safe by staff that had received training on safeguarding adults and understood their responsibilities to report concerns. Risks had been appropriately assessed and control measures were in place to minimise the risks.

People received their medicines as prescribed. Staff had training and were checked to ensure they continued to be competent when administering medicines.

Recruitment processes were designed to ensure only suitable staff were selected to work with people. There were sufficient numbers of staff to meet the needs of people who currently used the service. New staff were supported with an induction when they commenced work in the service, including shadowing opportunities. Relevant training had been received such as managing medicines, food hygiene, health and safety and first aid.

Staff were supported through annual appraisals and a number of supervisions throughout the year. Staff told us that they felt supported by the manager and that communication was effective.

Staff were aware of their duties under the Mental Capacity Act 2005. They obtained people's consent before carrying out care tasks and followed legal requirements where people did not have the capacity to consent.

We saw people were cared for and their dignity upheld. Relatives confirmed staff encouraged people to retain their independence on a day-to-day basis.

Care plans were personalised and centred on people's preferences, views and experiences as well as their care and support needs.

Measures were in place to assist people to raise concerns with staff. Complaints were investigated and

responses given.

Auditing and quality assurance systems were in place to identify any actions required to ensure the safety and quality of 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.

Staff received safeguarding training and understood their responsibilities to report concerns.

Medicines administration training took place with observations to ensure staff competence.

Potential risks were identified, monitored and managed to minimise harm.

There were enough staff and checks had been taken to ensure they were suitable to work with vulnerable people had taken place.

Is the service effective?

Good

The service was effective.

People who used the service received the support they needed on time.

Staff had received a range of training relevant to the needs of people in the service and had regular meetings with their manager to gain support.

People were cared for in line with the principles of the Mental Capacity Act 2005.

People's wellbeing was maintained with relevant health checks.

Is the service caring?

Good

The service was caring.

People had positive and caring relationships with the staff that supported them.

People were treated with dignity and respect.

People were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People's care records were individualised and they had been involved in developing them.

People were protected from social isolation and provided with opportunities to take part in things they enjoyed.

People were given opportunities to express anything they were unhappy about.

Is the service well-led?

Good

The service was well-led.

The provider and manager had ensured a good overview of the quality of the service and monitored this effectively.

The established staff team ensured a person centred service with a positive culture.

Auditing and quality assurance processes were in place.

Relatives and staff had confidence about the leadership of the service.

Meylan 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.

The inspection took place on 5 October 2017 and was unannounced. The inspection team consisted of two inspectors. Before our inspection we reviewed all the information we held about the service. The provider had submitted a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make.

During the inspection we reviewed three people's care information, looked at three staff records, policies, procedures, auditing and feedback from people. People in the service were not able to verbally give us their views. Therefore, we observed interactions throughout the inspection and sought feedback from four relatives. We also spoke with the Assistant Area Director, the manager, deputy manager and three members of staff.

Good

Is the service safe?

Our findings

People were protected from the risk of harm because care staff knew how to recognise signs of potential abuse and how to report their concerns appropriately. Up to date information on local safeguarding procedures were clearly displayed and there was an on-call manager 24 hours a day who could be contacted. Safeguarding training was delivered as part of the provider's induction and staff received refresher training on this topic. When we spoke with staff they were clear about their safeguarding responsibilities and how they could raise concerns. A member of staff told us, "People are very safe here. There are enough staff and I understand safeguarding and would report any concerns to my manager. I would also intervene if the situation was an emergency." Another commented, "Concerns would be reported to the line manager, support the service user and potentially suspend the staff member." We also saw that where necessary, safeguarding referrals had been made to the appropriate body. Staff had knowledge of whistleblowing and how to report concerns. A relative told us, "I feel my relative is safe in the care they receive. The door is securely locked to ensure they do not leave the house unaccompanied and they understand the reason for this."

Where people behaved in a way that may challenge others, staff managed the situation in a positive way to protect people's rights and dignity. We saw that the provider's positive behavioural support practitioner visited fortnightly and reviewed behaviour observation charts and, if needed, updated behaviour support plans. Behavioural Observation Charts were developed to provide information about what triggers may lead to behaviours, signs that this may be happening and what strategies could be used to avoid or de-escalate situations. These included pro-active approaches such as being aware of someone's mood before maybe going out on an activity and avoiding known triggers that may lead to behaviours happening. If behaviours did happen then advice of what to do was in place, such as reassuring the person or diverting them to something else. Information was also provided such as the use of physical interventions and PRN medications. Any incidents that did occur were clearly recorded so that these could be reviewed and advice added or updated if needed.

The positive behavioural support practitioner observed staff interactions with people in the service. We spoke with the practitioner who was visiting the service on the day of the inspection. They said, "I have no concerns of the care and support the service users receive, and feel they are kept safe and their rights are supported." We also saw that a pre-shift summary was in place detailing a quick guide to communication needs. For example, how speech was expressed and any triggers for behaviours such as change of routines. This meant staff could reference essential information quickly without reading through all care plans to ensure any changes in support was noted.

People had risk assessments and plans to manage these in respect of their individual needs. For example, a person who had epilepsy had a specific care plan to manage and minimise the risks. This described how the seizures presented, how often and how long. Equipment to monitor seizures was in place and half hourly checks took place. The equipment was regularly checked to ensure it was in working order. Staff we spoke with knew about how often checks should take place on the person. Risks around bathing had been considered and management plans in place. Risk assessments were reviewed regularly, or when a change

occurred. A relative told us, "The staff at Meylan House have demonstrated to be very careful caring for [name] and also carrying out risk assessments, for example recently when they took our [relative] on holiday.'

We also saw risk assessments and management plans for medicines, travelling in a vehicle, accessing the community, eating out, walks and visiting public attractions. These all described the 'Positive outcomes of taking risks', for example the enjoyment of seeing a film at the cinema. It also included measures to reduce any identified risks, for example, best places to sit and ensuring staff were observant and trained. This meant that people could enjoy as many experiences as possible balancing the benefits alongside the risks that may present.

There were also generic risk assessments completed to ensure a safe environment. For example, fire, hot water, kitchen, hazardous substances. This meant the environment had been assessed to maximise safety and minimise the chance of accidents.

Medicines were managed safely and people received their medicines as prescribed. We saw that medicines were stored in a designated locked cupboard. We examined the Medication Administration Record (MAR) and saw that there were no gaps in the recordings. Medicines were clearly labelled and stored separately to ensure people received their correct medication. We saw records and staff told us that all staff had received training in the safe management of medicines. We saw that staff's competency to administer medicines was checked regularly. A relative told us, "I have witnessed the administering of (name's) medication and this was done by two members of staff." Another relative said, 'They maintain a very good daily record of the medicines given and they have a very good storage place for every individual in the house, locked in the office." We also saw medicine audits were regularly completed.

Some people had been prescribed medicines to be administered on an 'as required' or occasional basis (PRN). We saw that guidance was provided within Medicines Administration Records (MAR) on how PRN medicines should be administered, should they require it. The provider maintained records of when these medicines were administered and the reasons for their administration. This ensured people's behaviours were not controlled by excessive or inappropriate use of medicines.

Staff said they felt staffing levels were sufficient to ensure people received their care safely and on time. The use of agency staff was minimised as rota gaps were covered by existing staff. This meant people were supported who knew their support needs well.

We saw a range of pre-employment checks were in place, such as Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals. This helps employers make safer recruiting decisions and employ only suitable people who can work with potentially vulnerable adults.

People were protected from the spread of an infection. Staff ensured the kitchen remained clean and free from potential cross infection. They adhered to food safety standards and ensured the food was kept at appropriate temperatures and prepared safely.

Regular checks and tests, such as gas, electricity, water safety, fire drills, weekly fire alarm tests and external checks of firefighting equipment, were completed to promote and maintain safety in the home. We saw these were completed at different times of the day to ensure all staff knew actions to take, including at night.

There were robust contingency plans in place in case of an untoward event. The contingency plan assessed the risk of such events as fire or bad weather conditions and how the service would continue in the event of these occurring.

Good

Is the service effective?

Our findings

People's needs were met by staff that had the relevant skills, competencies and knowledge. We looked at the training records which showed staff had completed a range of training courses which included: health and safety, moving and handling, first aid, safeguarding adults, the Mental Capacity Act, and infection control. The training records showed that staff training was up-to-date. A member of staff told us, "The induction training was comprehensive and enabled me to get to know the system and individuals I would be supporting. I have received training such as intensive interaction and first aid training."

New staff undertook an induction comprising a mix of training, shadowing and observing more experienced staff. Risk assessments were in place in respect of staff working who had not received specific training such as restraint. Staff told us the training covered all areas of the role and was relevant. For example, a member of care staff told us of specific training that had been arranged for a specific person to enable staff to better understand their behaviour and support them more effectively.

Staff told us they felt supported by the manager. Staff told us they had annual appraisal meetings and supervision meetings. A member of staff said, "I have supervision monthly. I also get support with issues from my colleagues. There are opportunities for promotion if wanted."

We saw records on staff files that they had discussed their roles and responsibilities. For example, upcoming training and completing a national qualification. The assistant regional director told us that there were plans to audit staff supervision records in order to inform whether staff were receiving the support they required to improve their roles and responsibilities. This was to ensure that the quality of supervisions were effective which would benefit people in the service. This would also improve staff skills and confidence.

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. We saw that mental capacity assessments had been undertaken for areas such as managing a person's finance, use of door alarms, and self neglect. The manager and the staff understood the principles. A member of staff said, "[MCA] is a huge subject including DoLs. People are assumed to have capacity, if not you should complete an assessment" and another said, "All people are independent and have a choice regarding food or activities."

Where necessary, the service had submitted applications to the supervisory body for a Deprivation of Liberty Safeguards (DoLS). DoLs ensure that people are only deprived of their liberty when this is in their best interests and legally authorised under the MCA. For example, we saw DoLS included the use of key codes and locks, constant supervision, medication and door alarms. There was evidence that the outcome for the application was regularly checked.

Where people could not verbally give consent we saw measures had been made to help the person to understand their care plans and support required. We saw that a member of staff had read the care plan through with the person explaining what was in it.

Documentation had prompts for care staff such as 'This is my level of understanding and ability to give consent. Remember to always assume capacity' and 'If staff show me the information in picture format, it must be colourful and have big writing. Best time to ask me is when I am happy.' For example, we saw a recent mental capacity assessment which had been carried out. It evidenced that the assessment had been carried out at different times of the day over multiple days to optimise the person's input. Where it was concluded that the person could not consent to their care plan, we saw actions such as 'Support [person] to do as much as he can, and encourage independence.'

People's health was optimised as the service ensured they had access to necessary health care and could access health professionals when needed. For example, we saw that people had Health Action Plans in place. This contained information such as having a yearly health check and having a flu vaccination and blood pressure checks. There was also a document that people could take if they were admitted to hospital. This provided information for hospital staff so they could quickly know the important elements of someone's needs. This is helpful when people are unable to verbally communicate their needs.

We saw people were involved in menu planning to reflect their individual tastes. People were supported to maintain a healthy diet to improve and maintain their health. A member of staff said, "People can choose their own food. Vegetables are always offered but not always eaten. This is their choice." A relative told us, "I believe they do provide a varied diet, though I do have concerns as my [relative] overweight. I understand that they can only guide as far as healthy eating and if they insist on wanting something they are not allowed to refuse."

Good

Is the service caring?

Our findings

We observed people being well cared for on the day of the inspection. The service was small and there was an established care team with little use of temporary staff. This ensured a continuity of care for people with staff they knew well. This meant staff knew people and their needs thoroughly which enabled them to support people in line with their needs, preferences and wishes. A relative told us, "I love the atmosphere at Meylan House. It is a happy house and the staff have always had a very good attitude. They promote wellbeing, manners, respect and boundaries between [people] and members of the staff. Our [relative] is always well dressed, clean and we feel [relative] is loved and appreciated by all the members of the staff."

On the day of the inspection, we observed caring and positive interactions between people and staff. We observed people in the service being at ease with staff. A member of staff told us of their enjoyment working with people in the service commenting, "[The home] is the best so far. It is like a home." A relative said, "Staff seem to be caring and professional."

Staff showed kindness whilst providing people with care and support. We saw that staff took time to talk to people to make them feel supported and comfortable. For example, we observed a staff member talk to one person and then give them assistance with a drink and a snack. They chatted to the person and seemed relaxed and at ease. The person appeared to be happy to have the friendly chat with the staff member.

People's care plans were prepared with respectful guidance about people's needs and how they wanted to receive support. People's care plans detailed information about the person's personality highlighting positive attributes such as 'What do people like about me? Chatty, bubbly, helpful, caring' and 'What is important? I like to make my own choices.' Additionally, the actions needed to be taken to comfort people were described clearly in their care plans. The records guided staff on how to react appropriately. For example, by speaking calmly, offering reassurance and identifying the source of a person's distress. Staff were always alert to any signs of distress and during the inspection we observed staff reading signs of distress and successfully supporting people.

In order to facilitate communication, most information was provided in a format that was easy to read, with symbols and pictures. People had various communication methods. For example, one person communicated with Makaton. Makaton is a language programme using signs and symbols to help people to communicate. People had communication passports which provided a guide to staff on how to communicate with them effectively and how the person communicated.

People were supported to make choices and decisions about their care. The choices included ways of spending their day, places to go, holidays and times to go to bed and to get up. For example, we saw that one person would tell the staff when they wanted to go to bed but also noted their normal sleep routine.

People's independence had been promoted and we saw people were encouraged to do as much as they could for themselves to maintain their dignity. For example, staff told us that treating people well was important. A relative told us, "Always under supervision, our [relative] has progressed a lot towards

independence." They went on to describe being supported to do the laundry, set the table, clean his room and preparing some meals. A member of staff said, "If a person needs help they will ask for it. We try to preserve their independence and encourage them to do as much personal care as possible to maintain their dignity."

We saw that relatives were welcome to visit at any time. We saw information recorded about important relationships and how often contact was usually made. This ensured that people were supported to maintain these relationships. A member of staff said, "We have good relationships with families and they can visit when they like."

People's wishes around what they wanted in the event of their death had been sensitively recorded. This captured information such as who was the next of kin, where they wished to be cared for, what sort of burial and choice of music and flowers to reflect their life.

We saw that records containing people's personal information were kept in the main office which was locked. This meant people's sensitive information was treated confidentially.

Good

Is the service responsive?

Our findings

The service had involved people in developing their care plans which reflected what was important to them. Staff showed an in-depth knowledge and understanding of people's care and support needs. All the staff members we talked to were able to describe the care needs of each person they provided with support. This included individual ways of communicating with people, people's preferences and routines. A member of staff said, "Person centred care is focussed on the individual, their needs, likes and dislikes, encouraging as much choice as possible. Encouraging independence and giving lots of choice." This meant that staff were able to offer very individualised care.

Care files contained sufficient information for staff to undertake the necessary tasks as well as including information which was person centered. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care. This meant that staff could build up a rapport with the person and know what was important to them. We saw care plans described how people wanted to receive care and what they could do for themselves. During the inspection, we heard a member of staff had been discussing how a person could maintain their bedroom so it didn't become too untidy. The person had suggested taking a photograph when it was tidy and displaying this so they could refer to it and help them know what it could look like. The staff member discussed this with the manager who agreed it was a great idea.

We reviewed a sample of daily notes and found them to be sufficiently detailed regarding the tasks the carer had undertaken. We saw that tasks on the care plan had been completed and recorded. People's care files were reviewed monthly and annually with relevant people involved such as relatives.

Each person had an allocated member of staff that who met with the person individually. Issues discussed included conflict with another members of house, what the person had enjoyed that month, for example, going to the fair and going for walks.

Communication was assisted by people supported to create 'social stories.' This technique was created by Carol Gray in 1991. They are short descriptions of a particular situation, event or activity, which includes specific information about what to expect in that situation and why. We saw an example of a social story prepared in an easy read format with photographs and other images in anticipation of moving into Meylan House. This had helped the person to start preparing for their eventual move to the service and what to expect.

People were involved in activities including using the computer, trampolining, bowling, going to the cinema and walks to the park. On the day of the inspection we saw a member of staff doing a manicure for one person. They were very pleased with the results and enjoyed the one to one attention.

The provider had a complaints policy in place and there was easy read guidance about how to make a complaint. However, this was not displayed. We discussed this with the assistant area director who agreed that this would be arranged via a secure notice board alongside other easy read documents such as the fire evacuation instructions. People also had regular meetings with their keyworkers so could discuss any areas

of concern at these in a confidential manner.

We saw a complaint had been handled thoroughly with meetings arranged and a written response. This was in line with the provider's policy. We asked staff how people could raise a complaint. They commented that "Apart from (name) all service users can say what they want. If unhappy they may go to their favourite staff." We saw there were regular meetings for people in the house where issues could be discussed. We saw one meeting that respect had been discussed and they reviewed the complaints procedure.

Good

Is the service well-led?

Our findings

There was a manager in the service. The manager was in the process of applying to the CQC to become the registered manager for the service.

We asked the manager what they considered the priorities for the service were. We were told this was to improve activities and set goals so that people could do more of what they enjoyed, especially community access. This would be assisted by recruiting more staff that were car drivers. The manager also intended to improve the supervision meetings with staff. Another aim was to review the format of care records to ensure they were relevant and information could be easily accessed by being streamlined. The manager acknowledged how well the team had managed with the changes in management and that they had continued to provide a good job supporting people throughout.

Staff were positive about the provider and management. Comments included, "I feel well supported by [manager] and organisation. Choice has strong core values of respect. The company expects a lot from staff. I would like more protected administration time, and there are plans to address this", "The manager is fairly new and has a lot to do. My line manager is very supportive and always has the time to answer questions. Communication is good" and "The manager shows good communication and leads well, and his line manager is very proactive and supportive." One relative told us, "We communicate very well and I think they listen and are always open to learn about my [relative's] preferences and needs. I really feel free to talk to them about anything we feel is necessary." However, another relative said, "I believe the management is open and transparent but would prefer there to be more communication from them. Occasionally I am not made aware of something until I make a visit. I would prefer to be contacted more often, particularly on health issues."

We found morale to be good amongst the staff and all staff we spoke with displayed a positive, caring attitude. It was clear in the observations throughout the inspection that the culture was caring, focussing on delivering good standards of care.

Regular staff meetings were held and recorded. We saw issues discussed such as ensuring supervisions sessions were attended and activities arranged for people. Discussions had also taken place about having a champion to lead on areas such as activities and dignity. .

We saw the outcome and actions from an annual quality assurance questionnaires. We saw the results from a questionnaire carried out in 2016 which had been analysed to produce actions. A questionnaire had also been carried out in 2017 but actions had not been analysed at the time of the inspection. We saw that the actions from the 2016 questionnaire had identified issues such as more activities, and employing more drivers were been addressed by the management. There was a reference to communication needing some improvement which reflected a comment we received at this inspection from a relative.

A range of audits were in place to monitor the quality of the service and to identify areas in which changes were required. Audits included medicines, infection control, health and safety and care files. As a result of

the audits, the provider and manager had a good overview of the quality of the service and any actions needed to improve quality or safety. Accidents and incidents at the service were recorded and monitored. We saw management monitoring reports for two months had reviewed accidents to see if any further actions or monitoring was required. The reports had not identified any accidents to be reviewed. However, it meant there was a system in place that identified risks to people who use the service.

The manager understood their legal responsibilities and ensured that the local authority's safeguarding team and the CQC were notified of incidents that had to be reported and maintained records of these for monitoring purposes. The provider had completed a Provider Information Return (PIR) and sent it to us. We saw that the information provided in the return was similar to what we heard and observed during the inspection.

Policies and procedures were detailed and gave adequate information to staff, people who use the service and their relatives, and were fit for purpose. We saw that they had been reviewed and that a system was in place for ensuring staff had read and understood them.