Care Quality Commission

Sovereign Guest Services Limited

Sovereign Court

Inspection report

Newbiggin Lane
Westerhope
Newcastle upon Tyne
NE5 1NA
Tel: 0191 271 6151
Website: www.

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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

Overall summary

This was an unannounced inspection carried out on 4 December 2015.

We last inspected Sovereign Court in August 2014. At that inspection we found the service was meeting all the legal requirements in force at the time.

Sovereign Court is a care home providing accommodation and personal care for up to 12 people with neurological disorders. Nursing care is not provided.

A manager was in place who had applied to become registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and were well cared for. Staff knew about safeguarding vulnerable adults. We observed staff provided care safely. Staff were subject to robust recruitment checks.

Summary of findings

Some areas of the premises were showing signs of wear and tear. A refurbishment programme was planned.

Staff had received training and had a good understanding of the Mental Capacity Act 2005 and Best Interest Decision Making, where decisions were made on behalf of people who were unable to make decisions themselves. Staff had completed other relevant training for their role and they were well supported by the management team. Training included care and safety related topics.

People's health needs were identified and staff worked with other professionals to ensure these were addressed. Arrangements for managing people's medicines were safe. Appropriate processes were in place for the administration of medicines. Medicines records were accurate.

Menus were designed with suggestions from people who used the service. Staff were aware of people's likes and dislikes and special diets that were required. People were supported to be part of the local community. They were provided with some opportunities to follow their interests and hobbies.

Staff knew the people they were supporting well. Care was provided with kindness and people's privacy and dignity were respected. Care plans were in place detailing how people wished to be supported and people were involved in making decisions about their care.

A complaints procedure was available and people we spoke with said they knew how to complain.

People and staff spoken with had confidence in the new manager and felt the service had good leadership. We found there were effective systems to assess and monitor the quality of the service, which included feedback from people receiving care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People received their medicines in a safe and timely way.

Staffing levels were sufficient to meet people's needs safely and flexibly and appropriate checks were carried out before staff began work with people.

People were protected from abuse as staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

Good

Is the service effective?
The service was effective.

Staff had access to training and the provider had a system to ensure this was up to date. Staff received regular supervision and an appraisal system was in place to support their professional development.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, if they were unable to give consent to their care and treatment.

Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs.

Good

Is the service caring?
The service was caring.

People were positive about the caring attitude of staff. During our inspection we observed sensitive and friendly interactions.

People's dignity and privacy was respected. Staff were aware of people's individual needs, backgrounds and personalities. This helped staff provide personalised care.

Staff supported people to access an advocate if the person had no family involvement. Advocates can represent the views of people who are not able express their wishes.

Good

Is the service responsive?
The service was responsive.

People received support in the way they needed because staff had detailed guidance about how to deliver people's care. Support plans were in place to meet people's care and support requirements.

People were provided with opportunities to access the local community. They were supported to follow their hobbies and interests.

People had information to help them complain. Complaints and any action taken were recorded.

Good

Summary of findings

Is the service well-led?

Good

The service was well-led.

People who used the service and staff told us the manager was supportive and could be approached at any time for advice and information.

There were systems in place to monitor the quality of the service, which included regular audits and feedback from people using the service, their relatives and staff. Action had been identified to address shortfalls and areas of development.

Sovereign Court

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.

Before the inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also contacted commissioners from the local authorities who contracted people's care. We spoke with the local safeguarding teams. We did not receive any information of concern from them.

This inspection took place on 4 December 2015 and was an unannounced inspection. It was carried out by an adult social care inspector.

We undertook general observations in communal areas and during a mealtime.

As part of the inspection we spoke with six people who were supported by Sovereign Court staff, three support workers, including the senior support worker, an agency support worker, one visiting health professional, one domestic, the registered manager and operational manager. We observed care and support in communal areas and checked the kitchen, bathrooms, lavatories and bedrooms after obtaining people's permission. We reviewed a range of records about people's care and checked to see how the home was managed. We looked at care plans for three people, the recruitment, training and induction records for four staff, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and the quality assurance audits the manager completed.

Good

Is the service safe?

Our findings

People told us they felt safe when receiving care. Comments from people included, "I feel safe here," "There are staff around if I need them," "I'm settled here," and, "I'd go and see the staff if I was worried."

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were able to describe various types of abuse. They could tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. Records showed and staff confirmed they had completed safeguarding training. Staff members' comments included, "I'd report any concerns to the manager," "I wouldn't put up with it," and, "I did safeguarding training as part of my induction." Staff told us they currently had no concerns and would have no problem raising concerns if they had any in the future.

The manager understood their role and responsibilities with regard to safeguarding and notifying CQC of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately by the manager. Five safeguarding alerts had been raised. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team.

We checked the management of medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration. Medicines were appropriately secured in a locked treatment room. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and they were sufficiently skilled to help people safely with their medicines. A staff member told us, "I'm still on induction so I don't handle medicines yet."

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for pressure area care, epilepsy, moving and assisting and distressed behaviour. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring. For example, "(Name) needs to keep their room uncluttered to enable them to move around the room safely."

Staff were aware of the reporting process for any accidents or incidents that occurred. These were reported directly to the manager. We were told all incidents were audited and action was taken by the manager as required to help protect people. The manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, a person was referred to the appropriate professionals when a certain amount of incidents were recorded.

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people using the service and their needs. There were nine people who were living at the home. Staffing rosters and observation showed they were supported by four support workers, including a senior support worker, from 8:00am-5:00pm. This number reduced to three support workers between 5:00pm- 8:00pm. There were two support workers including a senior support worker overnight from 8:00pm-8:00am.

Staff had been recruited correctly as the necessary checks to ensure people's safety had been carried out before people began work in the service. We spoke with members of staff and looked at four personnel files to make sure staff had been appropriately recruited. We saw relevant references had been obtained before staff were employed. A result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had also been obtained before they were offered their job.

Good

Is the service safe?

Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

The registered provider had arrangements in place for the on-going maintenance of the building. Routine safety checks and repairs were carried out by the handyman such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the hoist and specialist bath.

Good

Is the service effective?

Our findings

Staff were positive about the opportunities for training. Comments from staff included, "I've just finished some training," "Training is quite good," We get lots of training," and, "We do on-line training and face to face training."

Staff told us when they began working at the service they completed an induction and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. One staff member told us, "I'm still on my probation, I've done my induction training." The manager told us new staff completed a twelve week induction and studied for the new Care Certificate in health and social care as part of their induction training.

The staff training records showed and staff told us they were kept up-to-date with safe working practices. The manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. A weekly training league table displayed training results of some of the provider's others specialist services managed in the local area. We saw Sovereign Lodge had moved to second place showing a nine percent increase in training completed by staff members from the previous week. Staff completed training that helped them to understand people's needs and this included a range of courses such as dementia care, palliative care, equality and diversity, diet and nutrition, distressed behaviour and dignity in care. We discussed with the manager a recent safeguarding which highlighted the need for other training such as conflict resolution and mental health awareness. This training would give staff more insight into the different needs of people and awareness of how to diffuse a potentially challenging situation if it looked likely to occur. The manager said this would be addressed.

Staff said they received supervision from the management team, to discuss their work performance and training needs. Staff comments included, "I have supervision every two months," "I'm well supported," and, "I usually have supervision every two months with the manager." Staff told us they could also approach the management team at any time to discuss any issues. Arrangements were in place for staff to receive an annual appraisal to discuss their personal development and training needs to make sure they complemented the needs of the service and future service provision. One staff member said, "I have a meeting at six months with the manager as part of my appraisal."

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Sovereign Court records showed three people were legally authorised and other applications were being considered by the local authority. Staff had received Mental Capacity and Deprivation of Liberty safeguards training. This meant people's human rights were being protected.

People using the service were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'. The manager told us they worked with the local authority to ensure appropriate capacity assessments were carried out where there were concerns regarding a person's ability to make a decision.

We checked how people's nutritional needs were met and found people were assisted to access food and drink appropriately. Care plans were in place that recorded people's food likes and dislikes and any support required to help them eat. Some people accessed the kitchen to make their own drinks as they wanted and staff offered people drinks throughout the day, People's care records were detailed and provided information for staff. For example, "(Name) likes two cups of tea before they get up."

People's care records included nutrition care plans and these identified requirements such as the need for a modified diet. People were routinely assessed against the

Good

Is the service effective?

risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. For example, a care plan stated, "Staff to encourage and support (Name) to eat small portions of food often throughout the day." Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid balance' charts. People were positive about the food saying they had enough to eat and received a choice at meal times. People's comments included, "The food is good," "I get a cup of tea if I want it," "We have our main meal tonight, and, "There's a good choice of food."

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. Staff received advice and guidance when needed from specialists such as, the community nurse, dietician, speech and language teams, psychiatrist and General Practitioners (GP). Records were kept of visits and any changes and advice was reflected in people's care plans. Comments from a visiting health care professional we spoke with during the inspection included, "I think the staff work well, with (Name)," and, "I have no doubt they would contact me if they needed extra support. They are good at letting me know how (Name) is. I think they are doing a good job."

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. Staff told us a handover of verbal and written information took place for staff between each shift. Staff members' comments included, "I come in early so I can listen to the handover, I enjoy it" and, "Communication is good."

Some communal areas of the home were showing signs of wear and tear. The hallways and dining room walls were marked. Electric heaters were being replaced around the home and all walls where they had been replaced required redecorating as they were a different size to the previous heaters. The paintwork was chipped and several doorframes and doors were marked from wheelchair use along the corridors. The smoking room door did not close fully to its rebate. The manager told us the maintenance person was "touching up" the corridors. We had concerns the work required was more extensive due to the amount of wear and tear and should be carried out in a more timely way to reduce disruption to people who used the service. The manager told us a refurbishment plan was in place as the home had recently changed ownership and work had been identified and this would be addressed.

We noted a record was not available in the home to show if reported repairs had been carried out. For example, we saw two windows had been reported as leaking. The manager and most staff were unable to comment if they had been repaired as the external contractor no longer left confirmation at the home when work was completed, it was sent to head office. We spoke to one member of staff who could tell us the work had been done. A system was not in place internally in the home to record and confirm when people visited and such work was carried out. The manager told us this would be addressed.

Good

Is the service caring?

Our findings

People spoke positively of the care provided by staff. They told us staff were kind and caring. Comments included, "The staff are great," "Staff listen to me," "I've nothing but praise for the staff," "(Name) is great," and, "The staff are alright."

People were supported by staff who were warm, kind, caring, considerate and respectful. Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. People told us staff seemed knowledgeable about their care needs and knew how to look after them. They appeared comfortable with the staff that supported them. People said they were happy with the care and support they received. People's comments included, "I'm quite content here," and, "I can talk to staff if I need to." During the inspection we saw staff were patient in their interactions with people and took time to listen and talk with people.

People told us they were involved and kept informed of any changes within the home and staff kept them up to date with any changes in their care and support. Everyone had a communication care plan that provided information about the person and advised staff how people communicated. For example, "At times (Name) speaks in a quiet voice with their head down. Staff need to ask (Name) to repeat themselves to enable them to understand. (Name) will usually then speak louder and more slowly." The care plan also provided details of how the person communicated with family and friends outside of the home. For example, "(Name) communicates by letter with their relative in between them visiting."

People were encouraged to make choices about their day to day lives. They told us they were able to decide for example, when to get up and go to bed, what to eat, what to wear and what they might like to do. Care records detailed how people could be supported to make decisions. One person said, "It's up to me, it's my choice what I do." We observed staff interacted well with people and offered them choice. People told us staff always asked their permission before acting and checked they were happy with the care they were providing. For example, we observed a staff member asked each person if they were watching the television programme before they changed channels at someone's request.

People said their privacy and dignity were respected. We saw people being prompted and encouraged considerately. Staff were observed to be attentive, friendly and respectful in their approach. Staff knocked on people's doors and waited for permission before they went into their room.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision themselves. For example, an emergency health care plan was in place for a person. The care plan detailed the "Attempt resuscitation" directive that was in place for the person. Care records documented the end of life wishes of the person. This included spiritual requirements and funeral arrangements and who they wanted to be involved in their care at this time. For example, "No black clothing to be worn." This meant up to date information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

We observed staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the manger any issues or concerns. The manager told us an advocacy service was involved where people needed to have additional support whilst making decisions about their care. The service used advocates as required but most people had relatives. Advocates can represent the views for people who are not able to express their wishes. We were told two people had the involvement of an advocate.

Good

Is the service responsive?

Our findings

People's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort. People said they were supported and involved in planning their care.

Up-to-date written information was available for staff to respond to people's changing needs. Records showed that monthly assessments of people's needs were carried out with evidence of regular evaluation that reflected any changes that had taken place. For example, with regard to nutrition, pressure area care, mobility and falls and personal hygiene.

Records showed that information from assessments about people's medical conditions and their daily lives had been transferred to care plans. This was necessary to ensure staff could provide support to people in the way they wanted and needed to ensure their health and well-being. Care plans were developed from assessments that outlined how people's needs were to be met. For example, with regard to nutrition, mobility and epilepsy.

Staff responded to people's needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, a speech and language therapist and dietician were asked for advice with regard to nutrition for a person. Staff completed a daily record for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were usually up-dated monthly.

Care plans were detailed and provided sufficient information for staff to give care and support to people in the way they preferred. For example, care plans for personal hygiene recorded, "Staff to assist to wash (Name)'s back. (Name) will wash their arms, legs and feet," and, "(Name) will wash and condition their own hair. Staff to rinse."

Detailed records were in place for the management of some people who displayed distressed behaviours. These people had care plans to show their care and support requirements when they were distressed. The care plans gave staff guidance with regard to supporting people. For example, "(Name) displays inappropriate behaviour at times…. The episodes usually happen when (Name) is asked to do something they don't want to."

An activities organiser was employed for thirty hours a week as the result of people's feedback about activities. This person arranged a programme of entertainment and activities. For example, baking, exercises, pamper sessions and daily newspapers. We were told people were encouraged to remain independent in aspects of daily living and to retain former skills. We saw there was a weekly task list to show tasks people were allocated to take part in, with staff support if they wanted to be involved. For example, "setting tables, washing dishes, doing their own laundry and tidying and polishing their bedroom." Records showed entertainment included singers, entertainers and visits from local school children. People told us they were supported to go to out. People's comments included, "I like to go shopping," "I love to go to town," and, "We go out for meals."

People had the opportunity to give their views about the service. Monthly meetings were held with people. The manager said meetings provided feedback from people about the running of the home. We saw the meetings were an opportunity for people to give feedback about the care they received. For example, discussions about activities and menus. The meeting minutes however, did not give feedback at subsequent meetings to show the action that had been as a result of people's suggestions. For example, trips out. The manager said that this would be addressed.

People said they knew how to complain. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw three complaints had been received since the last inspection. They had been investigated and resolved satisfactorily.

Good

Is the service well-led?

Our findings

A manager was in post who had applied to become registered with the Care Quality Commission in November 2015. The manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities.

The manager said they had introduced changes to the service to help its smooth running and to help ensure it was well-led for the benefit of people. They responded quickly to address any concerns. Staff comments included, "(Name) is great," "The manager is approachable," and, "I think the manager is nice."

We saw records that showed staff meetings were held with the manager and all staff every month. Staff could give their views and contribute to the organisation's running. Areas of discussion included, staff performance, health and safety, safeguarding and support worker duties.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. The audits consisted of a wide range of weekly, monthly, quarterly and annual checks. They included health and safety, infection control, training, care provision, medicines, personnel documentation and care documentation. Audits identified actions that needed to be taken. An annual audit was carried out to monitor the safety and quality of the service provided.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to staff and people who used the service. We saw surveys had been completed by people who used the service, staff and visiting professionals in 2015. The results were analysed by head office and we saw the action that had been taken as a result of people's comments, to improve the quality of the service. For example, menus were reviewed more often and provided more choice for people. People were aware they could have a long lie in if they wanted in the morning and an activities person had been employed to improve activities and staff training had improved.