Care Quality Commission

Northern Life Care Limited

UBU - 67 Elland Road

Inspection report

67 Elland Road
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West Yorkshire
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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?	Requires Improvement

Summary of findings

Overall summary

UBU - 67 Elland Road is a 'care home'. People in care homes receive accommodation and personal care under a contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

UBU - 67 Elland Road is registered to provide accommodation and personal care for up to seven people who have learning disabilities.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

This inspection took place on 16 and 17 May 2018. The inspection was unannounced on the first day. This meant the staff and provider did not know we would be visiting. The second day was announced.

At the last inspection we found the provider did not always keep accurate and up to date health action plans and were rated requires improvement in the effective domain. At this inspection we found health action plans were accurate and updated to ensure people's needs were met.

There was no registered manager in post at the time of our inspection. However; the area manager was in the process of applying as a temporary measure until the manager could apply. 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.

Care plan records were not always accurate to show when actions had been taken, therefore we have made a recommendation about records management.

The provider had robust systems and procedures in place to keep people safe and staff were competent in their knowledge of what constituted abuse and how to safeguard people. There was a whistleblowing policy in place and staff knew how to raise concerns should this be required.

Medicines were managed safely although we did find gaps in recording when medicines had been administered. 'As required' medicines were administered when needed.

Risk assessments had been completed and reviewed regularly. Accidents and incidents were managed effectively and actions taken to mitigate future risks.

Staffing levels were sufficient to meet people's needs and robust recruitment processes were in place to ensure people were of suitable character. Training was mandatory for staff to ensure they had adequate skills and knowledge to meet people's needs. Staff were supported with supervisions and appraisals for further development.

Safety checks were completed regularly and the premises was clean, tidy and action plans showed continuous improvements were being made within the home.

The provider followed the Mental Capacity Act 2005 (MCA) guidance with capacity assessments and Deprivation of Liberty Safeguards (DoLS) applications made. Staff also understood MCA guidance and people were able to provide consent in a variety of ways including through facial expressions and body language.

People's nutritional needs were met and health professionals were involved in people's care when required. Health action plans were used when people had health appointments and records showed the improvements made to people's health.

We observed positive and friendly interactions between the staff and people living in the home. Staff were caring, kind and respected peoples wishes. We saw people were encouraged to remain as independent as possible using alternative communications to allow people to make choices about their care.

People's privacy and dignity was respected and staff provided explanations when carrying out any personal care to ensure people knew what was happening at all times.

Care plans were person centred and reviewed regularly with people living in the home and their relatives. Care plans included people's preferences, likes and dislikes.

Complaints were managed and actions taken to prevent future occurrences. The provider had also received a number of compliments about the care provided by staff.

Relatives and staff told us the team were supportive of each other and the manager was visible and approachable. The staff had recognised improvements that had been made by the manager and felt these were positive.

Regular meetings took place with people living in the home, staff and relatives to obtain feedback and inform people of changes within the home.

The provider had quality assurance systems in place to recognise and rectify issues which included audits. Surveys were used to gather people's views and ensure actions were taken to improve the quality of care being provided.

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 knew how to protect people from abuse and what to do if they suspected abuse was taking place.

Medicines were managed safely although records were not always completed.

Risk assessments were specific to people and updated regularly. Accidents and incidents were managed effectively with actions taken to mitigate future risks.

Staffing levels were sufficient to meet people's needs and robust systems were in place to recruit staff.

Is the service effective?

Good

The service was effective.

The provider understood how to support people in line with the Mental Capacity Act 2005 and used best interest decisions when required.

Training and induction programmes were provided to give staff the skills and knowledge to meet people's needs. Supervisions and appraisals also supported staff with their development.

People were supported with their nutritional needs and supported to access input from health professionals when required.

Is the service caring?

Good

The service was caring.

People were treated with care, dignity and respect. People had positive relationships with staff.

People's care records detailed their wishes and preferences around the care and treatment provided. Individualised communication methods were used to support people to make choices.

People were encouraged to be as independent as possible and involved fully in their care planning. Staff also provided explanations to ensure people understood their care.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and were regularly reviewed.

People were offered choices and provided with accessible information to help them make decisions about their care.

People were encouraged to partake in activities to avoid social isolation.

Complaints were managed effectively and people told us they knew how to complain if needed.

Is the service well-led?

Requires Improvement

The service was not always well led.

Records had not always been accurate or completed to show when actions had been taken.

Systems and processes were in place to monitor and improve services. Surveys were used to gather people's views.

Staff felt confident any concerns would be effectively managed. Meetings were held so people could raise their views and be informed of changes within the home.

Relatives and staff told us the culture was positive, honest and open.

UBU - 67 Elland Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 16 and 17 May 2018. It was unannounced on the first day and was carried out by one inspector. The second day was announced.

Before our inspection, we reviewed all the information we held about the service, including previous inspection reports and statutory notifications sent to us by the provider. Statutory notifications contain information about changes, events or incidents that the provider is legally required to send us. We also contacted the local authority, commissioners, safeguarding and Healthwatch to gather their feedback and views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Before the inspection, the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we were informed by the manager that no person currently living in the home was able to verbally communicate. This meant we were not able to gather people's views verbally but did this through observation. We also spoke with two relatives, three care workers, the manager, the area manager and the regional manager. We spent time looking at documents and records relating to people's care and the management of the service. We looked in detail at three people's care plans, medicine records, two staff personal files and a variety of policies and procedures developed and implemented by the provider.

Good

Is the service safe?

Our findings

The provider had robust systems in place for staff to follow and report any abuse. Staff had a clear understanding of how to report any concerns and knew how to keep people safe. For example one staff member said, "Some people have a DoLs in place, we keep the front door locked, we have a sign in sheet so we know who's in the building and we keep all people's medicines in a locked cupboard." There was a whistleblowing policy in place and staff said they felt confident to raise any concerns.

Risk assessments were in place and regularly reviewed to ensure people were kept safe from possible risks. For example, one risk assessment identified a risk of falls from a person's wheelchair as they were prone to sliding from seats and unable to weightbear. Equipment was used to ensure the person was supported in their chair and we saw a sensor pad on a sofa which alerted staff. This meant the risk of falls was reduced. Another risk assessment identified the need for the person to be regularly re-positioned and creams applied to reduce the risk of pressure sores.

One relative told us about how the staff managed risk as previously a person received wet shaves and due to their involuntary movements was once cut from this. The decision was made with the person and their relative that an electrical razor would be used to prevent this happening again.

Accidents and incidents were managed appropriately; there were incident reports for concerns raised and clear evidence of actions taken. For example, one person had previously had a choking incident, staff immediately began first aid and the food was removed. The staff also contacted the emergency services to ensure the person was safe and a review of their care took place to prevent future incidents.

We saw the provider had taken appropriate action to ensure the safety of the premises. This included fire, gas, electricity and water safety checks. We saw the fire risk assessment had been completed and reviewed on an annual basis. Fire alarm tests took place to ensure staff knew how to evacuate people in a timely manner and each person had a personal evacuation plan (PEEP) in place so staff knew how best to support people to evacuate the premises.

The premises was clean and tidy. At the time of our inspection renovation work was being carried out to improve the premises. This included new offices and new flooring to ensure the premises remained safe for those people living in the home. We also saw the provider had an action plan of improvements that were due to take place. One relative said, "It's always clean and well decorated. All in all it's a lovely place for people to live."

Staffing levels were sufficient to meet people's needs. We saw people's needs were met by staff and the rotas showed consistency in staffing levels. Staff comments included, "Yes, a bit short staffed but they do their best to get agency staff" and "Staffing levels are alright, before Christmas we used lots of agency but this is getting better as we now have less agency and more permanent staff." The area manager told us agency staff were used to ensure people's needs were met and they were in the process of recruiting more permanent staff.

The provider had robust systems and checks in place which ensured people were of suitable character to work with people in the home. This included pre-employment checks such as references being obtained and a Disclosure and Barring Service (DBS) checks prior to staff being offered employment. A DBS check is completed during the staff recruitment stage to determine whether or not an individual is suitable to work with vulnerable adults.

We found medicines were administered to people living the home however, accurate records of these were not always maintained. We have addressed our concerns about records within the Well- Led domain of this report.

We looked at peoples medication administration records (MAR)'s and found that not all medicines had been signed to record when medicines were administered. We looked at daily notes which did however, confirm medicines had been administered to people as prescribed.

Some people living in the home were prescribed, 'As required' medicines. We saw some protocols in place which provided clear instructions for staff on why the medicines had been prescribed. For example, with regards to dressings to prevent and manage pressure sores.

People's medicines were individually stored within their rooms in a locked box. Fridge temperatures had been completed to ensure medicines were stored at the correct temperature. Staff followed the procedure for administering controlled drugs in most cases and monthly stock checks had been completed to ensure people received the correct medicines.

There was an infection control policy which staff followed and we observed people washing their hands before preparing food and protective equipment such as gloves and aprons were available to protect against cross infection.

Good

Is the service effective?

Our findings

Staff told us they had the skills and knowledge to meet people's needs. One staff member said, "The training is good. If someone needs something different, training is provided. We have staff at the moment in training to support someone at a hydro pool."

Training was completed by all staff. Some of the training courses included, moving and handling, health and safety, fire safety, safeguarding, mental capacity act training and autism awareness. The registered manager had a matrix in place to show and monitor which staff had completed their training and when this was due to be updated. Most staff had completed their training with records showing over 80% having been completed.

An induction programme was in place for new staff which included a 22 stage process with learning objectives to be completed and shadowing of experienced staff for a four week period or more if required. Competency checks were also carried out to ensure staff were safe to work with people and a probationary period was in place for nine months.

Staff were supported with regular supervisions and annual appraisals which provided opportunities for staff to develop in their skills and knowledge. Staff told us they felt supported and one staff member said, "It's quite good, If you have got an issue we can just speak to the manager and feel comfortable with them. It's a really good staff team here."

Not all of the people who used the service had the mental capacity to make informed choices and decisions about all aspects of their lives. 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. The authorisation procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA and found DoLS applications had been applied for and renewed in line with the act. Mental capacity assessments were completed when there was a need. For example, we saw one person had a capacity assessment in place for their finances and the decision had been made that the person was unable to manage their finances due to the lack of capacity. Some people lacked capacity to consent to their personal care and we found some assessments had not been updated on their new computer system. The area manager showed us an action plan that highlighted the need for all capacity assessments to be put onto their new system and this was currently being implemented.

We saw individualised best interest meetings had taken place when a person was unable to consent to care. For example, one person required medical care to ensure their wellbeing and improve health. A meeting had taken place with staff and health professionals to determine the least restrictive action that was in the person's best interest.

Due to people's individual communication needs we found consent was obtained in a variety of ways including body language and facial expression. For example, one care plan stated, 'I show my consent to using my walker by standing at the walker and picking up my feet when walking. To show I do not consent I would shout out when my hands were placed on the walker and take my hands off the walker.'

The manager told us people chose when they wanted to eat their meals and there were no set times. We observed people eating at different times of the day in the dining area. We also observed staff offering drinks and snacks to people throughout the day. Staff supported people at meals times with some people requiring mashable foods to avoid choking and others who needed prompts. Staff knew how to best support people and care plans detailed peoples preferences for example, 'I usually have porridge with fruit in. I like this and show this by eating it all by myself with no prompting. If I didn't like something I would try and tip the bowl over.'

People's nutrition was monitored by staff with monthly weights completed to check if people required further input from health professionals. Staff told us they supported people to health appointments when needed, one staff member said, "We book the appointments and support them to do that and attend. We then log information, say what happened at the appointment and what actions to take."

At the last inspection we found health action plans had not always been completed and therefore a recommendation was made. At this inspection we found the health action plans had been completed and entries recorded when this had been reviewed. For example, one person had been seen by the district nurse after staff had noticed a pressure sore. The action plan stated a review of the sore would take place and this had been completed. We saw the daily notes had recorded when the district nurse visited and that the sore had healed.

Good

Is the service caring?

Our findings

We observed positive and friendly interactions between staff and people living within the home. We observed one staff member introducing themselves to a person, offering a hand to take the person to their bedroom. The person smiled, laughed and took the staff member's hands. At lunch time we heard people laughing and staff interacting with people around the dining room table.

One relative said they were "Happy" with the care their relative received and said, "The staff are marvellous. [Staff name] knows [Persons name] as well as I do because staff have been here a long time." Another relative commented, "Staff are brilliant, excellent and very involved. They are kind, generous and welcoming."

People's privacy and dignity were respected. We observed staff supported people to eat their meals and afterwards gently wiping food away from their mouth to ensure they remained well kempt. Staff told us if they were providing care they would do this in people's bedrooms, closing the doors and curtains when appropriate. We observed staff knocking on people's doors before entering bedrooms and informing people of why they had entered.

Staff told us they encouraged people to remain independent as far as possible. For example, they provided communication cards to one person who used these to indicate to staff their preferences and what they wished to do. Another person required support at meal times due to being blind and deaf. Staff supported the person to eat independently by gently touching the persons hand to collect the spoon of food which allowed them to remain independent.

All of the people living at the home were non-verbal however; some people were able to express their wishes through body language and facial expressions. Staff told us they were always looking at ways in which to promote peoples independence within the home. One person had set themselves a goal to become more independent and expressed their preferences by picking up or tapping objectives to show the choice they had made.

During the inspection an NHS intensive interactions team attended to teach staff about the variety of ways to communicate with people who may not be able to verbally communicate through means of touch, light and sound in some cases.

Care plan reviews were held quarterly with people and their relatives if they wished. One relative told us, "I'm very involved, they always ring or I can ring them to get an update. I'm involved in care planning and know all of the professionals involved in [Name]'s care. The communication is very good; they always call even if [Name] is going to an appointment."

Staff told us they always ensured they verbally explained to people what they were doing and this was clearly documented in care plans. For example, one person's medication care plan stated, 'Staff must show me tablets on the yogurt and tell me what they are for. If I agree to take the medication I will open my mouth and take it.'

People had individual 'communication cards' which provided details of their communication needs should they need to use these in the community. This included details of how the person may communicate and the best course of action to take if needing to speak with the person.

Some people living in the home had an advocate. An advocate is a person who can support others to raise their views, if required. The manager told us that should anyone wish to have an advocate they used a local agency which people had access to.

Good

Is the service responsive?

Our findings

We saw care plans were individualised and person centred. For example, people's preferences had been recorded so staff knew the best way in which to support each person living in the home. One care plan stated what the person wished to be called and their food preferences stated, 'I really like spicy food, the hotter the better!' Another care plan stated, 'I like 1-1 staff support this will be intensive interaction with staff in my room on my mats between 5-6pm normally, I like music, swimming and hydrotherapy, I like long walks, I also like visiting my family.'

People were offered choice about how they wished to live their lives for example, 'Where possible I should always be asked to make choices and can do this for things I do every day. I use simple Makaton (A type of sign language used to communicate) that I have learnt, where staff sign using my hands to indicate to me what it is they are going to do. Examples of this are when I am going to eat, drink and take my medication. My sign for drink is to take hold of a staff members hand and then put it to my face extending my index finger over my top lip.'

We also saw people had 'Life style plans' in their rooms which included a one page profile about the person, their likes, dislikes, hopes and dreams, goals, what is important to them and communication needs. Some of the 'Life style plans' had not been reviewed in a timely manner however, the manager showed us the action plan they had in place to update these for each individual and some had been completed at the time of our inspection.

Staff told us they knew people living in the home well as many people had lived there for several years and were able to identify what people needed without verbal communication. This was also reflected in people's care plans as staff built relationships with individuals. For example one care plan stated, 'I will indicate when I want to get up by sitting up in bed and clapping my hands together and rocking backwards and forwards. I have breakfast and usually like to choose porridge or Weetabix. I choose by rocking towards my preference.'

Accessible information was available for those people living in the home who were unable to read. This included some information being displayed in picture formats and the use of picture cards were used to help people make decisions about their care.

The manager told us most people living in the home were out during the day to avoid social isolation and during our inspection we saw people come and go to do activities, go out with relatives or attend day centres which provided activities. Staff also supported people with their activities for example; one person attended a hydrotherapy pool as they enjoyed swimming and were supported to do this. The manager also told us they had recently started to design a sensory garden for people to access.

One person living in the home had a passion for cycling and although the person was unable to cycle independently the provider had found a local service that enabled the person's wheelchair to be attached to a device so they could cycle.

In the last 12 months the provider had received one complaint. The area manager told us, complaints were managed with by their head office. Initial details would be inputted into their complaints documentation on a system which would then send this to the head office to respond and take actions when needed. We saw the outcome of the complaint which included a letter of apology and the actions taken by the provider. There was also a section available to record lessons learnt from any complaints received.

The provider had received several compliments from health professionals and relatives. Comments included, [Relatives name] is so happy with the support that [Name] is having and also how thoughtful the staff team is. [Relatives name] is so appreciative of how the team have stayed in contact with them and kept them updated with the support that [Name] has' and 'During a review meeting in connection with [Name], [Name] praised the team at Elland Road for making significant positive changes to the support of [Name] and to the communication links with Aspire. [Name] was so pleased that she wanted to use this experience as a teaching aid to show others how much improvements can be made with good communication and partnership working.'

Requires Improvement

Is the service well-led?

Our findings

We found shortfalls in some of the records in the service. Accurate and up to date records had not always been maintained. For example, we found one MAR which had 20 missed signatures for a prescribed medicine over a four week period. MAR records did not always specify when a person required their medicines and stated 'use as directed' which was unclear for staff who were administering the medicines. We did find people received their medicines as this was documented within people's daily notes and audits were being completed to monitor these issues. We found issues regarding medicine errors had been identified and there was an action plan in place to address these concerns.

Some people living in the home were prescribed 'Thick and easy' powders to add into drinks as thickeners to prevent choking due to swallowing difficulties. We found charts in place for staff to record drinks that had been given however; this had not always been recorded by staff. For example, the powder should be administered into all fluids and we found one chart with several days where no records had been completed. The provider told us they were planning to look at using a different recording tool to ensure staff completed accurate recordings.

We saw that staff had not always recorded specific times of when 'As required' medicines had been administered or incorrect dates were written. For example, 'noon' was documented rather than specific times of when the medication was administered therefore making it difficult for staff to know when it would be safe to administered further medication. Some dates recorded were incorrectly written and therefore not accurate. For example, some staff recorded dates that had not yet taken place. Prior to our inspection the provider had highlighted this as a concern following an audit and an action place was in place to address these concerns.

We found people's 'Life style plans' had not always been kept up to date as some of these had not been reviewed since 2016. The manager did have an action plan in place and was in the process of updating these at the time of our inspection. We saw some had been updated at the time of our inspection.

We found files in people's bedrooms included old documentation which needed to be archived as it made it difficult to find current information relevant to peoples care. The manager told us they were aware of this and had started to archive some documents to ensure there was no confusion about people's current needs.

Not all MCA documents were on the computer system used to record MCA assessments and this was part of their action plan to have all documented on their computer by the end of June 2018. For example, some assessments had to be sent to the inspector the day after the inspection as they were unable to obtain these on the second day of our inspection. This information should have been recorded within the provider's current system so staff could immediately access this information and understand whether people living in the home could make decisions for specific areas of their care.

Although fridge temperatures were completed for individual boxes in people's rooms, we checked the cupboard where other medicines were stored and found several days where the temperature had not been recorded. This meant the provider could not be certain that medicines were always stored at the correct temperature.

We recommended the provider review all records to ensure they were accurate and up to date in line with best practice.

Relatives and staff told us there was an open culture, that people supported each other and said the manager had implemented new ideas to improve the service. Comments included, "The manager is very proactive in getting things sorted", "We are a good staff team and very attached to the people who live here, I love supporting them", "I feel supported. The manager is great and coming up with new ideas, looking at more activities for people and creating the sensory garden" and "They are open and honest about what's going on."

The manager had only been in post for a short time and therefore the area manager told us they were currently in the process of becoming the registered manager and had an interview with the CQC on 17 May 2018 which is part of this process. The manager said they would become the registered manager once they had completed their probationary period which takes nine months to complete.

Monthly staff and resident meetings took place within the home. Staff meetings focused on health and safety concerns, policies and procedures. At the last meeting in April 2018, the manager told us consent, people's goals, human rights, compliments and implementing an infection control champion had been discussed. 'Resident' meetings discussed activities, any changes within the home and updates regarding the staff team.

Meetings also took place with relatives so they could express their views and suggest improvements. One relative told us, "We say what's gone well and what needs improving, it's also nice to see other parents."

The provider had quality assurance systems in place to recognise and rectify issues. We found that actions listed on audits were transferred onto an action plan which the manager worked through and recorded completion dates when actions had been achieved. The provider used graphs to identify areas of concern and improvement. For example, the well led audits showed there were fewer actions to complete from December 2017 to March 2018 due to improvements having been made.

Audits were completed quarterly, monthly and weekly which focused on the service being person led, people's personal safety and whether it was well led. Some of the areas look at within the audits included care planning, medicines, MCA assessments, health and safety, premises, equipment checks, staffing and engagement.

Annual surveys were used to gather people's views and we found the results were mainly positive. We also saw the provider had policies and procedures in place which were up to date and available to staff.