MacIntyre Care

Ceely Road

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This inspection took place on the 30 November and 1 December 2015 and was unannounced. The last inspection of this service took place in 2013. The service was found to be meeting the requirements of the regulations at that time.

Ceely Road provides residential care to six adults with a learning disability. It is a requirement of the registration of Ceely Road that there is a registered manager in place. At the time of the inspection a registered manager was in place but was overseeing the care provided in another service. An acting manager was covering in their absence. The registered manager and the acting manager were both present throughout the two days of the inspection. 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's relatives told us they were sure the service was safe, it was well managed and people were well cared for.

Some areas of the running of the home required some improvements, for example, infection control audits had not been completed. Although systems were in place to ensure the risk of infections were minimised, these were not always checked and documented. We have made a recommendation about how the home manages infection control. Other areas included the number of staff available to ensure people's needs were consistently met. Because staff were required to undertake domestic tasks such as cleaning and cooking, they were not always available to support people. We have made a recommendation about the staffing levels in the home.

Medicines were safely stored and administered. Records were up to date and showed people received their medicines at the time they needed them. Records related to homely remedies which are medicines bought over the counter did not always include documented evidence of agreement with the GP or pharmacist. This was not in line with the provider's policy but was being addressed by the acting manager.

Staff knew about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Where restraints had been put in place to keep people safe, authorisation had been applied for from the local authority. People's mental capacity had been assessed for some decisions, and where appropriate the opinions of others including family members and professionals had been sought to ensure decisions made were in the person's best interest.

Care plans and risk assessments were in place to ensure people's needs were identified and care was both appropriate and safe. Records showed people were appropriately supported with their food and fluid intake. Where specialist advice had been sought to ensure people could eat and drink safely this had been carried out by staff.

Staff knew how to keep people safe and how to identify and report concerns of abuse. They also understood how to respond to complaints and recognised the people living in the home may not be able to make verbal complaints. Where they felt through the interpretation of people's behaviour or body language they were complaining, they followed the same complaints procedure as for others. Action plans were drawn up to ensure complaints were learnt from and changes were appropriate were made.

People's relatives told us they thought the staff were knowledgeable and skilled to carry out their roles. Staff received induction, training, supervision and appraisals. They were supported by the senior staff who were available and accessible.

Communication with people was a focus within the home. The provider trained staff to equip them with the skills to carry out positive interactions with people. Signage around the home facilitated further communication with people, through the use of sign language, photographs and objects of reference.

Staff and relatives spoke positively about how the home was managed. They had confidence in the management and felt they were listened to and their opinions taken seriously. Quality assurance measures were in place in the form of audits and questionnaires. The information gathered was used to improve the service to people where possible.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

There was not always sufficient numbers of staff available to ensure people's safety and wellbeing.

Infection control audits were not being completed.

Medicines were not always stored, recorded or administered in line with the provider's policy.

Is the service effective?

Good

The service was effective.

Staff knew how to apply the Mental Capacity Act 2005 and The Deprivation of Liberty Safeguards to the care being provided in the home.

People received a balanced diet and where specialist advice was given on how to prepare food for people to ensure they did not choke, this was followed.

People's health was maintained and when necessary and appropriate people were referred to medical professionals for advice and treatment.

Is the service caring?

Good

The service was caring.

Staff interacted with people in an appropriate and meaningful way.

Staff knew how to protect people dignity and privacy.

Relatives were kept up to date and involved in how care was provided.

Is the service responsive?

Good

The service was effective.

People's care plans were reviewed regularly.

The provider had sought feedback from people and their relatives. They used the information to check the quality of the care and where possible make improvements.

Is the service well-led?

Good

The service was well-led.
Staff and people's relatives told us the registered manager listened to their comments and acted upon them.

Quality assurance audits were regularly undertaken and the findings used to improve the quality of the service to people.

Ceely 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 unannounced inspection took place on 30 November and 1 December 2015. It was carried out by an inspector. Prior to and after the inspection, we reviewed previous inspection reports and other information we held about the home including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about. We did not request the completion of a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five staff including the registered manager, the acting front line manager and the area manager. We were not able to speak with the people who lived in the home due to communication difficulties. We spoke with two relatives. We carried out observations of care and reviewed documents associated to people's care and their medicines. We reviewed records related the employment of staff and audits connected to the running of the home.

Requires Improvement

Is the service safe?

Our findings

Relatives of people living in the home told us they felt the service operated in a safe way.

During our inspection we noted a few areas that posed a risk to people's health and wellbeing. For example the lid to the bin in the kitchen had to be manually lifted because it was broken; this posed a risk to the spread of infection. Some small areas of the bathroom areas around the pipes and floor areas were not fully cleaned. In an upstairs bathroom there were no cleaning or sanitising products for hand washing or drying. It was explained to us that usually gel was available, but this was not present on the first day of the inspection. We were told this would be rectified immediately. We asked to see the infection control audit. We were told there was not one available. From our observations the home appeared clean and tidy apart from the areas we highlighted. We observed staff using aprons to prepare food, and we noted in the staff communication book that supplies of disposable aprons and gloves were available for staff to use when supporting people with personal care. A cleaning regime was in place with a thorough clean of the home being carried out on the first week of the month. Alongside this an infection control policy and risk assessment was in place along with an annual statement of infection prevention and control which had been completed in July 2014. However the areas we identified requiring improvement would have been noticed during an audit if one had been completed. This would have minimised the risk of the spread of infection.

We observed there were two staff plus the acting manager on duty on both days of the inspection. The registered manager told us the staffing levels were calculated in relation to the funding provided by the local authority and the specific needs of individuals. This meant the local authority carried out an assessment of each person's needs and allocated funding to pay for staff to enable the person's needs to be met. Staff told us there were insufficient staff members to meet the needs of the people living in the home and that their duties were task focussed. For example, on the first day of the inspection one staff member had transported people to their day services. This left a second staff member in the home with two people. The staff member was cleaning the kitchen as required by the cleaning schedule. The two people who were left in the home were watching a DVD. The staff member checked they were ok but was not able to spend time with them. On the second day of the inspection, different staff were on duty but the same arrangements took place, leaving people alone in the lounge, whilst the staff member prepared lunch and undertook cleaning tasks. A staff member told us "We are always having to prioritise things, one day things get missed so other things can be done." Another staff member told us "People have their routines, when there is not enough staff behavioural issues arise." Relatives had a mixed view of the staffing levels. One relative told us they thought there were sufficient numbers of staff whilst the other did not.

We discussed the staffing levels with the registered manager and the acting manager. They told us the acting manager was usually available during the day and they were able to offer assistance if required. They agreed that people were spending long periods of time without the company and support of staff. Staff intermittently checked people were ok and provided drinks and support when needed. A staff member told us "You are constantly listening out for them…The ladies don't get as much attention and have to wait their

turn." At the time of the inspection adverts and interviews were in place to recruit new staff into the 93 hours of staff vacant hours at the home. Agency staff were covering these vacant hours.

We reviewed the storage and administration of medicines with the registered manager at the home. People's medicines were stored in a locked cupboard. Up to date medication administration records, showed staff had signed when medicines had been given to people.

Protocols for the administration of 'as required' medicines were available. These protocols provided guidance as to when it was appropriate to administer an 'as required' medicine and ensure that people received their medicines in a consistent manner. The protocols described how a person may demonstrate their requirement for the medicine, so that staff knew when it was appropriate to administer it. As the medicines were being administered to people who may not be able to verbally request the medicine this was important information.

Other information included in the care plans described how the person preferred to take their medicines and if the person was able to swallow tablets or required liquid medicines. Checks were completed on the amount of medicines being stored for each person against what was received and administered. Further spot checks were completed by the registered manager on how staff administered and recorded medicines. This was to ensure staff were carrying out this task safely and correctly. Staff received training in how to administer medicines and carry out safe recording practices. The home had a policy on homely remedies. These are medicines that are purchased over the counter rather than being prescribed. We found two unlabelled medicines in the medicines storage safe. We understood from the registered manager that these had been purchased following the advice of medical staff. The homes policy referred to the need for discussion with the GP or pharmacist to ensure the medicines were safe to use. Although historically one person's GP had consented to the use of the medicine, documents were not readily available to evidence this. The other medicine was obtained on the advice of a dental nurse. The registered manager told us they would be reviewing the medicines with the GP in the next couple of weeks, following this they would document the advice given. This would ensure the medicine was still appropriate to the needs of the person and safe to use.

From our observations we could see staff followed safe procedures when carrying out moving and handling techniques. This was to minimise the risk of harm to people or staff during the process of assisting a person to move from one location to another.

Documents showed risks to people's health and welfare had been assessed and risk assessments had been completed. Care plans informed staff how to reduce the risk of injury to themselves and to people, for example, how to support people when out in the community. These were reviewed frequently and kept up to date. Staff told us care plans reflected people's changing needs and included information on any special requirements people needed. Staff adhered to speech and language therapy guidance when preparing food and drinks. For one person drinks were thickened and food was pureed to ensure the risk of choking was minimised.

Staff told us they were kept informed of any changes to people's immediate care needs during the shift handover where a verbal handover was received, other information was documented in the communication book, which staff read when they came on shift. This was to ensure care was appropriate and safe.

The provider knew how to recruit staff and how to carry out the necessary checks to make sure they were suitable to work with people. These checks included evidence of disclosure and barring service (DBS) checks. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and

prevent unsuitable people from working with vulnerable groups. Although the original documentation was stored in a different location, records demonstrated that applicants had completed application forms and references had been obtained from previous employers along with the necessary checks.

Staff knew how to identify and report concerns related to possible abuse. The home had a safeguarding adult's policy and procedure. This guided staff on how to respond to concerns of abuse. All staff had received training in how to protect people from abuse. Written guidance was also available to staff in the office on how and who to report concerns to in the local authority.

Safety checks were undertaken to ensure the safety of the building and the equipment, this included maintenance and checks of the water supply to prevent legionella and the fire equipment and alarm systems. Documents demonstrated regular fire drills were carried out at the premises.

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We recommend the service consider current guidance in relation to the prevention and control of infection in care homes.

We recommend the service review the staffing levels in the home to ensure they provide safe and consistent care.

Good

Is the service effective?

Our findings

Relatives told us they thought the staff were knowledgeable about their roles. We were told by the registered manager when new staff began work for the service they received induction training in the areas deemed mandatory by the provider. They were also issued with workbooks, which covered areas of work relevant to their role. A series of questions required answers and these were checked by the supervisor to ensure staff understood the requirements and responsibilities of their roles. Staff told us they felt they had received sufficient training to carry out their job. The training matrix showed the majority of staff were up to date with the required training.

Records indicated staff received support from the registered or acting manager through regular supervision and appraisals. Documents showed this allowed both parties the opportunity to reflect on the performance of the staff member and where appropriate to develop plans for improvement. Staff told us they felt supported and any feedback they received was constructive. It also allowed staff to raise concerns or questions and to suggest improvements in how care could be delivered. A second staff member commented "If I have queries they (manager) answer them, they do their best to support staff members and to meet everyone needs."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where restrictions were in place to maintain people's safety appropriate DoLS applications had been sent to the local authority for authorisation. Two DoLS applications had been authorised. Best interest meetings had been held to discuss and agree a best interest decision on behalf of people who did not have the mental capacity to decide for themselves. All staff were trained in MCA and DoLS. They demonstrated to us and understanding of how MCA applied to their role.

People were supported with their hydration and nutritional needs. Where people required support with eating or drinking this was provided by staff. We observed how people were supported with their lunch. Food was prepared in line with people's care plans. Where people required food and fluid to be thickened or pureed this was done to reduce the risk of choking. Where people had difficulties with food and drink specialist advice was sought and their advice was being followed. People's weight was monitored to ensure they remained healthy. Menus were designed with people's likes and dislikes in mind. A monthly tasting session was carried out to find out what people liked and disliked. The findings were incorporated into the menus. Where people did not like the food provided alternatives were offered.

People were assisted to access the healthcare support they needed when they required it. A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. Documents showed the home liaised with external professionals including the GP, dental practices and speech and language therapists.

Good

Is the service caring?

Our findings

Relatives told us they thought the staff were caring. One relative said "I give them 110% for the way they look after them (people). Everyone is content and well looked after." Another relative described the home as "everything one would hope for."

We understood that the people living in the home had limited ability to communicate with us verbally. Care plans addressed how staff could interpret people's communication through reading their body language, facial expression and the use of sign language. The provider delivered training to staff to enhance their ability to communicate with people. The training included 10 facilitation skills which included touch, warmth and positioning amongst others. These were key skills staff should endeavour to consider when communicating with people. Staff were also encouraged to use a tool to reflect on how they communicated with people. Where communication had proved successful this was shared with other staff, where areas of improvement were possible these were discussed in supervision. We saw photographs and signing notices were displayed around the home. These helped the people in the home and staff to remember to sign and informed people which staff were on duty. Pictorial activity plans were also being designed so people could see what activities were available to them each day. One person had objects of reference in their bedroom. Attached to each of the drawers was a miniature item of clothing. This helped them to identify where to find the clothing they required. This also helped maintain their independence.

From our observations we saw staff interacted with people in a positive and sensitive way. Staff clearly knew about the needs of people and treated people with compassion. For example, one person had difficulty in communicating their needs, staff took the time to try and understand what they were trying to communicate. There was a good rapport between staff and people, who appeared relaxed in the company of staff. They knew the importance of encouraging people to be as independent as possible. A staff member told us how they involved people in the different aspects of their care, for example, putting laundry away. They said it was important to encourage people to do what they could for themselves and for them to "Hang on to their independence. It is so easy to do things for them." We observed staff being courteous to people and asking permission or telling a person what they were going to do before doing it. People were treated with respect by staff this was evident in the way staff addressed people by their name and their interactions were friendly and respectful.

Staff knew how to protect people's dignity and privacy. They told us they knocked on people's doors before entering and closed curtains and doors when supporting people with their personal care. One staff member told us how they allowed people time and space to be on their own whilst discreetly monitoring their wellbeing, for example when the person was soaking in the bath.

Relatives were kept up to date with events in the home through quarterly newsletters. These detailed staff changes, activities and holidays amongst other information. One relative told us they did not feel there was good communication with the home, they had mentioned this to the acting home manager and they were meeting to discuss how this could be improved. However, the did tell us they were kept informed of any planned changes in care and when they spoke to staff and management they felt their views were listened

to and acted upon. Another relative told us they received information on fortnightly basis and they were kept up to date with changes and events they said "I am kept well informed"

Good

Is the service responsive?

Our findings

Peoples care was reviewed regularly, relatives told us they were involved in discussions about the person's care and were consulted with where changes were required. Care plans included people's needs and how they should be met by staff, for example, how people preferred to take their medicines. People's preferences, likes and dislikes were included, this enabled staff to ensure people were happy with the care being provided. Through our observations and discussions with staff they demonstrated an awareness of people's preferences, what people were able to do and what they needed support with. Risk assessments were in place to guide staff on how to minimise the risk of harm to people, these included areas such as choking, medicines and the risk associated with epilepsy amongst others.

Quality assurance checks were completed by the provider. Recent questionnaires had been sent out to people, relatives, stakeholders and staff to find out their views about the quality of care. As a result each service responded by drawing up an action plan to address the feedback given. A corporate response was given in response to the collective feedback from all the provider's services.

The home had a complaints policy and procedure. Staff knew how to respond to complaints and who to notify should they receive a complaint. Complaints received were responded to by the registered or acting manager. Action plans were drawn up to ensure complaints were addressed fully and to enable staff to learn from complaints. Audits of complaints were carried out by the area manager to enable monitoring and compliance. Relatives told us they had not had to make complaints.
Staff were also sensitive to the fact people living in the home may not be able to verbally complain. Staff were able to interpret people's body language, behaviour and facial expressions to know if they were unhappy. Where it was deemed that the person would verbally complain if they were able, this was recorded as a complaint, and responded to in the same way as any other complaint.

Compliments were also recorded. A compliments tree was displayed in the corridor. Visitors and staff had the opportunity to record a compliment on a leaf which was added to the tree. The acting manager told us this was one way of valuing the staff and boosting staff morale.

People attended activities both in the community and in the home. Some people attended day services, other activities we observed included listening to music and watching DVD's. Care plans recorded people participating in horse riding, swimming, and going to a social evening with other people who had learning disabilities. Holidays were also planned and carried out with people. The acting manager explained to us how they were planning to support someone to go on a short break to Scotland. This was to give the person the opportunity to experience a short haul flight in an aeroplane in the New Year.

Good

Is the service well-led?

Our findings

Relatives told us they had been impressed by the management of the home. The registered manager was described by one relative as "amazing." Another relative told us both the acting manager and the registered manager were "on the ball." Repeatedly throughout the inspection the registered manager told us they wanted the service to be the best service it could be for the people living in the home. Macintyre's value statement stated "MacIntyre's Mission is to be recommended and respected for offering the best choice, providing best value and employing the best people in support of children and adults with learning disabilities." Their vision was "For all people with a learning disability to live a life that makes sense to them." Whilst staff did not use the same wording it was clear from discussions with the registered manager, observations of staff and listening to what they told us, they were all aiming to achieve these values.

Throughout the inspection we saw both the acting manager and the registered manager supporting people with personal and general care. Both the acting and registered manager encouraged an honest and open approach; staff confirmed this was the case. The office door was open and people and staff came to seek support when needed. Staff told us they felt supported by the managers, one said "If the manager can deal with it, it gets dealt with." Another said both the staff and the people living in the home were quite happy, they put this down to being positively influenced by the management of the home. They said "They (management) try to be as fair as possible. Everyone gets treated the same whether they are the people we support or the staff."

Staff told us they found the management to be supportive and approachable. The found their supervision sessions and the monthly team meetings useful. This gave staff the opportunity to discuss ideas about how the service could be improved. One staff member described their supervision as an opportunity to "focus you on what you should be doing." The acting manager told us they used the staff meetings to discuss the care and welfare of the people living in the home alongside discussions and refreshers on policies and procedures. An agenda was drawn up to include one policy or procedure at each meeting. Minutes of the staff meeting held in November 2015 included discussions regarding what staff should do if the heating in the home broke down and the Control of substances harmful to health (COSHH).

The provider has a legal duty to inform the CQC about changes or events that occur at the home. They do this by sending us notifications. We had received notifications from the provider regarding changes and events at the home.

A number of audits took place at the home, these included, accidents and incidents, health and safety and safeguarding amongst others. The area manager undertook checks of audits; monthly, quarterly and annually. Where accidents had occurred we saw action plans had been put in place to prevent a reoccurrence. We saw further action plans were in place for areas that needed improvements as a result of the information gained during the audit.