

Carlton Nursing Homes Ltd

Carlton And Pelham House

Inspection report

2a Pelham Road
Undercliffe
Bradford
West Yorkshire
BD2 3DB

Tel: 01274270048
Website: www.carltoncare-group.com

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

We inspected Carlton and Pelham House on 9 August 2016 and our visit was unannounced. The service had previously been inspected in July 2013, when it had met all the standards inspected at that time.

Carlton and Pelham House is located in the Undercliffe area of Bradford, providing care and support to younger adults with learning disabilities. Accommodation is provided in two adjoining residential properties, each able to accommodate a maximum of four people in single en-suite bedrooms. On the day of our inspection, four people were living at the service; two people living in Carlton House and two people living in Pelham House.

A registered manager was in position. 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.

On the day of our inspection, the registered manager was absent and the service was being supported by the area manager and group governance lead.

People living at the service told us they felt safe and staff we spoke with confirmed this. Staff had received safeguarding training and told us how they would identify and report safeguarding concerns. Risk assessments had been completed to mitigate risks to people's safety. We saw evidence of consent and best interests meetings where appropriate.

The premises was clean, well maintained and appropriate safety checks were in place.

Effective recruitment processes were in place and appropriate staff training was up to date. Staffing levels were good and responsive to the needs of the people living at the service. Regular staff supervisions and annual appraisals took place.

There was a robust system for monitoring and detailing accidents and incidents with lessons learned and action plans formulated where required.

Medicines were safely managed and medicines audit systems were in place. Only one person was receiving support with their medicines on the day of the inspection.

The service was complying with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS).

People were supported with their dietary requirements and health and social care needs.

We observed staff treated people with dignity and respect and people were involved in the planning of their care. Staff knew people well and people's personal preferences were taken into account wherever possible.

The service promoted a high degree of independence among the people living at the service and goal planning was evident in people's care records.

Care records were person centred and updated regularly. We saw evidence care plans were put into practice by staff.

People living at the service were given opportunities for activities according to personal choice.

The service had a complaints procedure in place although no official complaints had been made recently.

Staff told us they felt supported by the registered manager and able to approach them with any concerns or issues. Regular staff meetings were held.

People living at the service were offered resident's meetings although preferred to feedback information through monthly and annual resident's surveys.

We saw a wide range of audit and quality assurance processes in place with analysis and action plans where needed.

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.

Effective safeguarding procedures and up to date risk assessments were in place. Staff had received safeguarding training and had a good knowledge of the subject.

People we spoke with told us they felt safe living at the service.

Medicines were managed safely.

Staffing levels were appropriate and safe recruitment checks were in place.

Is the service effective?

Good ●

The service was effective.

The service was acting within the framework of the Mental Capacity Act (MCA) 2005.

A system of training and development was in place, including service specific courses, staff supervisions and appraisals.

Care files contained evidence of consent sought and staff worked with external health professionals to ensure people's healthcare needs were met.

People's nutritional needs were supported appropriately.

Is the service caring?

Good ●

The service was caring.

Staff had a good knowledge of the people they were supporting and treated people with dignity and respect.

People were involved in the planning of their care and support.

People's independence was encouraged.

Is the service responsive?

Good ●

The service was responsive.

A range of activities were made available according to people's choices.

Care plans were detailed, person centred and people received person centred care.

A complaints procedure with action plans was in place.

Is the service well-led?

Good ●

The service was well led.

A range of quality assurance audits were in place with analysis and action plans where appropriate.

Staff felt supported and able to approach the management team with any concerns or issues.

Staff meetings were held regularly.

People living at the service were offered resident's meetings and completed monthly and annual satisfaction questionnaires.

Carlton And Pelham House

Detailed findings

Background to this inspection

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

This inspection took place on 9 August 2016 and was unannounced which meant the service had no prior warning of our visit.

The inspection team comprised two Adult Social Care inspectors.

Prior to the inspection, we gathered information about the service from notifications received by the Care Quality Commission and the 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. The service had returned the PIR in a timely manner.

We also contacted the local authority commissioning and safeguarding teams as well as health and social care professionals to ask them for their views on the service and whether they had any concerns.

During the inspection we reviewed four people's care records, some in detail and others to look at specific information, three staff files, medicines records, staff training information as well as records relating to the management of the service. We spoke with three people living at the service, one social care professional, four staff members, the area manager and the group governance lead.

Is the service safe?

Our findings

People living at the service told us they felt safe in the company of staff. One person told us, "I feel safe. The carers make me feel safe." They also told us they felt they could speak to staff if they were worried about anything. A staff member told us, "I feel all the residents are safe here."

Safeguarding procedures were in place and we saw they had been followed to keep people safe. This included liaison with the local authority and notifying the Care Quality Commission of any incidents. Staff had received safeguarding training and demonstrated they knew the correct procedure to follow to raise an alert. We saw information about safeguarding was displayed on noticeboards at the service.

Systems were in place to protect people from financial abuse. Where the service looked after people's spending money, well-maintained records were kept of any expenditure and receipts held on file. The team leader checked people's monetary balances on a daily basis to ensure any discrepancies were promptly identified. A staff member told us, "I can't withhold [person's] money. It's [person's] money."

We saw people had up to date risk assessments in place. These were detailed and person specific. However we saw some risk assessments had not been signed by the service user even though there was a space on the risk assessment form for this, and the person had capacity to do so. We spoke with the area manager and group governance lead who told us this was due to recent updating of the assessments. However, they agreed to take actions to ensure this was rectified and from our discussions we felt confident this would happen.

We saw the service had a no-restraint policy when dealing with behaviours that challenge, preferring to use positive behavioural support which is a recognised intervention which reduces the need for physical restraint. For example, we witnessed a person who was exhibiting behaviours that challenge on a number of occasions successfully being redirected from what was causing them to become upset. Some staff told us they would like further training in conflict resolution to make them feel more confident handling some situations. Some staff and a care professional also expressed concerns about the effectiveness of the no-restraint policy in extreme cases.

At the time of the inspection, staff were only supporting one person with medicines. We found these were managed safely. The systems in place gave us assurance that if further medicine support was required this would be done in a safe and appropriate way.

Medicines were administered by team leaders who had received training in the safe management of medicines. Their competency was assessed periodically to ensure they retained the required skills and knowledge to administer medicine safely.

We saw staff took care to ensure medicines were stored securely within locked cupboards or the locked medicine fridge. The temperature of the fridge and room where medicines were stored were recorded on a daily basis to ensure these remained within safe limits.

We looked at the medicines stored in the home. We identified that the date of opening was not always written on the side of bottled medicines. This meant that it would not always be clear when the medicines was due to expired. However in these instances we saw the bottle was recently prescribed, and were therefore assured that they were still within date.

Medicine Administration Records (MARs) were well completed indicating the person had received their medicines as prescribed. Where medicines were refused the reason was clearly documented. Stock balances of medicines were checked each day to ensure the correct number of tablets was present. We undertook a sample stock check and found the number of tablets present matched what records showed should be in stock. This provided us with assurance that medicines had been given as prescribed.

Where 'as required' medicines were prescribed we saw a protocol was in place instructing staff on when to offer this medicine. This helped ensure these types of medicines were given in a safe and appropriate way.

Systems were in place to ensure the prompt ordering of repeat prescriptions and the safe disposal of medicines.

We observed administration of medicines and saw staff offered the person receiving medicines appropriate encouragement to take these in as independent a manner as possible. For example, the person had been prescribed a sachet which required mixing with water. The person was able to mix this themselves.

Staffing levels were sufficient to ensure people received safe care and support. Staff we spoke with told us there were enough staff employed. One staff member said, "I think there's enough staff." Another told us, "I feel there's enough staff on." A person who lived at the service confirmed this, saying, "Enough staff around. I get the required support each week."

At the time of the inspection two people lived in each of the two units. During the day one team leader was on duty within each unit to provide support and prompting to the people who lived there. Additional support workers worked a variety of shifts, based on people's contracted hours of support. At night, one support worker was present within each unit. Staff and people who used the service told us there were enough staff to ensure appropriate care and that contracted hours of support were always met. This was confirmed by the staff rotas we reviewed.

Our observations of care and support led us to conclude there were enough staff to ensure people received a good level of support. The home utilised staff who worked elsewhere in the service to cover any sickness or unplanned absence to ensure consistent staffing levels were maintained. Where possible, staff were matched to support people based on people's individual preferences to ensure a good level of compatibility.

Prospective staff completed an application form and detailed their employment history and any qualifications. Checks were completed on staff character to ensure they were suitable for the role. This included obtaining a Disclosure and Barring Service (DBS) check, ID checks, obtaining satisfactory references and ensuring an interview was held.

We looked at the way incidents and accidents were managed by the service. In some instances, incidents and accidents were logged, investigated and appropriate action taken to prevent a re-occurrence. This included liaising with appropriate health and social care professionals and updating risk assessments.

Details of any incidents were sent to head office to ensure senior management were aware of events

occurring within the service.

The premises was managed safely and kept in a clean and hygienic state. We found the home to be well maintained with appropriate facilities present including spacious kitchen areas and living space. A maintenance worker was employed who was responsible for ensuring the premises was well maintained and safety checks undertaken. Health and safety checks were regularly carried out as well as regular checks on the gas, electrical, fire and water systems to help keep people safe.

Is the service effective?

Our findings

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw the service was working within the principles of the MCA. For example, we saw evidence of a capacity assessment which had taken place when there was doubt about someone's capacity to make their own decisions.

We asked staff about their understanding of MCA and DoLS. They told us basic details relating to their role, the principles of MCA and DoLS, how to apply it and what it meant for the people they supported. A staff member told us, "We can't say no to [person] if [person] has capacity. We can't stop [person] doing anything." The area manager also commented, "They have to be allowed to make decisions, even if they don't seem to be the right ones."

We saw care and support was managed in the least restrictive way possible. People accessed and left the service independently. Others were supported to undertake certain activities, such as shopping, in line with their preferences and support needs. Care records contained an assessment of people's ability to make decisions for themselves. People were offered choices on a daily basis, such as what they wanted to do and what they wanted to eat.

We saw people had indicated in their care records if they wanted to sign their individual plans of care or wanted staff to do this. Most people had signed documents within their care and support plan which included consent to use their photograph, consent to enter their rooms and consent to share information within the care and support plan. The service had detailed, person specific 'capacity and consent' care plans in people's care records. This, together with observed interactions during the inspection, demonstrated consent was sought at every opportunity.

In one person's care records however, we saw they had been assessed as having capacity but a letter had been sent to their relative asking for consent to the plan of care. Although this had originally been done in 2013, we saw the document had been reviewed and marked as valid in July 2016. We saw the person's care plans had not been signed by the person. We discussed our findings with the group governance lead and area manager who agreed this was not appropriate or in line with the person's capacity and would

investigate. Due to the overall high promotion of independence and consent within the service, and the evidence of signatures in other people's records we were confident this would be rectified.

People told us staff had the required skills to support them appropriately. New care workers were required to complete the Care Certificate. This ensured that new staff received a standardised induction in line with national standards. Staff also received an induction to the homes policies and procedures and ways of working.

Staff received regular face to face training updates in subjects such as moving and handling, safeguarding, mental health and learning disabilities and first aid. We saw this training was largely up-to-date. Staff also received training in subjects such as autism and epilepsy. Staff told us training was effective and demonstrated a good knowledge of the subjects we asked them about.

Staff received positive behaviour support training which focused on supporting people without the need for physical restraint and also breakaway techniques should they be required. The service practiced a no restraint policy with the aim of delivering care and support in the least restrictive way possible. We observed when behaviours that challenge occurred they were dealt with calmly and competently by staff. Details of any incidents of this nature were detailed on incident/behavioural forms, which provided clear information on the de-escalation techniques used and checks and evaluation of the person's mood post incident.

Staff received periodic supervisions and annual appraisals. These were an opportunity to discuss any concerns about their work as well as any developmental needs. Staff we spoke with confirmed these took place. Staff told us periodic observations also took place to ensure staff were treating people with dignity and respect and following correct procedures, for instance in the safe administering of medicines.

We found there was nobody at nutritional risk using the service. People were supported to prepare food for themselves and encouraged to eat a healthy diet. Staff gave appropriate support, assisting people to shop for ingredients and in the preparation and cooking of food, according to their support needs. One person told us, "I feel happy making my own food."

People's health care needs were being met by the service and people were supported to access a range of health and social care professionals, such as GPs, social workers and community nursing professionals. For instance, we spoke with one person who told us about a particular health related concern. We reviewed the person's details in their care records and saw appropriate referrals had been made and investigations were taking place. However, a care professional expressed some concerns about communication and recent conflicting information from the service regarding a person's future accommodation. We discussed these concerns with the area manager who assured us they would follow this up.

Is the service caring?

Our findings

People living at the service were treated with dignity and respect. One person told us, "I like the people here. Staff are nice. They ask permission to do things." Another told us, "Yeah, like it here, staff help you, with shopping and stuff."

Staff told us they would always knock before entering someone's room and were able to give us examples of how they treated people with respect. For example, a member of staff described how they discretely encouraged someone to take care of their personal hygiene without making them feel upset, embarrassed or alerting other people. This showed us they were aware of treating people as individuals and respectful of their individual needs.

People said staff respected their privacy and gave them appropriate personal space. For example, one person told us they held their own keys to their bedroom and staff could only enter with permission. This was confirmed with assessments we saw in people's care records where they were encouraged to keep keys to their rooms. This showed people's privacy was respected and independence was encouraged.

Staff we spoke with demonstrated an in-depth knowledge of the people they were supporting. The information staff told us about people corresponded with what was in their care files. This included understanding the triggers for distressed behaviour and how to manage this, as well as understanding people's likes, dislikes and personal preferences. This demonstrated that staff had taken the time to develop strong relationships with people and find out about how they liked care and support to be delivered. During the inspection we saw staff using de-escalation techniques to calm situations and the techniques used corresponded to the information in people's care records.

Staff spoke with people in a calm, sensitive and non-confrontational manner. We saw caring interactions between staff and people living at the service and staff spending time with people, chatting in a relaxed manner. People living at the service were relaxed around the staff and looked comfortable in their company.

We saw evidence people's positive achievements were highlighted in the service. For example, we saw a number of certificates displayed for a person's college achievements. They told us they were happy about this and wanted to achieve more qualifications and this was supported by the service.

People were involved in the planning of their care. For example, we saw people had been involved in setting and reviewing their personal goals, which were regularly reviewed. We saw one person had a weekly planner which showed they had activities in the mornings which they needed to get up early for. Their care records and goal planner indicated they wanted to do this without staff intervention. Staff told us they made certain they respected this and we saw the person successfully achieved these goals.

Personal preferences were taken into account. For example, one person had requested on the previous day for staff to wake them in the morning to go into town, but on the next morning the person had not wanted to

get up, saying they preferred to go later and wanted to stay in bed. The staff member told us that was their preference and choice.

We saw advocacy information was contained in one person's care files and displayed on an information board at the service.

Is the service responsive?

Our findings

Care records were highly individualised, comprehensive and easy to navigate. These included sections on goal planning, factors regarding people's care, desired outcomes and support interventions. People's care records included a section entitled 'All About Me' which was completed with the person and gave detailed information about likes, dislikes and support needs in order to formulate individualised plans of care.

Care records also contained information about people's mental health care needs. These included detailed information about people's diagnosed conditions, including signs, symptoms and behaviour triggers. This gave staff good knowledge to help support people's care needs.

We saw staff signed to say they had read and understood people's care and support plans. People's plans of care were in line with their individual risk assessments and care and support needs and were up to date and amended in line with people's changing needs. Daily records were completed and evidenced care had been provided in line with people's care and support plans.

We saw where new care and support plans had been put in place, these were detailed and person centred. The area manager told us the service had worked hard to ensure care plans were updated and included person centred information.

People's care records showed an emphasis on personalised goal setting with people's independence shown as high priority. For example, we saw one person's goal setting desired outcome was for them 'to become fully independent when making and attending doctor's appointments' and an action plan had been developed to support this outcome. We saw meetings had been held with people to identify their individual goals and these were reviewed regularly with the person. One person told us, "Have a care file. I can access and be involved in it if I want but I can't be bothered."

Information on how to complain was provided to people who use the service through the service user guide and information on display within the home. This was in an easy read format to aid understanding. We reviewed complaints records and found there had been no recent complaints received by people who use the service or their relatives. Where concerns had been received by third parties we saw these were investigated and appropriate action taken. The service also kept a record of compliments so that it knew the areas in which it exceeded expectations.

Staff provided supported activities and companionship to people according to their needs and preferences. Periodic trips out took place, such as to the seaside or theme parks. One person said, "Done activities, went to Coronation Street in Manchester." They also told us they were supported to play rugby and were planning a holiday abroad next year. Another person said, "I like going to the cinema, bowling and to the Alhambra (theatre). They (staff) take me to see a show sometimes. I'm going out shopping." People were also supported to be involved in activities within the home.

People were encouraged to live an active lifestyle and leave the premises to socialise and maintain links with the local community. For instance, we saw information posted about events at a local social club. Two people who used the service had gained employment and staff provided support and encouragement in helping these people to consistently attend these commitments. During the inspection we saw one of these people was provided with a good level of encouragement and prompting from staff to ensure they attended their work.

People's cultural and religious needs were assessed by the service and plans of care put in place where appropriate. For example, we saw care and support had been adjusted to meet a person's cultural diet through the provision of separate cooking equipment to support their preparation of halal food and staff supported the person to shop for halal meat. This showed us the service supported and made provision for people's different religious and cultural needs. We saw the service had a diversity assessment and policy in place which was reviewed on an annual basis and actions taken where needed.

Is the service well-led?

Our findings

The service had a registered manager in place, although they were absent on the day of inspection. The group governance lead told us about the contingency plan they had put into place to support the service appropriately during this period. The area manager was also providing support on the day of our inspection. They told us this was a new post the provider had created in order to offer additional support to the services within the group.

Staff spoke highly of the registered manager and told us they felt supported and able to approach them with any concerns or issues. Staff we spoke with confirmed a number of recent improvements had been made within the service under the registered manager's leadership, including improvements to the medicines management system.

Staff told us the registered manager was effective in their role and that morale was good under their leadership. One staff member said, "I know I can go to the manager with personal problems or if I've got a problem with another member of staff. [Registered manager] has always got time for you. I feel I'm well supported." Another staff member told us, "I feel I am supported by the manager and team leaders. We have regular team meetings. I feel I can bring things up. I also feel able to approach the manager about things." Another staff comment was, "Good staff. Work well together."

Systems were in place to assess, monitor and improve the service. Monthly audits were conducted in a range of subjects including infection control, hand hygiene, mattresses and medication. A monthly comprehensive quality audit assessing standards against the Care Quality Commission's five domains was also undertaken by a member of the quality team. It was evident these audits had been successful in identifying issues and taking action to improve the service. For example, medication audits and quality audits had showed improving compliance throughout 2016 with results and audit scores improving significantly. This demonstrated effective systems were in place to monitor and improve the service.

Staff were encouraged to escalate any risks to senior management through 'risk submission forms'. These were investigated by senior management with all risks discussed at the provider's governance committee meetings. This helped ensure issues were dealt with in a prompt and effective manner.

Staff meetings were held regularly which included full team meetings and senior staff meetings. These were an opportunity for staff to discuss issues about the service as well as discuss other relevant information such as service updates and people's care and support.

People living at the service were offered resident meetings and one person who used the service confirmed resident's meetings took place, but sometimes this was done individually due to the low numbers of people currently living at the service.

We saw people had not attended the meetings recently, saying they preferred to give their opinions about the service through the monthly service user questionnaire. This was in an easy read format, with a more formal survey sent annually. We saw results from the questionnaires and survey was analysed and action

plans put into place to address any concerns or issues raised.

The service kept up-to-date with best practice guidance to help ensure effective and high quality care. For example, research had been done around appropriate living environments for autistic people and this had been considered in the design and decoration of the building.

Statutory notifications to the Care Quality Commission were generally received in a timely manner. However, two recent incidents we saw recorded had involved the police but had not been reported to the Care Quality Commission. We spoke with the area manager and group governance lead who told us they would ensure this was done which was evidenced by receipt of the notifications following the inspection. We concluded since incidents had previously been notified in a timely manner, this was an isolated occurrence due to the current absence of the registered manager.