Saint John of God Hospitaller Services

Saint John of God Hospitaller Services - 3/4 Cuthberts Close

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

On the 12 and 15 February 2016 we inspected 3 & 4 Cuthberts Close. This was an unannounced inspection.

The service was last inspected in May 2014 and was fully compliant with the outcome areas that were inspected against.

3 & 4 Cuthbert Close provides accommodation and personal care to a maximum of eight people who are living with learning disabilities. All the accommodation is in single rooms and the service is located in the residential area of Queensbury, close to Bradford city centre.

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

People were protected from harm by staff who knew how to keep people safe and what action to take if they suspected abuse was happening.

Potential risks to people had been identified and assessed appropriately. When accidents or incidents occurred, risk assessments were updated as needed.

There were sufficient numbers of staff to support people and safe recruitment practices were followed.

Medicines were administered in a safe way. Storage and recording of medicines was audited regularly.

Staff had received all mandatory training and there were opportunities for them to receive service specific training. All staff training was up-to-date.

Regular supervision meetings were organised and the deputy manager had planned supervisions with staff as well as annual appraisals. Team meetings were held and staff had regular communication with each other at handover meetings which took place between each shift.

Consent to care and treatment was sought in line with the requirements of the Mental Capacity Act 2005.

The registered manager and deputy manager were seeking authorisation for people under the Deprivation of Liberty Safeguards legislation.

People were supported to have sufficient amounts to eat and drink and to maintain a healthy diet.

People had access to healthcare professionals. People's rooms were decorated in line with their personal

preferences.

Staff knew people well and positive, caring relationships had been developed. People were encouraged to express their views and these were communicated to staff in a variety of ways.

People were involved in decisions about their care as much as they were able. People's privacy and dignity was respected and promoted. Staff understood how to care for people in a sensitive way.

Care plans provided comprehensive information about people in a person-centred way. People's personal histories had been recorded and their preferences, likes and dislikes were documented.

Relatives acknowledged and we observed there was a variety of activities and outings on offer which people could choose to do.

Complaints were dealt with in line with the provider's policy, but there had been no formal complaints logged in the previous year.

People could express their views and discuss any issues or concerns with their keyworker, who co-ordinated all aspects of their care. The provider organised surveys for relatives to feedback their views about the service.

The culture of the service was homely and family-orientated. Regular audits measured the quality of the care and service 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.

People were protected from harm by trained staff. Risk assessments were in place.

Staffing levels were sufficient to keep people safe and the service followed safe recruitment practices.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had received mandatory training and this was up to date. There were opportunities for staff to complete additional courses.

Consent to care and treatment was sought in line with the requirements of the Mental Capacity Act 2005.

People had sufficient amounts to eat and drink. Specialist diets were catered for.

A variety of professionals supported people to maintain good health.

Is the service caring?

Good

The service was caring.

Positive, caring relationships existed between people and the staff who looked after them.

People were encouraged to express their views and communicated these in a variety of ways.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

Care plans provided detailed information so that staff could support people in a person-centred way.

People were asked what they wanted to do and were supported to do it.

Complaints were acted upon in line with the provider's policy. No complaints had been received in the last year.

Is the service well-led?

Good

The service was well-led.

People gave their feedback about the service provided by communicating their views to their keyworker.

Staff told us they were supported and lead by strong management.

Regular audits took place to measure the quality and safety of the service provided.

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Detailed findings

Background to this inspection

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

The inspection took place on 12 and 15 February 2016 and was unannounced.

The inspection team consisted of two inspectors.

Before the inspection took place, we looked at the information the Care Quality Commission (CQC) holds about the service. We spoke with one person that used the service and gained feedback through surveys the provider had requested from two relatives of people that used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spent time observing care and speaking with the deputy manager, service improvement manager, senior on duty and two staff members. We also spoke with two health care professionals who visited the service regularly. We asked for feedback from the City of Bradford Adult Protection Unit. We looked at three people's care plan documentation, three staff files as well as documentation relating to the management of the service such as training records, policies and procedures and information we had received about the service and statutory notifications we had received from the home.

Before the inspection, the provider completed 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.

Good

Is the service safe?

Our findings

A health care professional we spoke with said they had never seen anything which had worried or concerned them whilst visiting the service. They believed all the people that lived in the service were safe. Another health professional we spoke with told us that they thought all people were safe in the service and that staff did safeguard people from harm.

The people who used the service lived in two adjoined houses and had a learning disability. The layout of the building provided personal and communal areas for all people to access. This meant if a person required or wanted their own space, this was achievable. The provider had a maintenance person for the local area. If something was an emergency then they could respond immediately. This meant broken items in the service were not left for long periods of time and so did not cause unnecessary risk to people.

There was a secure door entry system in place to ensure unauthorised people did not gain entry to either home. When we arrived at the service, the door was locked and staff asked to see our ID badges.

We found that the registered provider had effective procedures in place for protecting people from abuse. Staff we spoke with told us about the different types of abuse that could occur and how they would respond. Staff had completed training about how to protect people who were vulnerable from abuse or harm. The service had a whistleblowing policy in place which was accessible to all staff who worked in the service. In our observations during the inspection, people were supported by staff to be safe. People were protected from abuse and harm and staff told us they recognised the signs of potential abuse. Staff knew what action to take if they suspected people were being abused. One member of staff said, "I would make sure the person was safe and report it straight to the senior person on shift." Another member of staff said, "We don't let that happen here but if I did see something I would make sure the person is safe and tell the manager or nurse."

Risks to people and the service were managed so that people were protected. We looked at three people's care files. We found that potential and identified risks to people's health and wellbeing were recorded, assessed and were seen to have been regularly monitored. This included challenging behaviour, choking, being left alone and activities. Specific risk assessments were also present for people going out into the community and for people's hobbies. Health and safety risk assessments were present and hazards had been identified. We saw health and safety assessments for fire, first aid, stairs, lift, clinical waste, pets and driving. This ensured staff had access to the most current information. Risk assessments were rated on how severe the risk was. This gave a clear indication where there was significant risk.

We saw that risk assessments were updated as people's needs changed. For example, one person had required different support needs following a health professional's visit. We saw they had changes made in their risk assessments as well to match the person's new needs. Accidents and incidents were dealt with appropriately, recorded and reported promptly to the registered manager or deputy manager by staff. Management would then investigate the accident or incident, take any further necessary action and log this information on to the provider's database.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. A minimum of four care staff and one senior were on duty throughout the day and these numbers dropped to two care staff and one senior on a night time. The service had access to an on call phone number were staff could speak with a manager at any time if they needed advice or support. Where necessary, agency staff were used to ensure people were safely supported. The deputy manager told us, "We try to use the same agency staff." This meant people were familiar with the staff who were caring for them. We found the service did make regular use of agency staff because they had struggled with recruitment. One staff member told us it was sometimes difficult working with an agency staff member as they may not be familiar with the service. Safe recruitment practices were followed and staff records confirmed that new staff had background checks on their previous employment through references and criminal checks through the Disclosure and Barring Service (DBS) before they were allowed to start work, to ensure they were safe to work with vulnerable adults.

Medicines were managed so that people received them safely. Medicines were stored in a medicine cabinet behind a locked cupboard. These cabinets were only accessible to staff who kept the keys safe and were trained in the administration of medicines. The temperature of the room where medicines were stored was monitored. We looked at the recording form and saw all temperatures below 25 degrees centigrade which was a safe temperature for safe storage of most medicines unless specified otherwise. Staff confirmed they had been trained and that their training was regularly updated. A 'medication profile' had been completed for each person which showed the prescribed medicines that needed to be administered and any topical creams to be applied. At the time of the inspection the service did not have any medicines that required refrigeration, but the service did have an appropriate medicine fridge when needed. We saw three bottles of medicines in liquid form were opened but did not have a date of when they were opened. However none of these three bottles were required to be used within a certain time frame after opening. The deputy manager agreed that it would be good practise to label all bottles when opened. We looked at the controlled medicines the service stored. We found these were stored and recorded in line with guidance. We checked the quantities for all of the controlled medicines and found records matched the quantity.

The provider had a medicines policy which had been read by all staff who administered medicines. Medication Administration Records (MAR) sheets showed when people had received their medicines and staff had signed the MAR to confirm this. Medicines were ordered in a timely fashion and any unwanted or out of date medicines were disposed of safely.

Good

Is the service effective?

Our findings

People received effective care from staff that had the knowledge and skills they needed to carry out their roles and responsibilities. New staff followed the provider's induction programme and commenced their training. In addition, they would shadow experienced staff as they learned about their job role and began to get to know the people they would be supporting. One member of staff told us, "So we all feel we've been trained."

Staff received all essential training, which was managed by the provider in a range of areas. These related to fire, manual handling, food hygiene, infection control, equality and diversity, food and nutrition and training that focused on people and on communication. Service specific training was accessed in order to give staff a wider range of skills more personalised to support the people who lived at 3 & 4 Cuthbert's Close. Such training included the managing of violence and aggression. The provider had an online system where management could log onto the system to see when staff training was due. The registered manager or deputy manager then contacted staff and arranged for them to attend the training. Records confirmed that staff training was up to date.

Staff had supervision meetings with their line managers and staff records confirmed that staff had received at least four supervisions in the past 12 months. Each supervision had a set of agenda items to be discussed which included issues such as people, holidays, safeguarding, care plans, learning and development and medicines. Progress was measured against the previous supervision, strengths and areas for improvement were discussed and action points set. On an annual basis staff had undertaken an appraisal with their line manager to review the past year and set targets for the coming year. Supervisions and appraisals were booked in advance for staff to be able to prepare properly for their meetings. Staff told us this gave them the opportunity to voice their opinions and they felt supported by the management team during these sessions.

Team meetings were held with staff. Team meeting minutes confirmed that discussion had taken place on health and safety, handover, people and any memos from the provider. Handover sheets with a communication book were completed on a daily basis. Staff also gave a verbal handover for updates of things that had happened on their shift. The handover sheet could be used as a backup and for staff that were not starting until later on each shift.

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 found the service had referred eight people for assessment and they were waiting for replies from the DoLS team. We looked at the referral paperwork and saw the service had identified areas of potential deprivation on liberty. Care plans were seen to contain DoLS applications and email correspondence from the Local Authority about the delay in processing these.

People were supported to maintain good health and had access to healthcare services. People received support from a variety of professionals such as a GP, dentist, optician, occupational therapist (O.T.) and chiropodist. A health professional that visited the service told us, "Staff are quick to tell me if they need my support" and, "They always follow my guidance and recommendations." Another visiting health professional told us, "The team are proactive in their approach; I have no concerns that people are not being supported with their health needs here." Care records confirmed that people had visited a range of healthcare professionals. In records we saw one resident recently had an O.T. assessment due to concerns about using the bath safely. Hospital passports had also been drawn up for people. These provided essential information about people if they had to be admitted to hospital.

People's individual needs were met by the adaptation, design and decoration of the service. One person was now using a shower with a shower chair due to safety reasons. A member of staff told us that the provider was looking into the possibility of an electric bath system, but that one person wouldn't like having to empty the water before exiting, so this was still being discussed.

People were supported to have sufficient amounts to eat and drink and were encouraged to maintain a healthy and balanced diet. The main meal of the day was served in the evening as the majority of people were out during the day. Menus were planned in advance and took account of people's likes and dislikes. If people did not like the main meal on offer, then there were always alternatives available. The deputy manager said that people were supported to choose their own meals and they were encouraged to have a balanced diet. Care staff prepared and cooked the meals and people were encouraged to help with this. Some people were at risk of malnutrition and had been assessed by a speech and language therapist. Appropriate diets were in place that were of a higher calorific value. For those people who were at risk of malnutrition, we saw Malnutrition Universal Screening Tools (MUST) in place so they could be monitored more closely. Records were kept of the amount people ate and drank when required. Weights were recorded monthly for each person, so that any increase or decrease in weight could be monitored and managed safely.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed that people were cared for by kind, caring and attentive staff who understood their individual needs. When asked about people's preferences and choices, one member of staff said, "We do a lot of work with people to find out their likes and dislikes." People could choose whether they wished to be cared for by male or female staff. We saw one person's care record indicated they only wanted support from female staff during personal care. We saw a female member of staff went into their room to support them with personal care on the day of inspection.

The service supported people to express their views and to be actively involved in making decisions about their care, treatment and support as much as possible. We observed staff encouraged people to make choices with day to day decisions and allowed people time to indicate their preferences. One member of staff described this as a challenge and said that some people were unable to communicate verbally. They referred to the different approaches to support people in decision making, for example the use of hand signals and the use of trial and error. Staff were able to understand people's body language and various signs were used to enable people to understand and communicate effectively.

Care records for one person showed that they had access to the support of an advocate and they should be contacted to be involved with decision making on the person's behalf. We spoke with two staff members about their knowledge of people. Both staff members had a good understanding of people's needs and likes and dislikes. One staff member said, "As long as these 'guys' are looked after, that's all that really matters." People had a section of their care records dedicated to communication. This document was called 'Support I need to make a decision'. Staff also told us people had goals they wanted to achieve and they were supported towards these goals. Some parts of these goals were about promoting their independence and supporting people to do as much as they can for themselves. Relatives fed back in the provider's survey, they had no issue with the level of privacy and dignity they had observed in the service.

Care plans had involved family members and people who were important to the person who used the service. People were allocated their own keyworker who co-ordinated all aspects of their care. Keyworkers met regularly with people to review their care on a monthly basis.

People's privacy and dignity were respected and promoted. When we asked staff about this, one said, "We close doors and curtains and make sure rooms (bathrooms) are available before we use them to support people." Another member of staff said, "We have training and meetings about treating people with respect and dignity." Visiting professionals that we spoke with on the day of inspection, told us they had only ever seen people treated with respect and dignity and had no concerns with this regard.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Before moving into the service people's care needs were assessed by the registered manager. The deputy manager told us the person, family members and professionals had been involved in people's care planning. Regular review meetings were held to monitor people's progress and welfare in order to ensure that people were happy and settled in well. Care plans reflected how people liked to receive their care, treatment and support. 'Individual living plans' had been drawn up for people. These plans provided information about people such as: 'How to best support me', 'Getting to know me', 'life history'; pen picture' and 'health history'.

Care records were person-centred and included personal profiles about people including areas where they needed support, such as mobility, communication, eating and drinking and personal care. People's interests were also included, as well as their aspirations and hopes for the future. Staff told us they used the care plans to support people in a consistent way. Care plans provided comprehensive information and guidance to staff on how they should support people. We read through three people's care plans and felt new staff had sufficient information to support those people in a person centred, safe and effective way while responding to their needs.

Daytime activities were organised for everyone, according to their preferences. People went out on the day of inspection to access the community. In peoples care records they had a plan of activities based on their likes and dislikes which included going out, shopping, meals out and swimming. Some people stayed at home during the day of inspection. We observed them looking at magazines, playing games and interacting with staff which they appeared to enjoy. Staff told us they supported people to go out as often as possible as they thought it was key for people to be involved with their community and try new things. We learned from the feedback survey that the provider had sent out, relatives were happy with the activities provided and one described them as 'excellent'.

Complaints and concerns were also available in an easy read format to enable the people who used the service to complain if they wished to. We looked at the complaints policy and saw the document referred people to the CQC and the ombudsman if they were not happy with the outcome of their complaint.

The service routinely listened and learned from people's experiences, concerns and complaints. People were encouraged to discuss any concerns they had with their keyworker or could talk with the registered manager or the deputy manager. Any complaints could then be dealt with promptly and appropriately in line with the provider's complaints policy. We were told that, if people had a complaint, "They could tell any member of staff." The deputy manager said they would always check with the complainant to ensure they were happy with the outcome and any action taken as a result of the complaint raised. No formal complaints had been received by the service within the last year. The service also monitored compliments to see what they were doing well. Nine compliments had been received in the past 12 months.

Good

Is the service well-led?

Our findings

The service promoted a positive culture and people were involved in developing the service as much as possible. Residents' meetings were not held as these had been assessed as not being an appropriate method of obtaining people's views. Instead people met with their keyworker on an individual basis. Any views could then be listened to and addressed. The service did have feedback from family from a survey that was sent out in August 2015. Responses had been compiled and covered areas such as, attitude of staff, efforts to involve relatives, showing compassions and respect, communication and overall impression of the service. All responses we saw from relatives were positive about the service, and some areas were deemed 'excellent' by relatives.

The culture of the home was one of encouragement and support and we observed this throughout the day. When people returned from their various activities they had been involved with during the day, they were enthusiastic to share with staff what they had done. People were encouraged to take their coats and outdoor shoes off and have a drink. One member of staff said, "We are all very positive here and try to make it like a home." The deputy manager said, "We have worked hard for a positive culture which can be hard to obtain at times."

Staff were supported to question practice and there was a whistleblowing policy in place. One member of staff explained, "If I had a problem with anything, I always share it", and, "I know where the policies are all kept."

The service demonstrated good management and leadership. Staff were asked for their views about the service through supervision and team meetings. This meant staff had a formal opportunity to raise their views and ideas at least once every two months. One member of staff said, "I really enjoy working here, the managers are very supportive." The deputy manager felt well supported by the registered manager and from head office and had supervisions at least every three months with an annual appraisal.

The provider and registered manager demonstrated an ability to deliver quality care and regular audits took place to assess the quality of the care delivered. Records confirmed that audits had been conducted in areas such as health and safety, manual handling, premises, food safety and risk assessments. Health and wellbeing audits were undertaken which measured how people were supported, both physically and emotionally. Audits were undertaken on a monthly basis and each month a different part of the service was audited. The different parts of the service audited were based on the health and social care regulations. We looked at the last audit completed on 14 January 2015 which had reviewed the service against regulations 16 (receiving and acting on complaints) and 17 (Good governance). Where action was required to be taken, the evidence underpinning this was recorded and plans put in place to achieve any improvements required. The provider's service improvement manager completed the 'baseline' audits which were undertaken.

Staff told us they knew how to report any accidents or incidents that occurred and said they would record any incidents in people's daily records, accident and incident report log and report the matter to a senior staff member. We found systems were in place to record and analyse accidents and incidents and look for

areas to improve the service and remove the risk of that accident or incident from happening again. Providers are required by law to notify us of certain events in the service and records showed that we had received all the required notifications in a timely manner.

People who visited the service and our observations backed up evidence from records reviewed during the inspection. We saw a positive culture in the service where efforts had been made to gain information from people about what they wanted to do and were then supported to do it. We saw people's bedrooms had been personalised and staff worked in a way that suited them. Visitors told us the home always appeared to have a positive atmosphere and that staff got the most out of people. Visitors also told us they believed the home was run well by the management.