BDC-Northern House Limited

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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

This inspection took place on 24 November 2016 and was unannounced. At our last inspection in December 2014 the provider met the regulations we inspected.

BDC Northern House provides accommodation and personal support for up to eight people with learning disabilities. Accommodation is provided over two floors and there is wheelchair access on the ground floor. There were seven women using the service at the time of our inspection.

When we inspected, a new manager had been appointed. They were in process of applying to register and were already registered for a second care home owned by the registered provider. The second care home was next door to BDC Northern House. 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 and their relatives told us they felt safe at BDC Northern House. Care records reflected people's identified needs and the associated risks to their health and welfare. Staff knew how to manage these risks and the correct procedures to follow if they considered someone was at risk of harm or abuse. The provider was open and honest when safeguarding concerns had been raised and worked with professionals to improve.

People were supported by adequate numbers of staff who had been safely recruited. Staff were provided with relevant training to meet people's individual needs. They were supported to maintain and develop their knowledge and skills through regular supervision.

The home was well maintained and equipped with appropriate aids and adaptations to meet people's individual needs. Health and safety checks were carried out to make sure the premises and equipment was safe for people to use.

People were supported to keep healthy and received the assistance they needed to eat and drink well. Any changes to their health or wellbeing were responded to quickly. Staff worked effectively with other professionals to ensure people received the care and support they needed. Medicines were managed, stored and disposed of appropriately. There were systems for checking that people received their medicines correctly and that staff administered medicines safely.

Staff treated people with dignity, respect and kindness. They knew people well and were aware of their needs, likes and dislikes and preferred methods of communication. Care records were up to date and gave staff information about how to support people in the right way.

People's care records recognised their rights and were person centred. People were supported to have

maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People took part in activities that interested them and were supported to maintain relationships with those close to them. Relatives and friends were welcome to visit when they wished and invited to participate in social events at the home.

There was an open and inclusive atmosphere in the service and the manager showed effective leadership. The manager knew what was working well and what needed improving in the home. Audits and checks were used to monitor the quality of care people received. People and their relatives were encouraged to share their views and experiences and were involved in developing the service.

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. There were sufficient numbers of staff to meet people's needs and keep them safe. Appropriate recruitment checks were undertaken to make sure staff were suitable for the role.

Risks to people's health and welfare were assessed and managed.

People lived in a safe environment that was well maintained.

Medicines were managed safely. People received their medicines as prescribed and when needed.

Is the service effective?

Good

The service was effective. People's rights were protected because staff were aware of their responsibilities under the Mental Capacity Act 2005.

Staff were provided with training and support that gave them the skills to care for people effectively.

People received the assistance they needed with eating and drinking and appropriate support to maintain good health and wellbeing. Staff worked well with health and social care professionals to identify and meet people's needs.

Is the service caring?

Good

The service was caring. People were treated with kindness and staff knew their background, interests and personal preferences well.

Staff were respectful and promoted people's dignity and independence.

People who used the service were comfortable with staff and there was a welcoming and homely atmosphere.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and reviewed to make sure they received the right care and support.

Care plans were personalised and described how people should be supported.

People were involved in activities they liked, both in the home and in the community.

There was a system to manage complaints and people were given opportunities to share their views.

Is the service well-led?

Good

The service was well-led. People, relatives and staff told us they found the new manager to be approachable and supportive.

Staff were clear about their roles and responsibilities and worked as a team.

There were systems for checking and auditing the safety and quality of the service. The manager knew what was required to develop the service.

BDC-Northern 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.

Before the inspection, the provider completed a Provider Information Return (PIR).The PIR 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.

Prior to our visit we reviewed the information we held about the service. This included notifications we had received from the provider and other information we hold about the service including any safeguarding alerts and outcomes, complaints and inspection history. Notifications are information about important events which the service is required to tell us about by law. We also reviewed information from the local authority commissioners who had completed monitoring visits to the service.

The inspection took place on the 24 November 2016 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with three people who used the service, the acting manager and three members of staff. Due to their needs, other people living at Northern House were unable to share their views and experiences. We observed the interactions between staff and people and reviewed care records for three people. During our visit we also spoke on the telephone with three people's relatives.

We looked around the premises and checked records for the management of the service including staffing rotas, quality assurance arrangements, meeting minutes and health and safety records. We checked recruitment records for two members of staff. We also reviewed how medicines were managed and the records relating to this.

Following our inspection, the manager sent us information we had requested about staff training, quality

assurance findings and planned improvements.

Good

Is the service safe?

Our findings

People living at Northern House were kept safe from the risk of abuse and avoidable harm. People who were able to comment told us they felt safe. One person said, "Yes, happy here. Like a cup of tea. Like it here." Relatives felt their family members were safe and happy. One told us, "I feel confident that [my relative] is safe and well looked after – I've never thought anything different." Another relative commented, "I am happy with her safety there – she seems to be very settled."

Staff were able to describe signs of abuse and were clear about their responsibilities should they suspect it. They knew how to contact external agencies if they needed to, for example, social services or the police. Staff were confident to report any concerns and understood whistle blowing procedures. One told us, "I would definitely take anything up if I wasn't comfortable – I would know who to go to if I wasn't happy with how the manager was dealing with it." A new staff member said that although they had undertaken safeguarding training in their previous job, they were asked to complete a refresher course which was arranged through the local authority.

Since our last inspection some safeguarding concerns had been raised in respect of people's care. Our records showed that the service worked in collaboration with the local authority to respond to these concerns. The provider and manager attended meetings and cooperated with any investigations. The local authority had monitored the home and the service had followed an action plan to address areas for improvement. The staff team had also updated their training in safeguarding. We found that the service had worked effectively with the local authority safeguarding team and commissioners to protect people and improve standards.

Potential risks to people's health, safety and welfare had been identified and staff had put plans in place to ensure risks were minimised. There was information about how to keep people safe at home and in the community. Examples included mobility and falls, eating and drinking, using public transport, and supporting individuals who may behave in a way that presented risks to themselves or others. People's risk plans had been reviewed and updated where needed.

Northern House was safely maintained and there were records to support this. Health and safety checks of the premises and equipment were carried out and systems were in place to report any issues of concern. The provider had emergency policies and procedures for unforeseen events such as utility failures or in the event of a fire. People had personal emergency evacuation plans (PEEPs). These included details about the help individuals would need to safely leave the building in the event of a fire or other emergency. Appropriate numbers of staff were trained in first aid and there was an on-call system in the event of emergencies or if staff needed advice and support.

Records of any incidents or accidents involving people using the service were maintained. These showed that appropriate investigations and follow up actions were taken following incidents and changes were made to people's risk and support plans as necessary.

People were protected from those who may be unsuitable to care for them. Appropriate checks had been carried out to ensure staff were fully vetted before they started to work at the home. These included a check with the disclosure and barring service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record. There was also information about employees' employment history, physical and mental health, proof of identity and a record of interview questions held on file.

Staff and relatives we spoke with felt there was sufficient staff to meet people's needs. One relative told us, "Whenever I'm there, and I do go on ad hoc basis too – it's very handy for me, well there always seem to be staff around." A staff member commented, "Yes, I think we have enough staff – we regularly have two staff on, and we can always ask for help from next door in an emergency." Staffing levels included a minimum of two to three staff during the day depending on people's routines and activities. One member of staff worked at night and there was a manager or senior on call in the event of an emergency. Allocation records confirmed these levels were maintained and appropriate arrangements were in place to cover unexpected staff absences or emergencies.

People's care records had information about their medicines and how they needed and preferred these to be administered. There were individual protocols where people needed medicines 'as required' or only at certain times. These helped ensure staff understood the reasons for these medicines and when and how they should be given.

Staff completed yearly training in medicines administration and the manager also assessed their competency to make sure practice was safe. One person's relative felt confident that medicines were managed safely. They told us,"[Name of person] does take medication – they have a good recording system, and it's also always monitored and looked at when it's [their] annual review."

We saw regular checks and audits had been carried out to make sure medicines had been given and recorded correctly. These included daily and weekly checks to identify and resolve any discrepancies. People's prescribed medicines were reviewed by relevant healthcare professionals as necessary. We checked the medicines for two people which corresponded with their medicine administration records (MARs). The records were up to date and there were no gaps in the signatures for administration. There was a system for checking all prescribed medicines and records for their receipt and disposal.

Good

Is the service effective?

Our findings

People were cared for by staff who understood their care and support needs. New staff completed a planned induction which involved shadowing another staff member before working independently. One staff member told us, "My induction was very good, they gave me time to really study all the residents' books, their care plans. I was put with staff who knew them well, and the manager too, I'd shadow with him. It was thorough, I always felt I could ask questions."

The provider had introduced the Care Certificate which is a nationally recognised framework for good practice in the induction of staff. Existing staff were due to complete a self-assessment to review their competencies against the expected standards. Following induction staff completed required training courses which included fire safety, first aid, safe handling of medicines, safeguarding, infection control and moving and handling. Other training was arranged in line with people's assessed needs such as managing epilepsy and supporting people with dysphagia (swallowing difficulties).

The training record showed when staff had completed training although we noted there were gaps for some staff. The manager confirmed that refresher training was scheduled to take place in the next few months. Staff told us they had recently updated training around medicines and infection control. Staff said they felt well equipped to do their job and there had been recent refresher training for all aspects of caring for people, provided by the local authority. One staff member commented, "Even if you have already done the training, it's good to have a recap and it makes you think about things again."

Staff had supervision meetings with the manager to talk about people's care, training and personal development needs. In recent discussions staff were reminded about safeguarding procedures and promoting dignity in care. The manager told us he was preparing to introduce observational checks of staff practice to monitor their competencies and learning. Staff told us they felt supported in their roles. One staff member said, "I started as a support worker, and I was just promoted to senior, they have been great to help me develop my skills."

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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.

During our inspection, we observed that staff sought people's consent before carrying out care tasks or

involving them in activities. The manager and staff asked for people's permission and used questions such as "Is it ok if ...?" "Would you like me to ....?" "I wonder if we should get ready then? What do you think?"

Care records demonstrated that people's consent and ability to make specific decisions had been recorded in their care plans. Where people had been assessed as lacking capacity to make certain decisions, records showed that the relevant healthcare professionals and those close to the person had been consulted. This was so their views could be sought and any decision they made on behalf of the person was in their best interests. We saw an example of this where one person required dental treatment.

The manager had assessed where a person may be deprived of their liberty and submitted applications as necessary to the supervisory body (local authority). For example, some people required continuous staff supervision as it was unsafe for them to access the community unaccompanied. At the time of our inspection applications were still in process and the manager was awaiting the outcomes.

People were supported to eat healthily and participate in meal preparation, menu planning and shopping for food. Staff knew people's favourite foods and were aware of people's dislikes and dietary needs. One staff member said, "We get to know what they like, and what they don't like. We change the menus, introduce new things, there's always a choice if they are not in the mood for what's on the menu." A relative told us, "They're very flexible around food, and it seems fine."

We observed people were free to come and go in the kitchen. Lunchtime was organised around people's activities and people and staff ate together for the main meal in the evening. Fresh fruit was readily available in the kitchen and the fridges and cupboards were well stocked. Staff confirmed there was always enough money to buy whatever food and supplies were needed.

Where people needed assistance to eat and drink there was a care plan in place to outline the support required. This provided information about people's likes and dislikes and how they should be assisted. There were reminder notices about how people liked or needed their food to be prepared and served, and these were presented in a colourful and person-centred way, on the inside of the kitchen units. In the lounge there were notices about the importance of drinking water, and signs of dehydration. Where there were concerns about people's weight or appetite, care staff maintained records so this information could be shared with relevant professionals, such as the doctor or dietician. One person had been in hospital, and staff explained they were keeping a close eye on what she ate.

People were supported to maintain good health and had access to health services for routine checks, advice and treatment. A person's relative told us, "They are very good about all health related meetings and they keep an eye on her health – if she's a bit chesty, they call the GP, and I was kept informed about a problem she was having with her eyes too." Another relative commented, "She gets her feet looked after well."

Following the most recent person's admission, a new patient check was arranged with the GP. Care records reflected individuals' healthcare needs and people had seen other specialists where appropriate. Where people had specific health conditions there was information available alongside the care plan which explained more about the condition and how to support someone with it. There was correspondence which showed that the staff team worked closely with other healthcare professionals to ensure that people received the services they needed. Accurate records were kept of these appointments and outcomes.

Relatives we spoke with felt their family member was prepared well for any medical appointments, and supported to attend these in the least stressful way. One relative told us, "I feel involved in the health side of things, we're told when they are going and can go along too if we want."

Good

Is the service caring?

Our findings

People were comfortable in staff presence and those who could talk with us were positive about the staff. During our inspection we observed meaningful interactions; staff knew people well and engaged individuals in conversations about their interests and preferences. When two people returned home from their morning at the day centre, they received a warm welcome from the manager and other staff, and there was a relaxed, friendly atmosphere throughout our visit. One person was keen to show us her painted nails which was clearly important to her.

Relatives told us the staff were kind, patient and caring. Comments included, "They do really care for [my relative] – I think it's first class, always really positive interactions" and "I have watched the staff – they are really caring, and they treat everyone with respect. It's not an easy job – they need to be patient and they are from what I have seen." One relative complimented a member of staff for visiting their family member in hospital, in their own time.

Staff treated people with respect and tried to involve them in making decisions as far as possible. We observed people were given the opportunity to express their opinions in a variety of different ways, and to make choices about things. Staff used signs and showed people objects when talking to them to support what they were saying. Where people had difficulty expressing themselves staff listened carefully and made sure they understood what the person was saying. Not everybody who used the service was able to express their views verbally. Staff recognised the gestures and reactions that people gave and what these were likely to mean. For example, one person became tearful and staff immediately identified what was upsetting them. They put on some music which had a positive impact for the person who smiled.

Staff knew how best to communicate with people in their chosen form. One staff member told us, "Although [name of person] can't verbalise, she knows what she likes. She will make a choice from two objects, and she will push things away." There was information about activities on display in the kitchen and dining room, and this was available in written and picture format.

People looked well cared for and were supported to dress in their personal style. We observed one staff member made sure a person was dressed appropriately for the weather, before supporting her to go out. At lunch staff gave people encouragement and support to make choices and eat their meals.

Staff supported people to maintain relationships and social links with those close to them. People visited their families and relatives were invited to parties or other social events in the home. Records showed that relatives were invited to review meetings and kept informed about any significant events. Relatives said they had been fully involved in the planning of their family members' care and support. Families told us they could visit at any time, and were free to go to their relative's room if they wished.

Support plans had been written in a way that promoted people's privacy, dignity and independence. Records were person centred such as "I like/I prefer" and "I need support with."

During our inspection, people chose where they wished to spend their time and the staff respected people's own personal space or preference for time alone. Staff were clear about their role to maintain people's dignity such as making sure they received personal care in private and knocking on bedroom doors before entering. The manager and a senior staff were dignity champions. Their role was to reinforce staff's understanding of key issues around respecting people's dignity and how to do this.

A person living at Northern House had passed away earlier in the year and staff had supported people and each other through the bereavement. A staff member told us, "We had someone come in and help with grief support, after [name of person] died. She spoke about how to help the residents and us, that was good. It was a sad time."

Staff were in the process of undertaking end of life care training. This was facilitated by the local hospice team, who also provided advice and support to the home about end of life care.

Good

Is the service responsive?

Our findings

Care records showed people's needs were assessed and determined before the service was provided. One person told us they visited the home and stayed overnight to see if Northern House was suitable for them. Their care records supported what they told us and showed how the person was involved in discussions about their care.

People's assessments provided relevant social and healthcare information and where appropriate, included information from social services. Records showed the manager and staff consulted with relevant care professionals and families to make sure they had full information about people. There were important details about a person's background, their medical history, interests, preferred routines and areas of independence.

People's care plans were accurate and up to date, reflecting the care and support people needed. The service worked with external professionals so staff could find out the best way to care for people and promote their well-being and safety. For example, the manager had referred a person for psychology and speech and language services when they identified a need. The person's care plan included specific guidance and recommendations for staff to follow.

People's diversity, values and human rights were respected. Staff recognised and supported people's individuality, including their spiritual, cultural and religious needs. Care records included information about any preferences. People had the right specialist equipment to promote their independence and meet both their physical and sensory needs. This included picture communication aids and mobility equipment.

Most people were unable to tell staff how they wanted to be supported, but staff knew what they liked and disliked. They were able to tell us what they would do if people were unwell, unhappy or if there was a change in a person's behaviour. Staff spoke about people's needs with knowledge and understanding. Their comments corresponded with what we saw in the care plans.

Keyworkers were responsible for co-ordinating people's care and support and wrote a monthly report on whether goals had been achieved as well as other significant events or issues. Staff also wrote daily reports about how people had spent their day and what support they needed. People had yearly review meetings. Reviews took account of health, social and emotional changes and involved people's care managers, family and other representatives as necessary to represent people's interests. These processes helped the manager and staff evaluate how people's needs were being met and whether changes were needed.

People had a timetable of activities and were supported to follow their interests. People took part in community activities such as local walks, shopping and trips to pubs, cafes, restaurants and the cinema. At the time of our visit some people had gone to day centre services and other people stayed at home to do activities which included arts and crafts, and music. Individuals did activities with their key workers on a one to one basis once or twice a week. During our inspection, one person showed enthusiasm before going out with a staff member for shopping and coffee. The manager told us there were plans to provide further

activities for people with sensory needs. This included buying more tactile and sensory stimulation items and organising music sessions.

Relatives spoke positively about the activities provided and said people were supported to go on holiday once a year. One relative discussed how their family member enjoyed going to a particular centre each day and told us, "She likes the routine and enjoys it."

Staff felt there was enough for people to do, although the home did not have its own transport and outings were limited at times, particularly for people who used wheelchairs. Staff told us people accessed their local community and they supported individuals to use public transport and arranged taxis when needed. We saw that the manager had recognised the benefit of a suitable vehicle for the home and included this as an objective in the yearly business plan.

There were no group meetings for people although keyworkers met with people each month to discuss any matters of concern and to look at progress and achievements. People used different communication methods and staff understood when a person was indicating how they were feeling and why this might be. Staff told us that relatives were encouraged to share their views and experiences of the service through questionnaires, visits and care plan review meetings. A staff member said, "Also, there is a book where people and other professionals can write comments, compliments or complaints."

People who were able to comment said they would speak to their family if they wanted to raise a complaint. Relatives told us they had not felt the need to complain but would be comfortable doing so. Their comments included, "I am sure they would listen, I have no reason to think otherwise" and "I feel I get on extremely well with the manager, I can ring him whenever. Things always get resolved, so if any little thing isn't right, I only have to ask once, and it's sorted out."

The complaints procedure was displayed within the service and available in picture format to help people understand the information. The manager kept a record of complaints and how these had been dealt with. There had been one complaint about the service in the last twelve months. Records confirmed that this was dealt with and resolved within the expected timescale.

Good

Is the service well-led?

Our findings

As part of the provider's conditions of registration, the service is required to have a registered manager. There had been a change in leadership since the last inspection. The new manager had been in post since September 2016 and was in the process of registering with CQC. They were already registered for a second home owned by the same provider which was located next door. The manager told us they divided their time between the two services accordingly. In the absence of the manager, staff told us support was always available through the provider's on call arrangements.

The manager told us how they were making progress with the development of the two homes they managed. They had redeployed senior staff and introduced new ways to monitor and evaluate the running of the service and the professional development of staff. They were standardising systems and records about people's care and implementing new competency checks of staff practice. The Provider Information Return (PIR) also included clear information about how the service performed and what improvements had taken place or were planned.

Relatives were aware of the change in leadership at the home and complimentary about the new manager, describing him as approachable, caring and supportive. One relative told us, "Yes, I would say that the leadership is good – the manager has a very hands on approach, and I think he's really keen to learn from the past."

The manager worked alongside staff so he could observe and support them. Staff understood their roles and knew what was expected of them. Staff told us they felt fully supported in their role by the manager and by the organisation as a whole. They also felt comfortable asking the manager for help and advice when they needed it. One staff member said, "[Manager] is very supportive, and I do feel appreciated by him and by BDC [the provider]." Staff also understood their right to share any concerns about the care at the service and were confident to report poor practice if they witnessed it. Information about the provider's whistleblowing procedure was available to staff.

Staff told us information was shared through face to face handovers and regular staff meetings. These meetings enabled the manager and staff to discuss people's care and support, day to day issues in the service as well as staff training and development. Recent discussions had taken place around cleanliness and infection control, dignity in care, safeguarding and abuse awareness. Staff had also talked about the recent bereavement in the home and how to support each other through this. A staff member told us, "We have staff meetings every month – in fact, we've got one on Saturday. [The manager] is always there if we need him. The meetings are like an open forum as well – we can raise ideas to improve things."

There were a range of audits and checks to monitor the quality of the service. These included checks on aspects of care such as medicines, care plans, risk assessments, health and safety and the presentation of the environment. An external auditor visited every three months to review the service in line with the fundamental standards and regulations. Any areas for improvement were identified in an action plan. We saw where actions had been taken as a result. For example, parts of the home had been redecorated.

The registered provider regularly visited the home. One staff member told us, "We also see [name of provider] nearly every weekend – he's always popping in; asks us questions, how we are, chats to the residents, checks things in the house – he's here a lot, and he's a real presence."

Throughout our visit, we observed the staff worked in a professional and calm manner. The manager demonstrated effective leadership, working as part of the staff team, enabling him to have good oversight of what was happening in the service.

The provider sent out yearly questionnaires for people's relatives and representatives to comment on aspects of the service. This included asking their views about the staff, people's daily care, cleanliness of the service and the management. The provider used the information to see if any improvements or changes were needed at the service. Findings from the most recent surveys from August 2016 reflected positive responses. One person's relative could not recall completing a survey and said, "I don't think I've been asked to fill in a questionnaire, but I give feedback all the time anyway." They also commented that they used to receive a newsletter about Northern House but hadn't seen one for a while. Another relative told us, "The one thing I do think, is that they could be better at communicating with me when there are staff changes, and when the manager changed for example. That's really important." The manager was aware that communication could be improved and had plans to resume the newsletter.

The service worked in partnership with other agencies. The manager had been engaging with the local authority safeguarding team and commissioners to review and improve the quality of care. This included attendance at forums, learning events and training courses. The manager told us the home was also working with a local hospice to learn about end of life care.

Registered persons are required by law to notify CQC of certain changes, events or incidents at the service. During our visit we checked information relating to accidents and incidents. These confirmed that appropriate action had been taken and where appropriate, the manager had told us about any reportable events.