Brookdale Healthcare Limited

Sheridan House

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

Overall summary

We carried out an unannounced inspection on 8 January 2015. At our last inspection in August 2013 we found that the provider was meeting their legal requirements in the areas we looked at.

The home provides care and support for up to nine people who have learning difficulties. At the time of our inspection there were eight people living at the home.

There was a registered manager at the home. 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 were safe and the provider had effective systems in place to safeguard people. People's medicines were administered safely and they were given a choice of nutritious food and drink throughout the day.

People were supported regularly by an advocacy service and three people had an appointed Independent Mental Capacity Advocate to support them. Staff supported people to follow their hobbies and interest.

Summary of findings

Support records included personal information, reflected people's wishes and were reviewed regularly. There were personalised assessments in place to reduce the risk of harm occurring to people, and the provider had plans in place to keep people safe in an emergency.

There was enough skilled, trained staff to meet people's identified support needs. The provider had a robust recruitment procedure that enabled them to be confident that newly recruited staff were suitable for the posts to which they had been appointed. Staff received on-going training and were supported to gain professional qualifications. They had regular supervision meetings at which their performance and training needs were discussed.

Staff were caring and protected people's dignity and privacy. They understood the provider's vision and values, which were embedded in their day to day practice. They felt supported by the manager and were aware of their roles and responsibilities.

The provider complied with the requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS). They had an effective complaints system and listened to people's comments on improvements that could be made to the service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

There were effective systems in place to safeguard people.

People's medicines were administered safely.

There were enough skilled staff to support people.

Good

Is the service effective?
The service was effective.

Staff received on-going training to maintain and develop the skills needed to support people.

Staff were able to communicate with people who lived at the home using non-verbal methods.

People had enough nutritious food and drink to maintain their health.

Good

Is the service caring?
The service was caring.

Staff interacted with people in a caring way.

People had access to an advocacy service.

Information about the home was available in a format that people could understand.

Good

Is the service responsive?
The service was responsive.

Support records included personal information and reflected people's wishes.

People were supported to follow their hobbies and interests.

The provider had an effective complaints system...

Good

Is the service well-led?
The service was well-led.

The provider's vision and values were clearly understood by everyone who worked at the home and these were embedded in day to day practice.

A range of quality audits had been completed.

The manager was visible and accessible to people and staff.

Good

Sheridan 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 8 January 2015 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed the information available to us about the home, such as notifications. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with two people who lived at the home, two support workers, the manager and team leader. We also spoke with a communication development worker with the speech and language therapy service. We reviewed the care records and risk assessments for two people who lived at the home. We checked medicines administration and reviewed how complaints were managed. We looked at three staff supervision and training records, and reviewed information on how the quality of the service was monitored and managed.

We carried out observations using the short observational framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Following the inspection we spoke with an occupational therapist and a mental health professional that supported people who lived at the home, an advocate for the people who lived there, an Independent Mental Capacity Advocate and the manager of a team that placed people at the home.

Good

Is the service safe?

Our findings

People who lived at the home had complex needs and were unable to tell us of their experiences or whether they felt safe. Feedback from a relative of one of the people who lived at the home as part of a survey stated, "I feel that [relative] is kept safe within the house." Two healthcare professionals who attended the home on a regular basis, agreed that people who lived there were safe. We observed that staff maintained people's safety during our inspection.

The provider had an up to date policy on safeguarding. Staff told us that they had received training on safeguarding from the local authority. They had a good understanding of what constituted abuse and told us of the procedures they would follow if they suspected abuse had occurred. The provider reported incidents of concern to the local authority and to the Care Quality Commission. The residential team manager from a local authority told us that the manager at the home had reported a number of incidents between two people who lived at the home. The frequency of the incidents had increased and the provider had co-operated with the subsequent investigation and resolution of the situation. This demonstrated that the provider had effective systems in place to protect people from harm.

We saw that there were personalised risk assessments for each person who lived at the home. Each assessment identified the people at risk, the steps in place to minimise the risk and the steps staff should take should an incident occur. We saw that where people demonstrated behaviour that had a negative impact on others or put others at risk, the assessment included information on what might trigger such behaviour, and steps that staff should take to defuse the situation and keep people safe. Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them.

Staff we spoke with told us that they were made aware of the identified risks for each person and how these should be managed by a variety of means. These had included looking at people's risk assessments, their daily records, entries in the communication book and by talking about people's experiences, moods and behaviour at shift handovers. Staff told us that people's moods were observed before they went out into the community and the risk of behaviour that might have a negative impact of others occurring was assessed, to ensure that an appropriate level of support was provided. This gave staff up to date information and enabled them to reduce the risk of harm.

Records showed that the provider had carried out assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments and the testing of portable electrical appliances. We saw that there was a maintenance log in which staff recorded any faults they identified, the date on which they were noticed and the date on which they were rectified. The provider had plans in place for emergencies, such as a gas or water leak, severe weather or pest infestations. Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained with it remained current. These enabled staff to know how to keep people safe should an emergency occur.

Accidents and incidents were reported to the team leader. We saw that they kept a record of all incidents, and where required, people's care plans and risk assessments were updated. Where incidents occurred when people had demonstrated behaviour that had a negative impact on others or put others at risk, we saw that the person's behaviour immediately before the incident was recorded. Staff told us that this enabled them to look for patterns and reduce the risk of an incident by using non-physical strategies and following identified criteria for planned interventions. There were monthly review meetings of intervention strategies completed by multi-disciplinary teams to enable staff to identify the most effective strategies in different situations. Staff told us that if any intervention involved restraint this was recorded immediately. Incidents that required restraint were reviewed by the manager and reported to the provider to enable them to check that it had been used appropriately. An incident occurred during our inspection and we saw that staff employed the non-physical strategies identified within the risk assessments to manage it. Records of accidents and incidents were reviewed by the manager to identify any possible trends to enable appropriate action to reduce the risk of an accident or incident re-occurring to be taken.

The manager told us that there was always enough staff on duty during the day for people to be supported on a one to one basis because of their complex needs, although only

Good

Is the service safe?

four people had been assessed as requiring this level of support. The rota we looked at showed that eight support staff were on duty during the day and three at night. The manager told us that the provider operated an 'on call' system so that additional staff could be available when needed. Staff told us that there was always enough staff to provide the support people needed. They told us that extra staff were provided for three days a week to facilitate people's activities in the community. We observed that people were supported on a one to one basis in the home during our inspection.

We looked at the recruitment files for two staff that had recently started work at the home. We found that there were robust recruitment procedures in place. Relevant checks had been completed to ensure that the applicant was suitable for the role to which they had been appointed before they had started work.

People's medicines were administered safely and as prescribed and by staff that had been trained to do so. The deputy manager told us that there was always two staff that had been trained to administer medicines on duty each day and no medicines were administered covertly. We observed that people were offered drinks to assist them to take their medicines. Medicines were stored appropriately and the temperature of the storage room was checked daily to ensure that the medicines were not exposed to long periods of excessive temperature which might affect their efficiency. We looked at the medicines administration record (MAR) for two people and found that these had been completed correctly with no unexplained gaps. There was a system in place to return unused medicines to the pharmacy. However we did identify a minor discrepancy which the manager told us that they would investigate and take action such as providing additional training if this was required.

Good

Is the service effective?

Our findings

People were unable to tell us whether they thought the staff were well trained. However, feedback from a relative during a satisfaction survey stated, "We cannot praise the management, team leaders and support staff highly enough, they are a brilliant team."

Staff who had recently started working at the home told us that their induction had been for one month and was comprehensive, with a mixture of training and shadowing of experienced staff to enable them to understand the needs of the people who lived at the home and acquire the skills needed to support them. They told us that they used the training they had received to support people whose behaviour could have a negative impact on others, in a way that reduced such behaviour.

The manager showed us that staff training was managed on the computer and we saw evidence that most of the staff were up to date with training considered by the provider to be necessary to support people effectively. Staff were supported to gain recognised qualifications in health and social care, with six staff currently working towards formal qualifications. Staff told us that they received training provided by the local authority, as well as the provider's 'in-house' training. This had covered areas such as safeguarding, food hygiene and health and safety. One member of staff told us that the safeguarding training they had received had highlighted for them that some practices which had been used for convenience, such as when one person ran out of shower gel and they 'borrowed' a bottle from another person for them until it could be replaced could be construed as abuse. They had immediately ceased to use these practices.

Staff had received training in communication by sign language as some of the people who lived at the home were able to communicate in this way, and we observed this communication in practice during our inspection. Staff were also competent in the use of other forms of communication, such as picture boards and responding to people's body language, to help them understand the needs of people who could not tell them. One staff member told us, "It's just about knowing the person."

Staff told us, and we saw from staff records, that they received regular supervision with their manager at which they could identify any training and development that they wanted to undertake. They also discussed any concerns they had about their work or the experiences of people at the home.

Staff were able to demonstrate a good understanding of the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). We saw that people's mental capacity to make decisions had been assessed and where appropriate best interest decisions had been made following meetings with healthcare professionals and people's representatives. We saw that best interest decisions had been made for one person that covered managing their finances and consent in relation to medication, support plans and to living at Sheridan House. There were DoLS authorisations in place for a number of people and their support plans reflected the terms of these.

Staff told us that they respect people's decisions as to their daily care and support needs, such as the time they get up, what they wear or what they want to eat. One member of staff told us, "Some want to sleep in until 10 or 11. We give them prompts but if they absolutely refuse we just have to let them have their way."

People decided on menus for the main meals at weekly meetings, with choices of what staff knew people liked to eat and healthy options such as fish or vegetarian dishes suggested to them. Staff told us that they knew people's preferences, such as rice or couscous instead of potatoes, and people let them know what meal they wanted by varied methods of communication. We saw that where people did not want the choices offered for the lunchtime meal on the day of our inspection, they were accompanied to the kitchen to choose what they wanted instead.

Records of food and fluid intake were kept for all the people who lived at the home and were maintained on a daily basis. People's weight was monitored and if necessary referrals were made to the local dietetic service. A dietician was visiting the home the day after our inspection to discuss the dietary needs of one person who was at high risk of developing diabetes. The person had expressed a wish to have assistance to lose weight and the manager had made a referral to the dietetic service.

People were supported to maintain their health and well-being. Appointments were made for them to receive dental, optical and foot care. Staff supported them to

Good

Is the service effective?

attend appointments outside of the home. Regular multidisciplinary team meetings were held at which people's mental and physical health needs were discussed by healthcare professionals and necessary referrals to healthcare services were made.

Good

Is the service caring?

Our findings

People were unable to tell us of their experience living at the home, although one person did tell us, "I like it." Feedback from a relative during a recent satisfaction survey stated, "Sheridan House is a lovely, homely environment where everyone is valued and cared for as a family." Feedback from another relative stated, "I couldn't have wished for better staff input and care in all they did for [relative]."

Healthcare professionals we spoke with agreed that the staff were caring towards people and treated them with dignity and respect. An Independent Mental Capacity Advocate (IMCA) who attended the home regularly told us that they saw, "…staff engaging in a nice and genuinely caring way" with people. We observed staff interact with people in a caring way. We saw that they always spoke with people as they passed them and asked if they were alright or wanted anything. People's support records included a section entitled 'All About Me' which provided information for staff about people's preferences, their life histories and things that were important to them. This had enabled staff to identify ways in which people would wish to be supported. Staff clearly knew people's likes and dislikes and the triggers for behaviour that could have a negative impact on others.

We saw that people were actively involved in making decisions about the way in which their support was provided. Staff told us that people's bedrooms were being redecorated and each person had chosen the colour they wanted. People's rooms were personalised and reflected their individual interests and taste. People were given choices, such as in how they spent their time during the day and the staff supported their choices. We saw that one person wished to return to bed after having eaten their breakfast, another person wished to use the computer, and staff assisted them to do so.

Information about the home was available in an easy read format that people who lived at the home could understand. People had access to an advocacy service and three people had an IMCA. An advocate attended the home every two weeks to support people to express their views.

Staff told us how they maintained people's dignity. One member of staff told us, "We always give people privacy. We make sure if we're giving personal care that we close the doors." During our inspection one person was repeatedly trying to remove their clothing and expose themselves. Staff spoke with them kindly but firmly to prevent them from doing so and used distraction techniques that worked for short periods to avert the behaviour. The IMCA told us that when staff were required to observe someone they supported at all times, this was done in a way that was as unobtrusive to the person as possible. This was at arms-length in a safer environment, but more closely in one that posed a risk of harm to them. The IMCA said that this had been done in a way that respected the person's personal space.

Staff described how they maintained confidentiality about people. One member of staff told us, "Anything to do with our service users is confidential and we only tell people who need to know. We do not talk about anything that happens in work out of it." We saw that one person's support records stated that they must be consulted and a mental capacity assessment completed before any information about them is shared. This enabled the provider to determine whether they were happy for the information to be shared or it was shared only after it had been determined that it was in their best interests to do so.

Staff told us that people's relatives were able to visit at any time. We noted that in feedback from a satisfaction survey relatives' of one person stated, "As parents we have always been made to feel welcome."

Good

Is the service responsive?

Our findings

People had a wide range of support needs. We saw that support records included personal information and reflected people's wishes. The plans included information on people's communication, behavioural and care needs and detailed how people wished to be supported in these. Information from relatives and people who knew them well had been included when the plans were developed. The support records included information about what was important to people. One person's record showed that being happy and football had been identified as being important to them. Staff bought sports magazines for them and arranged for them to watch football when it was being shown on television. Their record also showed that they enjoyed going to the pub for a drink and their support plan showed that they were accompanied to the local pub on Thursdays.

The team leader told us that each person had been assigned a key worker who was responsible for identifying the person's support needs. Each person had a weekly meeting with their key worker, their support plans were reviewed on a monthly basis and people agreed goals to work towards. We saw that people had recovery plans within their support plans on which goals achieved were identified. One person had agreed a goal to complete their personal care as independently as possible. We were told that this person was now taking showers on a regular basis with a reduced level of support. We saw that staff signed the records to show that the goals had been agreed and understood by the individual.

We saw that staff responded quickly when people let them know that they wanted support, such as to get a drink or have assistance with their personal care.

People were supported to follow their hobbies and interest. We saw a number of activities going on throughout the day. The development worker from the speech and language therapy service visited the home twice a week and worked with people individually and in groups. On the day of our inspection they were encouraging a person to take part in a board game. Staff were supporting one person to do sewing, another person to spend time on the computer, where they chatted on line with acquaintances, and a third person was playing another game with a member of staff. We saw that staff used distraction techniques to avert an incident in a kindly way by encouraging the person to do an activity that they liked.

In addition to a questionnaire completed by people at the home in October 2014, the provider had sent satisfaction surveys to relatives' of people who lived at the home in which they were asked for comments on the home and the quality of the service provided. Relatives were also able to add any additional comments. One relative had suggested that the provider should provide a table tennis table for people to use. Following this suggestion a table tennis table had been purchased and was available for people to use if they chose to. This showed that the provider listened to comments made by people and acted upon them.

The provider had a complaints system in place and information was available to people in an easy read format. Staff told us that they would assist people to make a complaint if they wanted to, and the advocate was also available to support people throughout the complaint process. However, there had been no recent complaints received about the home or the care provided to people.

Good

Is the service well-led?

Our findings

The manager told us that they had recently moved their office so that it was now adjacent to the main lounge area. This enabled them to easily observe care, as well as being more accessible to people and the staff.

Staff were involved in developing the service by way of regular staff meetings and opportunities to give feedback at supervision meetings. We saw that staff had contributed to discussions at a staff meeting held in November 2014 when they had suggested that there should be a treat box from which people could help themselves to snacks throughout the day. Staff had also suggested that people have a regular shopping day on which they could buy their toiletries and other items that they required. We saw that these suggestions had been implemented.

Staff were aware of the provider's whistleblowing policy and procedures and said that they would not hesitate to use them. One member of staff told us that they had raised a whistleblowing with the provider. They told us that a full investigation had been carried out and they had been kept informed until the investigation was concluded. They had been advised of the result of the investigation and the changes that the provider had implemented as a result of it.

Staff we spoke to told us that the provider's vision and values were clearly understood by everyone who worked at the home and these were embedded in their day to day practice. One member of staff told us that the aim was for people, "…to live full, fulfilled lives with as much skill and independence that they can."

A senior support worker told us that they worked closely with the support workers and were able to observe their behaviour and interactions with people who lived at the home. They also monitored the written daily notes staff completed to check that the content reflected the care provided to each person. They told us that they discussed any identified shortcomings immediately and followed them up during supervisions, to check that lessons had been learned. Staff told us that they felt supported by the manager and were aware of their roles and responsibilities.

A range of quality audits had been completed, including infection control, people's finances and health and safety. Where actions had arisen from these audits we saw that these were monitored until they had been completed. We saw that the manager had recently introduced a new schedule for quality audits at intervals from between one and three months instead of attempting to complete all of them on a monthly basis. The manager had identified priority audits, such as infection control, medicines administration and people's support records, which required to be completed on a monthly basis because of the risks posed by any shortcomings. Other audits with a lower identified risk, such as specialised equipment and complaints would be completed on a quarterly basis.

In addition to the audits completed by the manager and the team leader, the provider had a system of unannounced inspections at the home to check compliance with the legal requirements. The last inspection had been completed in October 2014. An action plan had been developed to address a number of shortcomings that had been identified, such as the inconsistency in the completion of food and fluid charts and obtaining evidence of the legal right for relatives or friends to make decisions on behalf of people. The manager told us that a number of actions had been completed, such as the updating of support plans, but some were still ongoing at the time of our inspection.