Swanton Care & Community (Autism North) Limited

Tynedale

Inspection report

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Date of inspection visit:
19 November 2015
20 November 2015

Date of publication:
26 January 2016

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

The inspection took place on 19 November 2015 and was unannounced. A second day of inspection took place on 20 November 2015 and was announced. We previously inspected Tynedale on 8 April 2014 and found the service was meeting the requirements of the regulations we inspected.

Tynedale is registered to provide residential care and support for up to four adults with a learning disability or autistic spectrum disorder. At the time of our inspection there were four people living in the home of whom one was in hospital.

At the time of our inspection there was a registered manager in post. 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.

Relatives told us people were safe. One relative said their relation was "safe, happy and always clean".

Staff had a good understanding of safeguarding. All safeguarding concerns were recorded, investigated and outcomes fed back. Incidents and accidents were also recorded and investigated along with actions taken and lessons learnt. The registered manager analysed incidents and accidents to identify any trends that may require further action to be taken to prevent reoccurrences.

Electronic systems were in place for the recording, investigating and monitoring of safeguarding concerns, complaints, accidents and incidents. Electronic logs and records were kept for all and included details of investigations, outcomes and action taken. Lessons were learnt from safeguarding concerns, complaints, accidents and incidents and appropriate feedback was given to the relevant people.

Risk assessments were in place for people where risks had been identified. There were also risk assessments regarding the premises and environment.

There were up to date checks and risk assessments in place in relation to fire, electrics, gas safety and legionella. Personal emergency evacuation procedures (PEEPs) were in place for people who used the service.

Medicines were managed effectively with safe storage and appropriate administration, reflective of the individual needs of people.

Staffing levels were not always consistent and therefore did not always meet people's needs. The registered manager organised rotas around the levels of staff required to meet the individual needs of the people receiving the service. However, additional staffing was not always in place to cover leave for the cook and domestic.

Staff understood the needs of people within the service. Staff described how they provided support to people and how they met their needs.

Staff were supported to fulfil their caring role. One staff member told us they "feel supported by the manager". Staff received regular supervision and annual appraisals which were up to date.

Every person within the service had a communication tool within their care files which contained information of their individual communication needs. Clear detailed instructions of how staff should communicate with each person and how people could communicate were included. For example, that they wanted something. Communication strategies used within the service included picture exchange communication systems (PECS), photos, objects and gestures.

People's care records contained best interest decisions which corresponded to the information contained in deprivation of liberty safeguard (DoLS) authorisations and care plans put in place, for example, restraint. DoLS authorisations were in place for every person receiving the service and were also stored within care files alongside mental capacity assessments and best interest decisions.

We observed people and staff during mealtimes. People were enjoying their meals, some independently and others with support from staff. There were choices available for people at mealtimes in terms of food, time and location. Staff supported people in a patient, gentle manner and appropriately paced for each individual.

People had access and received services from a wide variety of professionals, appropriate to their care needs and in line with care plans.

Care plans were in place to meet the needs of individual people including personal care, eating and drinking and medication. Care plans were personalised and written in the first person. They were detailed and gave clear directions how to meet the specific needs of each individual.

People's care plans were reviewed on a regular basis. All care plans were up to date and reflected the needs of each individual person.

There was an up to date complaints procedure which detailed all stages to be followed by the registered manager and staff when dealing with complaints received. We saw this this procedure used in practice.

A range of regular audits were carried out by the registered manager and members of staff that related to the service the home provided as well as the premises and environment.

There was a range of activities available for people in the service. Activities ranged from arts and crafts, baking, sensory games, watching films, karaoke and everyday tasks to park visits, coastal walks and beach trips.

The home had a detailed system in place for the daily handover of information. Written records and diary sheets were completed daily by the lead staff members.

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.

A relative told us that people are safe.

Staff had a good understanding of safeguarding and knew who to report any concerns to.

Premises were maintained with appropriate checks being carried out in relation to fire, electrics, gas safety, legionella and lifting equipment.

Staff were recruited with the right skills and experience and all appropriate checks were completed.

Is the service effective?

Good

The service was effective.

Staff had training, regular supervision and annual appraisals to ensure they had the skills and knowledge to care for people.

The Mental Capacity Act (2005) was followed appropriately and Deprivation of Liberty Safeguard (DoLS) were authorised.

People had access to healthcare professionals as they needed them.

Is the service caring?

Good

The service was caring.

Relatives told us that people were settled and happy.

Staff interaction with people whilst providing support was positive, warm and genuinely affectionate.

Staff treated people with dignity and respect and spoke to them in a respectful, friendly manner.

People had access to appropriate advocacy services.

Is the service responsive?

Good

The service was responsive.

People were supported to fulfil their personal preferences and choices.

Complaints were effectively managed, with outcomes fed back to complainants and lessons learnt recorded and acted upon.

Care plans were up to date, detailed and reflected the individual needs of each person.

People had hospital passports contained in care plans, which were used to share important information with hospitals when people were admitted.

A range of activities were on offer for people that were suitable and appropriate for individuals and in line with their preferences.

Is the service well-led?

Good

The service was well led.

The registered manager operated an open door policy. Staff told us they felt that the registered manager "is very approachable".

The registered manager had a visible presence in and around the home, ensuring a good quality service.

A range of quality assurance systems were in place to measure quality of the service and drive improvement.

Tynedale

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 comprehensive inspection took place on 19 November 2015 and was unannounced. A second day of inspection took place on 20 November 2015 and was announced.

The inspection was carried out by one adult social care inspector.

The provider was not asked to complete 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.

Before the inspection took place we reviewed the information we held about the service. This included notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch. (Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England).

People who used the service were not always able to verbally communicate how they felt about the home, staff and service provided. Therefore we spent time observing how staff supported people. We spoke with one relative and three members of staff, including the registered manager and two care workers. We looked at three people's care records and four people's medicine administration records (MARs). We reviewed three staff files, including records of the recruitment processes. We reviewed the supervision, appraisal and training records as well as records relating to the management of the service. We also completed observations around the service.

Good

Is the service safe?

Our findings

A relative told us people were safe. One relative said their relation was "safe, happy and always clean". Staff had a good understanding of safeguarding. One staff member named several forms of abuse, gave examples of possible signs of abuse and told us they would "report any concerns straight to the manager". If the registered manager was unavailable then one staff member told us they would "speak to the lead senior on duty".

There was a whistle blowing policy in place that was readily available and accessible for staff. Copies of the policy were displayed on the noticeboard. Staff were aware of the whistle blowing policy and one member of staff told us they "would feel comfortable raising issues" with the registered manager and were confident the registered manager "would act on issues" they raised.

A safeguarding file was in place which included the policy and procedure for reporting and dealing with concerns. There was a safeguarding log of concerns and alerts that had been raised which corresponded with records held by CQC. Investigations, outcomes and actions taken were stored electronically and available to view. The registered manager explained that the investigations were electronically stored as well as safeguarding audits carried out by the registered manager to ensure all steps were taken when dealing with a safeguarding issue. Evidence of investigations and outcomes were seen during our inspection.

There was an incident and accident file which contained detailed reports for all incidents and accidents that had occurred. Records included details of events that had occurred, a record of investigations, all action taken and lessons learned following any event. An electronic log of all accidents and incidents was updated by the registered manager and submitted to the provider on a monthly basis for collation and analysis. Results were then shared with the registered manager.

The registered manager informed us that she also "analyses incident and accident reports to identify any trends" or "preventative measures that could be put in place or actions that need to be taken". During our inspection we noted one recurring incident with a person who used the service which resulted in a referral to a care professional. The person's relevant care plan and risk assessment were updated to show what care and support staff should be provided to ensure the person remained safe.

Risk assessments were in place for each person living at Tynedale. Where risks had been identified there were appropriate monitoring forms in place, for example, weekly weight charts. All risk assessments linked to appropriate care plans which detailed how care and support was to be provided to each person to mitigate those risks. For example, where someone had been assessed as being at risk of choking, there was an appropriate eating and drinking care plan in place. The care plan detailed how the person's food should be prepared and presented as well as what support should be provided.

There were a range of generic risk assessments in place relating to the premises and environment. These included slips, trips and falls, radiators and hot surfaces, control of infection/infestations and medicine

administration. All generic risk assessments were reviewed on a regular basis to ensure they were up to date and relevant to the service.

During our inspection we saw appropriate maintenance records for all lifting equipment. Maintenance checks were completed six monthly. Maintenance checks were carried out by the provider's maintenance person. Regular checks included water temperatures, light checks and door handles. All maintenance requests were recorded in the maintenance book and carried out by the maintenance person or appropriate contractor where necessary. This meant that the provider made sure the premises were safe and well maintained for the people who lived there.

There was an up to date fire risk assessment in place. Regular fire safety checks were carried out in varying frequencies to ensure the premises remained safe in case of a fire. Checks included fire alarms, fire doors, emergency lighting and fire extinguishers. There was an inventory of smoke alarms that were also regularly checked to ensure they were in working

The service carried out quarterly fire drills within the home. Personal emergency evacuation procedures (PEEPs) were in place for people who used the service. These included details of each person, such as their room number, level of mobility and the support they required to evacuate the building. These procedures were found to be up to date and relevant to each individual as well as being readily accessible to staff to ensure they evacuated people appropriately and safely.

The building was clean and appeared to be well maintained with appropriate test certificates for gas safety, fixed electrics, portable appliances testing (PAT), legionella and fire alarms. All checks were complete and up to date.

Medicine was administered by two staff, one of which must be a grade 2 or above for them to have job related responsibility. Staff completed daily and weekly medicine audits and stock checks to ensure the safe management of medicines. There were no issues identified from the audits completed.

There was a medicines file that included guidelines on handling medicines, a strategy and good practice guide for safe handling, management and administration of medication and MARs completed for all people who received the service. All MARs were completed with no identified gaps. Topical medicine applications were recorded separately and over the counter medicines were signed off as safe by a GP prior to being administered to people.

Changes to people's medicines were recorded to show new medicines as well as those discontinued or changes to dosages. Records about medicines taken out of the building were completed and signed by a member of staff and the person receiving the medicine to show they accepted responsibility. For example, one person was going on an outing with their parents for the day and the form was signed by the person's father.

The registered manager had a robust recruitment process that was followed so staff were recruited with the right skills, experience and competence. Relevant checks were carried out for each member of staff including reference checks, health checks and a disclosure and barring service check (DBS) prior to someone being appointed. DBS checks are used as a means to assess someone's suitability to work with vulnerable people.

Staffing levels were not always consistent so people's needs were not always met. A relative told us "there aren't always enough staff on shift as people phone in sick" and "staff cover for the cook and domestic when

they're on leave". The cook and domestic were on leave during our inspection and cover was provided by the four care staff on shift, with support from the registered manager. This meant that there were not always enough staff to meet the staffing ratio needs for people as recorded in care plans.

Staff told us there were enough staff to meet people's needs. The registered manager organised rotas around the levels of staff required to meet the individual needs of the people receiving the service, for example one to one support, two to one support. In addition to the allocated care staff there was a cook, a domestic and the registered manager on day shifts.

There were two waking night staff allocated to cover each night shift. The registered manager told us that all flats have alarms on the doors to notify staff if people get up and leave their room during the night so staff could attend to their needs whilst ensuring they remained safe.

During the inspection we observed that people were supervised and their needs were seen to quickly. People were given support by staff in a timely manner and a comfortable pace to each individual.

Good

Is the service effective?

Our findings

People were cared for by skilled and competent staff. Staff received training including those deemed mandatory by the provider. Mandatory training included mental capacity, deprivation of liberty, safeguarding vulnerable adults, positive behaviour support, moving and handling, health and safety and first aid. Additional training was available to staff members for completion including records management, information security and nutritional wellbeing and hydration. Training records showed that some training was out of date for staff. The registered manager told us that this training had been scheduled. Records showed that staff competency was assessed for specific things such as medicine administration.

Staff understood the needs of people within the service. Staff described how they provided support to people and how they met their needs. One member of staff explained preventative methods they use when supporting people to minimise the risk of challenging behaviour.

Staff were supported to fulfil their caring role. One staff member told us they "feel supported by the manager". Staff received regular supervision. There were noticeable gaps for three members of staff but the registered manager explained that these gaps were due to sickness and maternity leave. The registered manager also told us they had recently recruited a new senior carer and they were taking a more structured approach to supervisions going forward. There was a plan in place to complete supervisions for staff who had been on leave. Supervision records included discussions that had taken place, developments and actions agreed.

Staff received annual appraisals with the registered manager. During appraisal meetings staff and the registered manager discussed performance, achievement and personal development. There was an appraisal matrix in place which detailed when appraisals were completed and when new appraisals were due to take place for each member of staff.

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.

People's care records contained best interest decisions which corresponded to the information contained in the DoLS authorisations and care plans put in place, for example, restraint such as using key pads on front

doors to prevent people going out unsupervised, people being supervised during outings and the use of distraction methods. DoLS authorisations were in place for every person receiving the service and were also stored within care files alongside mental capacity assessments and best interest decisions.

People could have their lunch anytime. During our visit we observed people eating at different times and in different locations, for example, one person liked to eat their meal in the conservatory. Menus were planned by the cook on a four weekly basis. One staff member told us that the cook "takes people's preferences into consideration" when planning the menus. Some people were unable to choose which option of meal they would like so staff made the decision on their behalf, whilst taking into consideration their preferences, likes and dislikes. One relative told us their relation "can't make choices in relation to what he eats" and they were "happy for staff to make the choice" on his behalf of the foods and meals they know he likes".

Staff told us that two options were available for people each meal time and some people could make decisions using pictures. During a lunch time we observed meals being brought out to people in the dining room and the conservatory. Staff offered everyone a variety of drinks to have with their meals which included flavoured juices and water. We observed that people ate their meals independently with encouragement and positive prompting from staff.

People had access to professionals such as from opticians, dentists, chiropodists, speech and language therapists and psychiatrists. Records were kept of any appointments or contact with those as well as doctors, occupational therapists, community treatment team and hospitals. Care files contained clear records of contact with all professionals. This included doctor and hospital involvement for one person receiving ongoing treatment.

The décor throughout the home was bright and homely with appropriate signage indicating the location of toilets, bathrooms and people's individual rooms. The lounges contained appropriate furniture. One relative told us that the "home is lovely and is always clean".

Good

Is the service caring?

Our findings

The atmosphere within Tynedale was calm, quiet and welcoming. One relative told us their relative "is settled and happy" at Tynedale. They also informed us that they were "happy with the service" and they felt "staff know and understand" their relative's needs and could provide appropriate care.

During our inspection we saw people smiling and laughing and interacting in a friendly manner with staff. Throughout the inspection we observed positive interactions between people and staff members, such as encouraging people to join in activities or supporting them with daily tasks like taking their clothes to the laundry and making a cup of tea.

One relative told us that "the home and staff are lovely" and "the home is always clean". They told us that "the lounge is large and ideal for [relative]" as they like space to sit and watch dvds.

We also observed people receiving verbal support, prompting and encouraged to make individual choices and decisions where possible using a range of communication methods such as PECS. For example, a person pointing to pictures within their PECS to tell staff what they wanted to do.

One staff member told us they used information recorded in care plans to delivery appropriate support and meet people's needs but that they also got to know each person individually and felt this gave them more of an understanding of how best to meet people's needs.

Staff treated people with dignity and respect. We observed staff spoke to people in a respectful, friendly manner and asked people if they wanted to do something prior to encouraging or prompting. Staff respected people's decision if they didn't want to do something, like take part in an activity. Permission was sought by staff prior to carrying out any activity of support, for example, assisting a person to put on their coat for an outing.

During meal times we observed the table used were set nicely with napkins, cutlery and placemats. The dining room and the conservatory were decorated in a homely way with curtains, pictures and appropriate furniture. Food was well presented and looked appetising. Staff verbally supported people gently and patiently, providing prompts and encouragement when required and at a pace comfortable to each individual. One person was seen to be given the appropriate space to enjoy their meal on their own, in line with their eating and drinking care plan.

We observed staff engaged people in some individual activities which they enjoyed, for example, one person enjoyed arts and crafts and painting in the dining room with a member of staff. The person was smiling and naming colours to tell staff what colours they were using. Another person was supported by a staff member to make cakes at the dining table. All engagement observed between staff and people was positive, friendly, familiar and with genuine affection.

At the time of the inspection one person required the support of an advocate. Care file records showed one

person received support from an independent mental capacity advocate (IMCA). Information regarding those services were available within the home. Observations and care plan files clearly demonstrated that other people had family involvement and support.

There were pictures, ornaments, flowers, a television, radio, computer and variety of furniture throughout the ground floor, giving it a homely feel. People were supported to go into the kitchen and choose their own snacks.

There was an enclosed, communal garden to the rear of the home with some appropriate seating. The registered manager informed us that some people "like to go into the garden" when it's warmer.

Good

Is the service responsive?

Our findings

We saw people were supported to fulfil their personal preferences and choices. During our visit we observed people making decisions in relation to activities. It was clear that people were in control of their care, what they wanted to do and when they wanted to do it. Staff responded appropriately to decisions made by people. For example, one person decided they were ready to go out into the community. Another person decided they no longer wanted to paint. They communicated their decisions with gestures, such as moving away from the activity area.

Each person had a communication tool within their care files which contained information of their individual communication needs. Clear detailed instructions of how staff should communicate with each person and how people could communicate were included. For example, how they would show they wanted something.

Communication strategies used included picture exchange communication system (PECS), objects and gestures. The registered manager told us about a new strategy they were introducing to people called the objects reference programme chart. This strategy consisted of objects representing specific activities then these being taught to people so they could anticipate where they were going or what they were being asked to participate in. Relatives and staff told us specific ways people communicate which corresponded with instructions recorded in care files. One relative informed us that one person "would tap on things" like cupboard doors or "point to pictures" in their PECS book.

People's care files included care plans around their individual social and communication needs as well as community presence and participation. Plans included community activities each individual enjoyed taking part in. Community activities varied for each person as they were personal to their preferences. These included activities such as park visits, coastal walks, bowling and trips to Roker Park.

People had a detailed document within their care files called 'Living My Life' which contained information in relation to people's needs, dependencies, preferences, likes and dislikes. The document covered areas such as food, relationships, activities, exercise and outings. Care plans were in place to meet the needs of individual people including personal care, eating and drinking and medication. Care plans were personalised and written in the first person. They were detailed and gave clear directions how to meet the specific needs of each individual. For example, one record about eating informed that the person liked to eat their meals alone, at the table in the conservatory. Another record around laundry stated that the person liked to do their own laundry and gave details on how staff should support them to do so.

People's care plans were reviewed on a regular basis. All care plans were up to date and reflected the needs of each individual person.

People had hospital passports within their care plan files. These passports would be transferred to a hospital with a person should they need to be admitted. The passports, when completed, would contain all

relevant and necessary information regarding the person that would then be shared with medical professionals should people go to hospital. The service used these passports effectively as it was evident from care files that one passport had transferred to the hospital with the person.

One relative told us they knew who to complain to and felt comfortable doing so. There was an up to date complaints procedure in place that detailed all potential stages of the process depending on escalation. Relatives told us they knew who to complain to. One relative told us they "were satisfied that the manager listened to their complaints" and the registered manager provided feedback to them on findings and actions. We saw records of complaints received with detailed investigations, outcomes and feedback to complainants and higher management.

Staff informed us people let them know when they were unhappy with something or didn't want to do something, for example, if they felt that staff or other people who use the service are too close to them. Staff were confident that family members would complain if they were unhappy with the service. One staff member told us "relatives complain to the manager when they aren't happy with something".

Good

Is the service well-led?

Our findings

The home had a registered manager. The registered manager had been registered since 16 June 2014 and was proactive in submitting statutory notifications for specific events. A notifications file was available to view and contained a log and copy of all notifications they had sent.

The registered manager operated an open door policy within the home to enable and empower staff to come to her with any queries, issues or problems. During the inspection we observed staff entering the registered manager's office freely to speak to her or to obtain specific files. A member of staff told us the manager "is very approachable" and resolved any issues raised.

Throughout the inspection visits there was a management presence in the home with the registered manager being readily available for staff, people who use the service, relatives and other professionals to speak to. During evenings and night times there was a senior care worker on duty and out of hours contacts available who staff could speak to if needed. This meant there was always access to management.

The provider had a quality monitoring system to check the quality and safety of the service. This included a number of audits that were completed by the registered manager and staff members in relation to the service including fire safety checks and drills. Other audits regularly carried out related to areas such as medicines, bedrooms, documentation and safeguarding which were effective in identifying issues and required improvements. For example, bedroom audits completed identified issues with a broken door handle. Appropriate action was taken and a new door handle was installed.

Friends and family surveys were sent out annually to relatives regarding the service people received. The last surveys were sent out earlier this year, responses were mainly positive around staffing and care but issues were raised regarding food, not taking people's personal preferences into consideration and activities were referred to as adequate. The registered manager informed us that discussions had taken place with the cook and menus were reviewed. This meant the service sought relatives' views and acted on their comments and suggestions to improve the service.

The registered manager informed us that they "had a structured approach to activities that supported people to acquire new skills". Activities viewed in people's daily planners included day to day independent tasks such as making beds, doing laundry and vacuuming. Planners also included other activities, such as park outings, coastal walks, cake making, karaoke, matching box, play dough, Roker beach and a disco.

Regular staff meetings were held with the registered manager. Topics discussed during the meetings included safety issues, medication, daily records and updates on people who use the service. The registered manager told us they "encouraged the involvement" of people in the staff meetings and that one person who used the service attended the staff last meeting held in November. Minutes of meetings were stored and were readily available with agreed actions included for staff to review.

The home had a detailed system in place for the daily handover of information. Written records and diary

sheets were completed daily by the lead staff members. Handovers included detailed information relating to each person's routine, bath temperature, diet intake, toileting, behaviour, contact with relatives, communication and activities. From information contained within daily handovers staff could identify any action or additional checks required, such as making health appointments.