Turning Point

Sheldon Ridge

Inspection report

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West Yorkshire
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Sheldon Ridge on the 27 June 2018. The inspection was unannounced. At our last inspection in December 2015 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns.

Sheldon Ridge is located in the Bierley area of Bradford and provides nursing and accommodation to 12 people who have a learning disability and complex needs. Accommodation is split into two ground floor units each containing single occupancy bedrooms. Each unit has its own dining and lounge area. To the exterior of the building there is a communal garden.

Sheldon Ridge is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service was working in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

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.

People who used the service were unable to verbally communicate with us therefore we observed people's gestures and body language to determine their level of engagement with staff. People appeared comfortable and relaxed in the company of staff and staff clearly understood people's individual methods of communication.

Policies and procedures ensured people were protected from the risk of abuse and avoidable harm. Staff told us they had regular safeguarding training, and were confident they knew how to recognise and report potential abuse. Where concerns had been brought to the registered manager's attention, they had worked in partnership with the relevant authorities to make sure issues were fully investigated and appropriate action taken to make sure people were protected.

The registered manager and staff were observed to have positive relationships with people living in the home. People were relaxed in the company of staff and there were no restrictions placed on visiting times for friends and relatives.

From our observations it was clear staff knew individual people well and were knowledgeable about their

needs, preferences and personalities.

Appropriate Deprivation of Liberty Safeguard (DOLS) applications had been made to the local authority and people's mental capacity to make their own decisions had been assessed and recorded in line the requirements of the Mental Capacity Act 2005. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible.

Each person had a support plan that was person centred and sufficiently detailed to ensure they were at the centre of their care. People's care and support was kept under review and, where appropriate, they were involved in decisions about their care. Risks to people's health and safety had been identified, assessed and managed safely. Relevant health and social care professionals provided advice and support when people's needs changed.

There were enough staff on duty to support people when they needed assistance. However, the deployment of staff and the skill mix on some shifts was not always appropriate to meet people's needs.

The registered manager followed a robust recruitment procedure to ensure new staff were suitable to care for vulnerable people and arrangements were in place to make sure staff were trained and supervised.

Medicines were managed safely and people had their medicines when they needed them. Staff administering medicines had been trained and supervised to do this safely.

Appropriate aids and adaptations had been provided to help maintain people's safety, independence and comfort. People had arranged their bedrooms as they wished and had brought personal possessions with them to maintain the homeliness. The home was reasonably clean and tidy. However, staff were not always following the infection control policies and procedure in place.

There were a range of leisure activities for people to participate in, including both activities and events in the home and in the local community and it was apparent people enjoyed a full and active social life.

We saw the complaints policy was available in both a written and easy read [Pictorial] format. The policy detailed the arrangements for raising complaints, responding to complaints and the expected timescales within which a response would be received.

There was a quality assurance monitoring system in place that was designed to continually monitor and identified shortfalls in service provision. Audit results were analysed for themes and trends and there was evidence that learning from incidents took place and appropriate changes were made to procedures or work practices if required.

We found all fundamental standards were being met. Further information is in the detailed findings below.

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.

Staff were recruited safely. However, we recommended the registered manager reviews the skill mix and staff deployment to ensure people are provided with the care and support they need at all times.

Staff understood how to keep people safe and where risks had been identified, action had been taken to mitigate those risks.

People received their medicines safely and as prescribed.

Staff were not always following the infection control policies and procedure in place.

Is the service effective?

Good

The service was effective.

People were supported by staff that received appropriate training and supervision.

People's right were protected because the service was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were referred to relevant healthcare professionals if appropriate and staff followed their advice and guidance.

Is the service caring?

Good

The service was caring.

The registered manager and staff were committed to a person-centred approach to care and support.

The service actively sought opportunities to help promote

people's life experiences and independence.

People were supported to maintain relationships with their family and friends.

Is the service responsive?

Good

The service was responsive.

People received a service that was flexible and responsive to changes in their needs.

Care plans were in place to ensure staff provided care and support in line with people's preferences.

There was a range of activities for people to participate in, including activities and events in the home and in the local community.

There was a complaints policy available in both a written and easy read [Pictorial] format.

Is the service well-led?

Good

The service was well-led

There was a registered manager in post who provides leadership and direction to the staff team.

Staff enjoyed their work and told us the senior management team were always available to offer guidance and support.

Systems were effective in assessing and monitoring the quality of care provided to people and to drive improvements.

The service sought and acted upon feedback from people who used the service, relatives and outside agencies to improve the quality of care and support provided.

Sheldon Ridge

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 checked 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 27 June 2018 and was carried out by two adult social care inspectors. The inspection was unannounced.

Before the inspection we reviewed the information we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams.

The provider had completed a Provider Information Return (PIR). The PIR is a document which gives the provider the opportunity to tell us about the service. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included four people's care records, two staff recruitment files and records relating to the management of the service.

We spoke with two relatives, two qualified nurses, four care workers, the chef, the activities co-ordinator and the registered manager.

Good

Is the service safe?

Our findings

People were kept safe from abuse and improper treatment. Care plans contained information about how to keep everyone who used the service safe and secure. One relative we spoke with told us, "We are confident [Name] is safe. We can go home and are content."

Staff had completed safeguarding training and said they would not hesitate to report concerns to a senior member of staff, the registered manager or the safeguarding team. The registered manager had made appropriate referrals to the safeguarding team when this had been needed. This meant staff understood and followed the correct processes to keep people safe.

People were protected from any financial abuse. The manager held money for safekeeping on behalf of people who used the service. Records of monies held were kept and receipts for any purchases were obtained.

Accidents and incidents were recorded and analysed to see if any themes or trends could be identified. Records showed what action had been taken following any accident or incident to reduce or eliminate the likelihood of it happening again. Risk assessments had been completed where areas of risk to individuals had been identified and action taken to minimise any risks had been taken. For example, one person had a specialist alarm in place so staff could respond quickly if they required assistance.

Staff received training in responding to behaviours that challenge. The training provided used positive behaviour support approaches and plans. The focus of the training was on de-escalation to actively reduce risk or the need for any form of restraint. Techniques to help people should they become anxious were documented in their support plans. We saw staff were quick to recognise and deal with any signs of anxiety people showed at an early stage. People appeared relaxed and comfortable in the presence of staff and indicated when they wanted assistance or social contact.

Records showed safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. Whilst there were enough staff to keep people safe there were occasional shortfalls when the actual number of staff on duty was less than had been planned. For example, some staff we spoke with told us when care workers were off work due to leave or sickness their shifts were not always covered. On the day of inspection there was some confusion over the duty rota and the service was one support worker down for part of the afternoon. In addition, relatives commented they did not think the skill mix of staff was always right, for example, when agency staff were being used. This was discussed with the registered manager who told us they had already identified this and assured us they were dealing with it.

The care team were supported by a housekeeper, chefs and an activities co-ordinator. The registered manager explained the housekeeper was on sick leave at the time of inspection and their hours were being covered by an agency worker, three days per week.

We found medicines were safely and securely stored and the temperature of the storage area and fridge

were monitored daily. The registered manager told us only qualified nursing staff or team leaders specifically trained in the safe administration and management of medicines administered medicines. On the day of inspection, we saw medicines being administered by the nurse on duty with patience and kindness. We looked at a sample of medication administration records (MARs) and saw people were given their medicines as prescribed.

There was a stock control system in place for medicines prescribed on an 'As and when required' [PRN] basis and the protocols in place gave clear guidance to staff on under what circumstances PRN medicines might be administered. Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These are called controlled medicines. We checked the controlled drugs cabinet and no concerns were identified.

We saw a range of checks were undertaken on the premises and equipment to help keep people safe. These included checks on the fire, electrical and gas systems.

Personal emergency evacuation plans (PEEPS) were in place. We saw the fire alarm was tested and fire drills were held. The last fire drill had taken place on 30 April 2018 and it had been noted some staff needed to be spoken with as they did not respond. One of the fire marshals told us the fire procedures had recently changed and they were going to contact the fire service for further advice.

The premises were divided into two bungalows each with six people. There were sufficient communal areas which included a dining room and lounge in each unit. There were adequate toilet and bathroom facilities. The premises were sufficiently maintained and we did not identify any hazards or risks to people's safety. Doors to kitchens and offices were kept secure with keypad locks.

The home was reasonably clean and tidy and people had arranged their bedrooms as they wished and had brought personal possessions with them to maintain the homeliness. However, the visitors we spoke with told us they did not think their relative's bedroom was always as clean as it should be. We noted an odour of stale urine in some areas and concluded this was because care workers were not putting soiled incontinence pads into disposal bags before putting them in the clinical waste bins. We also noted some of the clinical waste bins were broken. This meant staff had to lift the lids with their hands. We also saw staff wearing more jewellery than they should have been which also posed an infection prevention risk. Following the inspection, we received evidence from the registered manager to show these concerns had been identified through the providers quality assurance process before our inspection and were being addressed.

We saw staff had access to personal protective equipment, such as gloves and aprons and were using these appropriately. The service had been awarded a five star rating for food hygiene by the Foods Standards Agency. This is the highest award that can be made and demonstrated food was prepared and stored hygienically.

Good

Is the service effective?

Our findings

Staff commented positively about the training they received and told us they were prompted to ensure they kept their mandatory training up to date. One staff member said, "The training is very good and you can request specific training relevant to people 's needs if you wish." Another staff member said, "We do quite a lot of training, it's on going all the time and if we can ask for a refresher if we need it." Staff also told us they were also supported to obtain qualifications relevant to their role.

The registered manager told us new staff completed induction training and were enrolled on the Care Certificate. The Care Certificate is a set of standards designed to equip social care and health workers with the knowledge and skills they need to provide safe, compassionate care. We spoke with a new member of staff who explained their induction training consisted of some e-learning, face to face training and working with experienced care workers.

The training matrix showed staff were up to date with training which included introduction to learning disabilities, positive behaviour management, moving and handling, emergency first aid at work and safeguarding. We saw staff had also received specialist training in topics such as epilepsy awareness and autism.

Staff were provided with formal one to one supervision sessions every four to six weeks which gave them the opportunity to discuss their work role, any issues and their professional development. Staff told us they felt supported and said they could go to the registered manager or one of the nurses at any time for advice or support. Annual appraisals were also completed.

People's care plans contained detailed information about their nutritional and hydration needs. They also contained information about people's likes and dislikes, how they needed to be supported with meals and drinks and any specialist cutlery or crockery they liked to use.

We spoke with the chef who explained various people's dietary needs and preferences to us. It was clear they had a good understanding of people's dietary needs and preferences. A three-weekly cycle of menus was in operation, which were changed seasonally.

People who had been assessed as being nutritionally at risk were being weighed regularly. Records were also being maintained of what they were eating and drinking. Staff were able to explain how they fortified one person's diet and when they may need to refer them to their GP or dietician for additional advice.

The registered manager explained before anyone moved into Sheldon Ridge they would be assessed to make sure staff would be able to meet their needs, taking into consideration the needs of the people already living there. If they considered they could offer a service the individual was invited to visit, to stay for a meal and stay overnight as many times as they wished to make sure the home was the right place for them. However, as there have been no new admissions to the service since 2005 it was not possible to make a judgement about the assessment process.

People's healthcare needs were being met. In the surveys relatives had completed in April 2018 we saw the following comments in relation to healthcare; "[name] has been poorly recently and the staff have been brilliant." "Any problems health wise are well taken care of." In the two care files we looked at we saw people had been seen by a range of healthcare professionals, for example, GPs, occupational therapists, practice nurses, dieticians, speech and language therapists, dentists and opticians. We saw the service had received a recent compliment in relation to staff supporting someone to a health care appointment. It stated, "The accompanying staff from Sheldon Ridge were excellent and should be commended for their professionalism and assistance during [name's] attendance today."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 authorisation to deprive a person of their liberty were being met. The service was acting within the Mental Capacity Act. People's capacity to consent to their care and support arrangements was assessed. Where people lacked capacity and it had been assessed that the accumulation of restrictions amounted to a deprivation of liberty, appropriate DoLS applications had been made.

People were asked consent before care and support was provided. Where people lacked capacity best interest decisions had been made involving families and healthcare professionals. For example, the best interest process had been followed for one person who needed to have their tablets (medicines) crushed.

In one of the care files we looked at it stated one of the relatives had Lasting Power of Attorney (LPA). However, it did not state what the LPA was for and there was no evidence the LPA document had been checked for authenticity. A LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no longer able to or if you no longer want to make your own decisions. LPA's can be put in place for property and financial affairs or health and welfare. It is important this information is available so it is clear people are making decisions they are legally empowered to do. Following the inspection, we received written confirmation from the registered manager which showed they had established the LPA was for financial affairs only. The registered manager confirmed this information had been placed on file.

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Good

Is the service caring?

Our findings

Relatives told us the quality of the staff team was the best it had ever been in their experience. They went on to say one particular care worker had a very special, trusting relationship with their relative.

Care files contained people's life story details, information about their life at Sheldon Ridge and their likes and dislikes. The care records also focussed on people's skills and their personalities. This helped staff to get to know people and develop relationships with them.

Surveys had been sent to relatives in April 2018 and all the people who had responded said they were made to feel welcome when they visited. One person stated, "I am welcomed as members of my own family would welcome me, with genuine warmth."

Staff encouraged people who used the service to be as independent as possible. The support plans we looked at contained information about the tasks people could complete and the level of support they needed for others. This was designed to ensure staff did not do things for people that they were able to do for themselves, therefore promoting and maintaining their independence and quality of life.

Throughout the inspection we observed staff supporting people in a calm manner. Staff responded promptly to people's needs and requests, but also allowed time to sit with people providing friendly conversation or just company. We heard staff speaking to people in a way that showed they knew them well and cared about them.

However, the lunchtime meal was over and done with very quickly and was not a social occasion. We saw in one person's care plan staff needed to sit by the side of them when assisting them with meals and drinks. We saw a care worker standing over them when assisting them with a drink. This was discussed with the registered manager who confirmed this matter would be addressed with the individual staff member through supervision and training.

People who lacked capacity to make important decisions, and had no one to help them with this, were assisted to access the services of a local advocacy service. Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in advising or representing them.

We looked at whether the service complied with the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our observations of care, review of records and discussion with the registered manager, staff and relatives demonstrated that the service was proactive in promoting people's rights.

The service had policies and procedures in relation to protecting people's confidential information which showed they placed importance on ensuring people's rights, privacy and dignity were respected. The registered manager was aware of the new General Data Protection Regulation (GDPR); this is the new law

regulating how companies protect people's personal information. We saw staff had received information about handling confidential information and on keeping people's personal information safe.

There were robust arrangements for the management and storage of data and documents. Records and reports relating to people's care and welfare were stored securely and data was password protected and could be accessed only by authorised staff.

At our last inspection this domain was rated outstanding. While we saw some examples of positive and caring practices during this inspection, we didn't see sufficiently strong evidence to demonstrate the provider had consistently ensured they continued to meet the exceptional and distinctive characteristics of an outstanding service.

Good

Is the service responsive?

Our findings

The care plans and supporting documentation we looked at were person centred and provided staff with the information required to provide people with appropriate care, support and treatment. We found the care plans contained information about people's past and current lives, their family and friends and their interests and hobbies. We saw information was provided in pictorial format and included specific information about people's dietary needs and the social and leisure activities they enjoyed participating in. They gave clear information about the support everyone required.

The registered manager had also devised a 'One page profile' for each person, which gave a quick overview of them as a person. These profiles were very useful. For example, one of the inspectors was speaking with a very new member of staff. One of the people who used the service came and sat with them. The care worker told the inspector the person liked to have their hair stroked, which was confirmed by other staff.

People's end of life care needs were planned for. Care plans were in place which contained information about how they wished to be cared for at the end of their life and information about specific requests.

People's care plans gave details of one activity for each day of the week. For example, using the in-house multisensory room or music session. The activities co-ordinator worked two days a week and took a lead role for organising activities out in the community. The service had its own mini bus which could be driven by a number of staff. On the day of the inspection one person was supported to a trampolining session and another person was going swimming with a member of staff. The service was busy, with people coming and going, throughout our inspection visit. One staff member said, "It's a nice place to work, very centred on the guys here and what they want to do."

We looked at what the service was doing to meet the Accessible Information Standard (2016). The Accessible Information Standard requires staff to identify record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. The registered manager and some of the nurses had recently attended training in relation to the accessible information standard. They explained they would be cascading this information to other members of staff. We saw people's communication needs were assessed and support plans put in place to help staff meet their needs.

During the inspection we saw staff used different communication techniques to ensure information was appropriately communicated to people so they understood what was being asked of them. For example, we saw staff observing people's body language or 'triggers' as a way of determining if they consented to care and treatment. We also saw information was provided in pictorial and easy read formats

We found complaints were taken seriously and investigated. We looked at the complaints log and saw complaints and any concerns raised were being documented. The complaints procedure was on display within the home and available in an easy read format. However, there was nothing documented about the outcome of complaints and if they had been resolved to the complainant's satisfaction. This was discussed

with the registered manager who assured us they would address this matter. Relatives told us they had and would raise any concerns with the registered manager.

Good

Is the service well-led?

Our findings

Staff we spoke with all told us they would recommend the service as a place to live and a place to work. One staff member said, "I really enjoy working at Sheldon Ridge. We have a good staff team and are well supported by the manager and senior management."

There was a registered manager in post who provided leadership and support. Relatives told us, "[Name of registered manager] knows everyone who lives here. They are caring, listen and understand. When they had to deal with a difficult situation they did this in an open and honest way. Their influence has rubbed off on other members of staff." Staff told us, "[Name of registered manager] is one of those people you can really tell how you feel." "They are approachable."

Throughout our inspection we observed the registered manager interacted with staff and people who lived at the home in a professional manner and had a visible presence around the home. We found the registered manager and the senior staff members we spoke with were open, honest and positive in their approach to the inspection process and where possible areas for improvements were identified they took the appropriate action.

We saw the service worked closely with health and social care professionals to achieve the best care for the people they supported. The registered manager and staff had developed strong links and worked in close partnership with the specialist community based healthcare professionals.

People's views about the service were sought. We saw relatives had been sent satisfaction surveys to complete in April 2018. Six had been returned which provided positive feedback about the service being offered. Surveys had also been sent to people who used the service. Five of these had been returned all of which had been completed by relatives. All the comments were positive and did not identify any areas which could be improved. We spoke with the registered manager about this and how they might find a more objective way of getting the views of people who lived at the home. They agreed this was area they could develop.

The registered manager had sent out surveys to 50 members of staff for them to complete anonymously, 17 had been returned. The responses had been analysed and an action plan developed. For example, staff had felt the communication between management and staff team needed to improve. The registered manager reflected on this and spoke with staff to get some examples, they then put measures in place to improve communication.

The provider information return [PIR] showed an internal quality audit was carried out by the provider on an annual basis based on the Commissions [CQC] five domains. A range of other meaningful audits were also carried out by the registered manager or designated staff members at regular intervals throughout the year. We found most of concerns highlighted in the body of the report had been identified through the internal audits systems although the registered manager confirmed there was still room for improvement.

The registered manager told us the care provider Turning Point had an organisational structure which ensured front line managers were supported in their role by senior management and there were clear lines of accountability. They also told us they could draw on the skill and expertise of other key people within the organisation if they had a problem.

Adult social care providers are required by law to notify The Care Quality Commission (CQC) of significant events that occur in care settings. This allows the Commission to monitor occurrences and prioritise our regulatory activities. At the last inspection we found the service had not submitted all required notifications to the Commission. On this inspection we checked the records available and found the service had met the requirements of this regulation.