Somerset County Council (LD Services)

Newholme

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

This inspection took place on 28 August 2015 and was unannounced.

The service provides accommodation and support for up to eight adults with a learning disability or autistic spectrum disorder. At the time of the inspection there were eight people living in the home with complex care and communication needs. Most of the people had severe learning and physical disabilities including mobility needs. People had limited or no verbal communication skills and we were only able to engage in short conversations with two of the people. People required staff support with all of their personal care needs and needed two staff to support them when they went out into the community.

The service had a registered manager. 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.

Summary of findings

We were unable to communicate verbally with most of the people therefore we relied on our observations of care and our conversations with people's relatives and staff to help us understand their experiences.

People received care and support in line with their individual care plans. They appeared very happy and comfortable with the staff who were supporting them. We observed people responded positively when staff approached them with smiles and happy facial expressions. One person said "I like it here very much". Relatives told us they were very happy with the care provided. One person's relative said "Staff are very caring and always look after [their relative] very well". Another person's relative told us "The manager is fantastic and they all seem to work together as a very good team".

We observed staff treated people in the home with kindness, dignity and respect. The staff were exceptionally friendly and considerate and supported people and their colleagues extremely well.

People's relatives said they were always made very welcome and were encouraged to visit the home as often as they wished. They said the service was very good at keeping them informed and involving them in decisions about their relatives care.

Individual communication profiles were available to help staff understand the non-verbal ways in which people expressed their preferences. We observed staff always checked with people before providing care or support and then acted on people's choices. Where people lacked the mental capacity to make certain decisions about their care and welfare the service knew how to protect people's rights.

There were enough staff deployed to meet people's complex needs and to care for them safely. People were engaged in a variety of activities within the home and in the community and there were usually sufficient numbers of staff to support people to go out most days of the week. This ensured people experienced a good quality of life.

Staff received appropriate training to support people's mental and physical health needs. People received their medicines safely and were supported by a range of external health and social care professionals.

The service's quality monitoring systems enabled the service to maintain high standards of care and to promote continuing service improvements.

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 sufficient numbers of suitably trained staff to keep people safe and meet each person's individual needs.

People were protected from abuse and avoidable harm.

Risks were identified and managed in ways that enabled people to lead fulfilling lives and remain safe.

Good

Is the service effective?
The service was effective.

People received effective care and support from staff trained in providing care for people with complex communication and support needs.

People were supported to live their lives in ways that enabled them to have a good quality of life.

The service acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

Good

Is the service caring?
The service was caring.

People were treated with kindness, dignity and respect.

The staff and management were exceptionally friendly and considerate.

Staff had a very good understanding of each person's communication needs and the ways they expressed their individual preferences.

People and their relatives were supported to maintain strong family relationships.

Good

Is the service responsive?
The service was responsive.

People and their relatives were involved to the extent they were able to participate in the assessment and planning of their care.

People's individual needs and preferences were understood and acted on.

People, relatives and staff were encouraged to express their views and the service responded appropriately to their feedback.

Good

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

The service promoted an open and caring culture centred on people's individual needs.

People were supported by a motivated and caring team of management and staff.

Good

Summary of findings

The provider's quality assurance systems were effective in maintaining and promoting service improvements.	

Newholme

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 28 August 2015 and was unannounced. It was carried out by one inspector. Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other data and enquiries. At the last inspection on 31 October 2013 the service was meeting essential standards of quality and safety and no concerns were identified.

The provider experienced technical difficulties submitting their 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 the improvements they plan to make. Due to formatting issues the electronic version of the PIR was not accessible prior to inspection. We discussed the content of the PIR during the inspection and the provider subsequently submitted a hard copy to us.

We were only able to have limited conversations with two people who lived in the home, the rest of the people were unable to communicate verbally due to their language and learning difficulties. To help us understand people's experiences of the service we observed how people were supported and also had conversations with their relatives and the staff. During the inspection we spoke with the deputy manager and four other members of care staff. We reviewed three care plans and other records relevant to the running of the home. This included staff training records, medication records, complaints and incident files. Following the inspection we telephoned three people's relatives to gain their views on the care and support provided by the service.

Good

Is the service safe?

Our findings

We had limited conversations with two of the people who lived in the home but the majority of people were unable to communicate verbally due to their learning and physical disabilities. We observed care practices and talked with people's relatives and the staff to gain a better understanding of people's experience of the service.

People's relatives told us they did not have any concerns about their relative's safety. One of the relatives said "I would recognise the signs if there was anything wrong. There is a pleasant atmosphere in the home and there are no tensions". All of the people looked happy and no one appeared anxious or displayed signs of distress. Staff told us they had never had any reason to raise concerns about any of their colleagues.

People were protected from the risk of abuse through appropriate policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff said they were confident that if any concerns were raised with management they would be dealt with to make sure people were protected.

The risks of abuse to people were reduced because there were effective recruitment and selection processes for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and references had been obtained.

Care plans contained risk assessments with measures to ensure people received care safely. Risk assessments covered issues such as support for people when they went into the community, participation in leisure activities and use of equipment to reposition people. There were also risk assessments and plans for supporting people when they became anxious or distressed. Staff received training in positive behaviour support to de-escalate situations and keep people and themselves safe.

Staff knew what to do in emergency situations. For example, protocols had been agreed with specialists for responding to people who had epileptic seizures. Staff received training in providing the required medicines and knew when and who to notify if people experienced prolonged seizures. Staff told us if they had significant concerns about a person's health they would call the emergency ambulance service or speak with the person's GP.

Each person had a personal evacuation plan in case they needed to vacate the home in an emergency. The service also had a crisis plan for ensuring people continued to receive care and support if the home had to be vacated for a longer period.

Records showed there had been very few accidents or incidents over the previous 12 months. The deputy manager was covering for the registered manager, who was on leave on the day of the inspection. The deputy manager knew about the various statutory notifications providers were required to submit but said no notifications had been necessary during the last 12 months. There had been a small number of incidents recorded where a person self-harmed when they became agitated or distressed. Effective action had been taken to address the issues which had caused the person to become agitated. All incidents were logged and actions taken to keep people safe and prevent future occurrences were recorded. The provider had access to the service's electronic incident records for monitoring and review purposes.

Regular health and safety checks were carried out to ensure the physical environment in the home was safe. The registered manager carried out a set programme of weekly and monthly health and safety checks. The provider's estates department also carried out periodic health and safety checks, maintenance and repairs. A range of health and safety policies and procedures were in place to keep people and staff safe.

There were sufficient numbers of staff deployed to meet people's complex care needs and to keep them safe. On the day of the inspection there were four care staff on duty. The deputy manager told us this was their minimum safe staffing level. They were already one staff member down on the rostered numbers due to sickness absence and a second member of staff had called in sick that morning. Staff told us it was unusual to have just four staff on the morning shift. Normally five or six staff were on duty. The deputy manager said when they were short staffed they could usually get help from another unit. A new system of 'cluster teams' was being introduced to facilitate cover between units.

Good

Is the service safe?

Despite the short notice absence on the day of inspection, we observed staff were available to support people in a timely manner when they needed assistance or attention. Staff were busy but still maintained a friendly, patient and supportive approach and no one was made to rush. Staff worked well as a team and supported each other to complete the various tasks without neglecting any of the people. One member of staff said "The staffing levels vary with sickness and personal problems. Six staff is ideal but usually there are five in the morning and four in the afternoon and that's fine. Even with four staff we prioritise things to ensure everyone receives the care they need". Another member of staff said "It can be difficult on some shifts but generally it is OK. We cannot always take people out as much as we would like, but we always try to ensure they have a good quality of life".

Staffing difficulties were due to recruitment issues rather than funding. The service rostered in six staff for each morning shift but on a fair number of days only five staff were available. Some days there were only four staff available but this was an infrequent occurrence. The deputy manager said the organisation was making a major effort to improve and streamline recruitment processes.

Systems were in place to ensure people received their medicines safely. Care staff received medicine administration training and had to be assessed as competent before they were allowed to administer people's medicines. People's medicines and their medicine administration records (MAR) were kept in locked medicines cupboards in each person's room. Medicines were always administered by two members of staff, one read out the prescription and dose from the MAR sheet and the other gave the medicine to the person. This double check helped ensure the correct medicines were administered. No medicine errors were recorded in the last 12 months.

Good

Is the service effective?

Our findings

People's relatives told us they felt the service was effective in meeting people's needs. They said the staff had a very good understanding of their relative's needs and preferences. One person's relative said "The staff are excellent and look after [person's name] really well". Another person's relative said "They managed [their relative's] health problems well. They have been very good". We observed people appeared well cared for and they seemed happy with the support they received from staff.

Staff were knowledgeable about each person's individual support needs and provided care and support in line with people's care plans. Staff told us they received training to ensure they knew how to effectively meet people's learning and physical disability needs. This included safeguarding, first aid, infection control, moving and handling, administration of medicines, and physical and non-physical interventions. Advice and training was obtained from external specialists when needed, such as percutaneous endoscopic gastronomy (PEG) feeds. This is where a special tube is used to provide liquidised nutrition and fluids for people who are unable to swallow. Staff told us the provider also supported them with continuing training and development such as vocational qualifications in health and social care and supervisory courses for shift leaders.

One of the people with learning disabilities was also living with dementia. Staff received dementia care training to help support this person. The service had set up a dementia care group and was gathering further information from specialist external sources. We were told they wanted to become a resource for dementia care advice to the provider's other learning disability homes. The need for dementia care was increasing as people with a learning disability were living longer.

A new member of staff told us they attended a week's induction course which covered the basics of the role. They then shadowed an experienced member of staff for two weeks to get to know people's individual support needs and communication methods. Their competency was assessed over a six month probationary period against written standards of performance. New staff were assigned a mentor and received individual supervision sessions on a regular basis.

Staff said everyone worked well together as a very friendly and supportive team which helped to provide effective care. A recently appointed member of staff said "All of the staff get on brilliantly together. The more experienced staff always help me if I have any queries". Care practices were also discussed at one to one staff supervision sessions and at monthly team meetings with the registered manager. Performance and development appraisal meetings took place annually.

Individual communication profiles were available to enable staff to communicate effectively with people. Some people were able to have conversations with staff but had limited understanding due to their learning disability. Most of the people in the home were unable to speak but communicated through facial expressions, body language, physical gestures or by making other vocalisations. We observed people making choices in ways that suited their individual communication methods. For example, some people showed they preferred a particular choice by pointing or alternatively pushing away things they did not want.

Where people were unable to make an informed decision the service followed a best interest decision making process. Staff received training in the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The service followed the MCA code of practice to protect people's human rights. The MCA provides the legal framework to assess people's capacity to make certain decisions at a certain time. We observed an MCA poster in the office with prompts to remind staff about the key requirements of the Act.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The service had submitted DoLS applications for each person living in the home. This was needed because people needed certain restrictions to help keep them safe and people were unable to leave the home without staff support. This showed the service was ready to comply with the DoLS requirements. The deputy manager said they periodically reviewed all restrictive practices with a view to reducing the number and impact of any restrictions on people's freedom and choices.

Good

Is the service effective?

People had sufficient to eat and drink and received a balanced diet. People with special dietary needs were assessed by a dietician and a speech and language therapist. For example, one person who had difficulty swallowing had their own soft diet. Two people who were unable to eat or drink orally received nutrition through a PEG feed tube. People at risk of malnutrition were weighed regularly and the service received regular nutritional advice from the speech and language therapist.

Staff planned meal menus for the week ahead based on people's known preferences and they always included a choice of at least two options. They were happy to change and be flexible to meet people's preferences on the day. We observed staff offering people meal choices during the inspection. Some of the people were able to express their meal preferences verbally but most of the people indicated this by either accepting or refusing the food offered. We were told the service was planning to move to individual menus in the future.

We observed care practices over the lunch time period. People received good portions and appeared to enjoy their meal. Some of the people were able to eat their meals independently whereas others required one to one staff support. Where people required support, staff assisted them to eat their food at an appropriate pace and no one was rushed. We heard staff encouraging people to eat their meals and engaging people in friendly banter throughout the meal time period. They continually checked to see if people were happy and whether they wanted more to eat or drink.

Staff carried out regular health checks to help people maintain good health and identify any changes. The deputy manager said the local GP was "brilliant" and healthcare professionals from the practice were happy to visit whenever requested. Other professionals provided input and advice as needed. This included specialist nurses, speech and language therapists, physiotherapists and occupational therapists. Care plans contained records of hospital and other health care appointments. They included health action plans and hospital passports providing important information to help hospital staff understand people's needs. Some of the people with more complex needs also had an assigned social worker to act as their care manager.

Adaptations were made to the premises to support people's needs. Most of the home's entrances, hallway and corridor were suitable for wheelchair access. However, we observed the door to one of the two kitchen/dining areas was quite narrow and both kitchen/dining areas were in need of refurbishment. A member of staff told us they had requested the refurbishments over a year ago but they were still waiting for the provider to carry out the necessary adaptations.

Two people's bedrooms had en-suite facilities and there were two communal bathrooms with equipment for assisted bathing. Some bedrooms contained light and sound equipment to stimulate people's senses. Other bedrooms were decorated in primary colours as this helped avoid over stimulation of people with autistic spectrum disorders. Rooms also contained ceiling hoists to facilitate repositioning of people with mobility difficulties. The home had two well-furnished TV lounges and good sized outside spaces. People with sufficient mobility were able to access the various parts of the home independently. Others needed staff support due to their disabilities. We observed three people in wheelchairs were sitting in the garden enjoying the fresh air and sunshine when we arrived.

Good

Is the service caring?

Our findings

People had limited verbal communication skills but one person who lived in the home said "I like it here very much". People's relatives told us they were extremely happy with the way staff cared for their relatives. One person's relative said "They are all very pleasant and very caring". Another person's relative said "They are definitely caring. When [person's name] went into hospital staff visited them every day and brought in clean clothes. They were fantastic, even the hospital staff commented on how good they were".

Throughout the day we observed staff caring for people in a very friendly, considerate and patient manner. For example, we observed the deputy manager escorting an older person with a walking frame to walk along the corridor to the lounge area. The deputy manager walked slowly and patiently down the corridor continually reassuring the person and checking they were alright. When they arrived at the lounge area a second member of staff assisted them to very gently lower the person into their favourite arm chair. They then offered the person two daily newspapers which they enjoyed reading. Before leaving the lounge the deputy manager asked the person if they would like the volume on the television turned down while they were reading.

Although most of the people had very limited communication and language skills they appeared to understand when staff spoke with them and often responded with happy facial expressions such as smiles or made other vocalisations such as laughter. People appeared very relaxed and happy with the staff supporting them. A new member of staff told us "At job interviews they are more interested in our personality and our empathy with people rather than in formal qualifications". Throughout the day we observed all of the staff were exceptionally friendly and supportive of people and each other.

During the lunch time meal we observed people received the staff's full attention. Staff attempted to interact positively with people on a continual basis and people also initiated interactions with the staff. For example, we heard one person laughing and joking with a member of staff over lunch. Another person sat at the same table didn't say anything but was smiling and happy listening to the friendly banter. We saw other staff supporting people who were unable to eat their meal without assistance. Staff were extremely kind and patient and continually checked the person was OK and enjoying their meal.

Staff understood people's needs and preferences and engaged with each person in a way that was most appropriate to them. People had limited or no verbal communication skills and lacked understanding due to their learning disability. Most of the people communicated through physical forms of expression or other vocalisations. They had lived in the home for many years and staff had become familiar with their preferences and individual ways of communicating. Nevertheless, members of staff still checked to make sure people were happy with the choices offered to them. For example, we heard one member of staff say to a person "Why don't you try on your glasses, you don't have to wear them but see how you feel".

Care plans contained a section on 'How I can be involved' which detailed the best way to communicate with each person and how to help them make choices. For example, one person who could not speak needed to see an object of reference with an image and simple word prompts. Staff had used photographs and easy to understand phrases to help them to choose a new television for their room.

Staff treated people with compassion, dignity and respect. For example, we overheard one person who had a mishap say to a member of staff "I'm all messy" and then started apologising profusely. The staff member reassured them saying calmly "Don't worry, let's go to the bathroom". Another member of staff said whenever possible they tried to let people have their preferred member of care staff when providing personal care. They said they always knocked on people's doors before entering, closed the door when providing personal care, and put a towel around people when undressing or going to the toilet. They said "We try to treat people in the way we would like to be treated ourselves".

Staff spoke to people in a respectful and caring manner. When staff talked to us they were always very respectful in the way they referred to people. We observed staff responded politely to people's approaches even when they were already busy supporting someone else.

People were supported to maintain ongoing relationships with their families. Relatives were encouraged to visit as often as they wished and told us they were always made to

Good

Is the service caring?

feel very welcome. One relative said “Until recently, I visited every week. Staff always make us a cup of tea and have a little chat with me when I visit”. Another relative said “I normally visit once a month. There are no restrictions I usually just ring to check [relative’s name] is in and then say I’m coming”.

Good

Is the service responsive?

Our findings

People contributed to the assessment and planning of their care to the extent they were able to, but all lacked the mental capacity to make certain decisions. Staff understood people's individual communication needs well, and assisted them to express their needs and preferences in ways they could understand. A relative of a person who could not communicate verbally said "Staff understand [their relative's] facial expressions and can tell if anything is troubling them. They are very good at recognising the signs". Relatives were encouraged to participate in discussions about people's care plans and to express their views. One relative said "They always let me know what is happening and call me if anything is wrong".

Each person had a personalised care plan based on their individual learning and physical disability needs. Care plans included clear guidance for staff on how to support people's individual needs. As well as detailing people's support and communication needs, care plans identified each person's personal likes and dislikes, daily routines and activity preferences. They also included information on how each person made choices and decisions.

The service had introduced the new standard format local authority Support for Living Plan, covering all aspects of a person's support and care needs. This included annual reviews for each person with the involvement of a close relative, or other appropriate representative, to assist with making certain decisions in the person's best interests. At reviews the person's individual support needs, preferences and experiences of the service were taken into account. Key personal outcomes were agreed based on the most important issues for the person concerned. An action plan to implement each of the agreed outcomes was then developed and regularly monitored to check on progress.

Where people or their relatives expressed a preference for support from a particular member of care staff, the service tried to accommodate these preferences. Staff members of the same gender were usually available to assist people with personal care if this was their preference. For example, one female preferred to be supported by female care staff and we saw staff respected this preference. Another person was always shown photographs of two members of staff each morning and then chose which one they wanted to provide support. Another person had a picture of all the staff in their room as they liked to know who was working on each shift.

People had their own individualised bedrooms. Each room was furnished and decorated to the person's individual needs, tastes and preferences. For example, one person's room contained pictures and models of trains and classic cars which reflected the person's hobby. Another person's room was minimalist to help them remain calm and not get over stimulated.

People were supported to spend time in the community and to participate in a range of activities in line with their personal interests. This included visits into the village, local park, shopping trips, lunches, hairdressers, attending day centres and clubs, local church services, day trips to the seaside and other places of interest. Activities available within the home included use of a range of sensory equipment in people's rooms, watching TV and DVDs, reading materials, playing games and socialising with staff. People were supported to access the home's private gardens. We observed three people with mobility problems sitting outside in the sun and enjoying the fresh air. Later when the sun went in staff asked them if they wanted to come back inside.

People's relatives and the staff told us the registered manager operated an open door policy and was always accessible and visible around the home. Relatives were encouraged to feedback any issues or concerns directly to the manager or to any other member of staff. One relative said "If I had any concerns I would go into the office and find out about it. The manager is always happy to talk about things. They are very good". Relatives said the management regularly called them to let them know if there were any issues or updates regarding people's health and well-being.

The provider had an appropriate policy and procedure for managing complaints about the service. This included agreed timescales for responding to people's concerns. We were told no written complaints had been made about the service in the last 12 months. One relative said "I've never had any reason to complain, they are very good". Another relative said "I've only once ever had a concern. This was when a member of staff from another home came to work there. The manager kept a close eye on them and eventually they went".

Good

Is the service well-led?

Our findings

Relatives of people who lived in the home were very complimentary about the service. One relative said "I don't think you can fault it" another relative said "We really appreciate everything they do. We are so pleased [their relative] is there".

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. Staff and people's relatives told us the registered manager encouraged an "open door" culture and was very approachable and supportive. One person's relative said "I can talk to [the manager's name] about anything. She's a lovely person and a fantastic manager. She talks to [their relative] and always listens to what they say". Another person's relative said "I rarely need to see the manager because things are going very smoothly. But they are always happy to talk to me if there are any issues".

Staff said they felt very motivated and they were all dedicated to ensuring people received the best possible care and support. They said the registered manager was passionate about the service and entirely focused on people's needs. They described the registered manager in glowing terms, such as "Brilliant" and "Very supportive and approachable".

The registered manager was on annual leave on the day of the inspection. The deputy manager who was covering said "The service ethos was to provide person centred care and make it each individual's own home. We are looking into every aspect of people's care and how we can improve their quality of life". To ensure staff understood and delivered this philosophy, they received training specific to the learning and physical disability needs of the people living in the home. There was a comprehensive induction programme for new staff and continuing training and development for established staff. The philosophy was further reinforced through monthly staff meetings, daily shift handover meetings and regular one to one staff supervision sessions.

Decisions about people's care and support were made by the appropriate staff at the appropriate level. There was a clear staffing structure in place with clear lines of reporting and accountability. The registered manager and deputy supervised the support team leaders and they supervised the support workers. All of the staff we spoke with said they worked well together as a very friendly and supportive team. One member of staff said "We have a really nice team. We know we can all count on each other". Specialist support and advice was also sought from external health and social care professionals when needed.

The provider had a quality assurance system to ensure they continued to meet people's needs effectively. The registered manager carried out a programme of weekly and monthly audits and safety checks. A monthly service review was carried out by the registered manager's line manager (service manager) to check the home's compliance against the provider's learning disability service requirements. Where action was needed this was noted on a service action plan and progress was checked again at the next service review. People's relatives and other representatives were encouraged to give their views on the service either directly to the management and staff or through regular care plan review meetings.

The registered manager participated in a number of forums for exchanging information and ideas and fostering best practice. They attended internal provider managers meetings, multi-agency meetings, conferences, seminars and accessed a range of online resources and training materials from service related organisations. The provider's policies and procedures were regularly reviewed and up dated to ensure they reflected up to date good practice guidelines and legislation. This helped ensure staff practices were up to date and people were supported and cared for appropriately.

People were supported to be involved in the local community. Staff supported people to go out most days of the week. This ranged from attendance at specialist day centres for people with learning disabilities to a variety of social and leisure activities. For example, one person was prone to becoming distressed or upset. They were being supported by staff to attend various different day provision settings. The aim was to find which setting suited their needs best and enabled them to interact best with other people.