Leonard Cheshire Disability

The Manor - Care Home Physical Disabilities

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?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

The Manor - Care Home Physical Disabilities 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 Manor - Care Home Physical Disabilities is a two storey building with three adjacent bungalows and is registered to accommodate up to 22 people. At the time of this inspection there were 21 people living at the service.

The inspection took place on 5 January 2017 and was unannounced. At our previous inspection on 15 December 2015 the service was rated as 'Good'. At this inspection it remained 'Good'.

A registered manager was 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.

Staff had received training about keeping people safe and they were knowledgeable about describing the signs and symptoms of any potential harm. Staff empowered people to be safe and staff knew the reporting process should this ever be needed if a person was harmed. People were given as much information as they needed about staying safe.

Risk assessments were in place and these were accurate and up-to-date. Where people needed external support, this was sought from for example, a speech and language therapists. This was to help ensure people's care was as safe as it could be.

People's needs were met by staff who were recruited safely, deployed to ensure people's needs were met and trained appropriate to their role.

People were administered their prescribed medicines safely. Staff administered people's medicines who had been trained and deemed competent to do this by the registered manager. Medicines were managed safely in line with current guidance.

Staff were supported in their role and they knew what standard of care was expected. Incidents were used as an opportunity for learning and to help drive improvements.

People were enabled to access healthcare services. People's nutritional needs were met by staff who knew each person's needs well. Staff knew when people needed support and also when to respect people's independence.

The premises and equipment were safely maintained and helped people to improve their independence.

A positive and good working relationship existed between the registered manager, staff and relevant stakeholders. People were supported in partnership with other organisations including the local authority and care commissioners to provide joined up care.

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

People were involved in their care and relatives or friends helped provide information which contributed to people's independent living skills. People were treated equally regardless of their needs. Staff helped people to take part in and enjoy pastimes and social stimulation that were important to them.

People's care plans were as detailed and staff used people's personal life histories to help get to know what was important to each person. Staff understood what mattered to people when providing personal care by involving them and encouraging independence.

People were provided with information and or enabled to access advocacy services when required.

Complaints were investigated in line with the provider's policies and procedures. Support was available if people needed to raise concerns or make a complaint.

Support arrangements and procedures were in place to understand and meet the needs of people requiring end of life care when this was required.

The registered manager motivated the staff team with regular meetings, formal supervision, mentoring and being shadowed by themselves or experienced staff members.

The registered manager understood their responsibilities and worked with people, staff and the provider to improve the quality and safety of care that was provided. Quality assurance procedures, a programme of audits and leadership helped drive improvements in the quality of service that was provided.

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 remains Good.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Outstanding ☆

The service had improved to Outstanding.

People's lives were transformed by staff who had a complete understanding of how to meet each person's needs.

Accessible systems were in place to support people to raise a concern or make a complaint. Responses to complaints were used to drive improvements.

Systems were in place to help ensure, if required, that people would be supported with a pain free death.

Is the service well-led?

Good

The service remains Good.

The Manor - Care Home Physical Disabilities

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 5 January 2017 and was unannounced.

The inspection was undertaken by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of this type of service. Their area of expertise was physical disabilities.

Before the inspection the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least annually. This provides us with information about the service, what the service does well and improvements they plan to make. We used this information to assist us with the planning of this inspection. We also looked at other information we hold about the service. This included information from notifications the provider sent to us. A notification is information about important events which the provider is required to send to us by law such as serious injuries.

Prior to our inspection we contacted organisations to ask them about their views of the service. These were Healthwatch, the local safeguarding authority and commissioners of the service. We also contacted the local authority physical disability partnership (LDP). These organisations' views helped us to plan our inspection.

We spoke with eight people and a visiting relative. We spoke with the registered manager and the deputy manager. We also spoke with two team leaders, one care staff, the chef, the activities coordinator and the administrator.

We observed people's care to help us understand the quality of care that people received. We looked at four people's care plans, staff training and supervision planning records and four people's medicines administration records. We looked at audit and quality assurance and audit records in relation to medicines management, care plans and people's feedback about the service. We also looked at two staff recruitment files, staff training and supervision planning records.

Good

Is the service safe?

Our findings

The service had a zero tolerance of bullying and harassment policy in place for both staff and people. The policy was communicated to all staff and people using the service in a variety of formats. People told or communicated to us they felt safe. One person said, "I am safe here. I do sometimes have to wait a short while but this is usually for people with a more urgent need. [This did not impact on the person's safety] I can and do go out when I want with them [staff]." We saw people being supported by staff with the right skills to go to a cinema and keep people safe such as with transport and moving and handling. Staff had continued their training and remained confident about what keeping people safe meant no matter what people's needs were. Staff had received training about keeping people safe and they were knowledgeable about describing the signs and symptoms of any potential harm. Staff empowered people to be safe and staff knew the reporting process should this ever be needed if a person was harmed.

Where there was a need to share information with a speech and language therapist about risks for people's safe swallowing this had been completed. Risk to people such as those for swallowing, managing people's behaviours which could challenge others and moving and handling had been recorded, assessed and regularly reviewed. We found these to be an accurate reflection of how risks to keep people safe were managed. This included any person who needed to have restrictions in place to keep them safe such as bed rails. Staff had received training on safeguarding people in a way which used positive behavioral support (PBS). PBS is a person-centred approach to people who display or are at risk of displaying behaviours which challenge. Staff used these communication strategies from people and adapted their care accordingly to prevent these situations from occurring.

Records we looked at conformed that checks had been undertaken for subjects such as legionella management. Other checks for fire equipment and medicines' storage temperatures had been completed. Where the need for a competent person to undertake these checks was required this need had been met. For instance, servicing of people's hoisting and lifting equipment.

We found that staff continued to be recruited in a safe way and that each staff member had been provided with the training, experience and knowledge they needed to have the skills for their role. For instance, by having an acceptable Disclosure and Barring Service check for any criminal records which could put people at risk. We observed that people's requests for assistance were responded to within a few minutes. A staff member told us, "We can always get staff cover if there are any absences. We don't need to use agency staff anymore. There is time to chat with people and communicate in other ways." Another staff member said, "I have done fire safety, health and safety and infection prevention and control training." We saw that staff's competence was tested on the subjects they had been trained on. This was to help promote safe systems of work and care practice.

We found that people's medicines continued to be administered and managed safely and that people could be as independent with their medicines as they wished. Only trained staff whose competency was assessed administered medicines. One care staff told us, "I just have one more observation [of their medicines' administration] and I will hopefully be signed off as safe." We saw that protocols were in place for people's

medicines when they were to be given as required. These were administered in line with healthcare professional's guidance. Information was also provided about each person's medicines should they move between services such as into or out of hospital.

Processes were in place to support people in an environment which was clean. Infection prevention measures were in place such as staff training, the use of protective clothing by staff. Where measures were required to segregate areas to provide good standards of hygiene, this was maintained. For instance, areas with food preparation or medicines' storage.

The registered manager and provider took on board any learning following incidents and when things had not always gone as planned and this helped keep people safe. The organisation had taken learning to promote people's safety in an equal way no matter how complex their needs were. For example, with people's safe moving and handling.

Good

Is the service effective?

Our findings

The assessment process to help determine people's needs was comprehensive. This assessment looked at but was not limited to people's physical support needs, emotional support, medicines, independence and nutritional support. As part of people's assessed needs, any necessary equipment and staff with the right skills were put in place. Where required additional training was undertaken to meet each person's needs. One relative told us, "They [staff] know [family member] ever so well. Probably as good as me, if not better." We found that people could be introduced to the service as slowly as they wanted such as day, night, weekend visits and then longer stays to see if the service met their needs.

Staff received training that included refreshers for the subjects they had previously been trained on. One person communicated to us how "good" staff were in meeting their needs. One staff member told us they had undertaken training on safeguarding, equality and diversity, medicines' administration, the MCA (Mental Capacity Act 2005) and the equipment people used such as an electronic wheelchair. Records viewed showed us that further training was planned to give staff additional knowledge. Training was also provided for volunteers who supported people using the service to live a better life.

People were supported to choose, eat and drink sufficient quantities of foods and fluids. Adapted cutlery, plates and drinking vessels were available as required. Staff consulted with people at monthly meetings as well as day-to-day contact on what they would like to eat. Staff ensured this was available to meet any diverse needs. Staff monitored people's daily food and drink intake to ensure they had enough nutrients.

The chef was knowledgeable about each person's nutritional needs. They were able to tell us about people preferences and those that required special diets such as soft or low sugar foods. One person said, "I look forward to Fridays as it is fish and chips day. People who required a special diet such as those who were fed through a tube into their stomach (Percutaneous Endoscopic Gastrostomy) were also supported to maintain adequate nutritional intake.

External healthcare support from a dietician and or speech and language therapist was requested when required to support people with healthy eating and drinking. One person had been identified as having a need for an organic food diet rich in vitamins and minerals and this had been provided in a person centred way. For example, by having this sourced by the person, freshly prepared and served in their room. The person told us, "This food is my medicine."

People continued to be enabled to access healthcare support such as hospital appointments, GP or dental services. Information was provided to people about healthcare that was available in a format that enabled them to make choices. For instance, picture cards, sign language as well as electronic communication devices.

The registered manager told us how, as part of the services improvement, each person had been able to choose colour schemes as well as how their room was decorated. Where electronic wheelchair or passenger lift access was required this had been provided. This was to promote access with wheelchair friendly ramps.

The recent building improvements project to the service had benefitted people significantly. One person communicated to us, "It's so much better now." They told us that this was because, "It's [the building] bigger and has made me much happier." The person then went back to their room chuckling at the happiness the improvements had meant to them.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We found that staff understood the MCA and its code of practice supported people to make informed choices as well as reviewing people's mental capacity. One person told us, "I am always asked what I prefer. It's my choice after all." One staff member said, "If people struggle to make a choice we give them options such as different clothes, meals and pastimes." We saw that where people had been deprived of their liberty that this was lawful and that they had in place someone to represent their views and support the person in all matters relating to the DoLS. We found that restrictions on people's liberty was for the minimum amount of time and in the person's best interests where people's mental capacity was expected to improve and that a system was in place to review this situation. A social worker told us, "From my experience staff have been supporting people to achieve good outcomes that the individual has identified themselves."

Good

Is the service caring?

Our findings

People were well cared for by staff who treated each person equally no matter what their needs were. We found that staff were respectful of people's cultural and spiritual needs and supported people who liked to attend church services. People's care plans included sufficient detail and guidance for staff to provide people's care in an individualised way. For instance, by ensuring that a cotton cloth was placed in a specific way before repositioning the person. One person told us, "Staff treat me really well. They are very good at cheering me up. I need some help with [personal care] and they give me privacy." We observed that staff were compassionate in speaking with people as well as those people who used non-verbal means to communicate. We saw a member of staff checking to make sure people had enough clothing on to keep warm when they went out as well as commenting favourably about the colouring of a picture one person was doing.

Staff described to us the circumstances they needed to be mindful of to protect people's dignity and promote person centred and compassionate care. For instance, by explaining to people what they were going to be doing especially before commencing any personal care. They then sought permission by using various ways to communicate with people. These included sign language, picture cards and objects of reference which people could point to. This helped people could understand as much as possible all aspects of their personal care. One person said, "They [staff] knock, ask if they can come in and if I'm happy for this they can help me." We observed staff being polite and sensitive about each person's needs as well as making sure people's dignity was protected.

We observed that staff were respectful to people's needs and they spoke with them at a level the person preferred such as by sitting with, or near to, them. One person indicated to us that staff were, "very nice". We heard staff asking people if they needed any help to cut up their dinner, if they needed any pain relief as well as being able to have a laugh and some fun.

We found that advocacy including that from people's relatives as well as formal independent mental capacity advocacy was promoted. This helped people to be as involved in and answer questions about their care as much as practicable. The registered manager showed us records which confirmed those people who were using the services of an advocate on a regular basis.

People's care records were up-to-date, were held securely and staff respected people's confidentiality. One staff member said, "We have the time we need to complete training when it is due as well as providing compassionate and respecting people's privacy.

We saw and people told us that relatives or friends could visit whenever they wanted and at a time people preferred. One person told us, "My family came and we had Christmas dinner together." One relative told us, "I call in most days and we [family member] go out for lunch. There are no restrictions. Lunch time is a protected time for people but I can join them if I want."

Outstanding ☆

Is the service responsive?

Our findings

People and those with authority to act on their behalf helped contribute to the planning of their care. This helped people to have the level of independence they preferred. Each person had a care plan that was detailed and tailored to meet their individual needs. If required, greater detail was included in people's care plans. In some cases people, where they were able and had a preference, had written their own care plan in great detail. This helped ensure their care was truly person centred. In addition, each care plan had a detailed account of people's life history which helped staff to provide care that that was based upon people's preferences.

A social worker told us, "They [Registered and deputy, manager] are committed to doing the best they can for the residents and I have noticed this a lot, particularly with my two service users. They go above and beyond to make sure they get the support they need." We saw that this was because people led lives they would not otherwise have been able to without the support and care they had received. Another social worker fed back to us, "For one of my service users in particular he is supported through visits by a member of staff and this is because he has built up a rapport with them and feels more comfortable with them around. They support him to communicate his wishes and feelings to me and are respectful of these at all times."

One person over time and before moving into the service had developed their own sign language. With perseverance over time and information from a family member staff had learned to understand what the person was communicating. As a result of this situation the person's world had been opened up in a way they had not ever previously experienced. For example, they could now ask in their own way for assistance with everyday activities such as personal care. They were now able to engage in the wider community for example by being included in all conversations and not being isolated. This showed us that staff had outstanding skills and an excellent understanding of each person's needs and how they wanted their person centred care to be provided.

Where people had communication which was in a non-verbal form we found that staff used their acquired skills to ensure people's needs were responded to. This was also for any person with a sensory impairment. Our observations showed us that staff then responded to the person's satisfaction by completely understanding exactly what the person was communicating. We saw that staff also used other non-verbal communication skills to excellent effect such as eye contact, facial expressions, gestures and body language to respond promptly to any person's anxieties.

On another occasion a person was making significant progress with a physiotherapy programme and additional exercises which staff could assist them with. This programme had noticeably changed their physical and mental wellbeing. One person communicated to us they were doing "much better" with the physiotherapy facility. This and the preceding evidence meant that no matter how diverse people's needs were staff went the extra mile to meet these. Records confirmed the improvements in people's independent living as well as people being enabled to do things they had not previously been able to.

One person told us that, "[The registered manager] has made a tremendous difference. It [the service] would not be as amazing without them. She has fought so hard for our benefit." We saw that since our previous inspection that various facilities had been added such as more en-suite bathrooms and a purpose designed activities room with a height adjustable sink to allow access for people who used a wheelchair. Other equipment including a fridge, washing machine and cooker which promoted people's independence and to learn independent living skills such as baking. There was also a new physiotherapy and gym room which had, with staff's input, significantly contributed to improving people's health and wellbeing.

For two people who had arrived at the service and were not expected to be able to ever walk again, were now independently mobile with the use of walking aids. This happened in conjunction with external healthcare support and staff's persistence and this had taken several months work to ensure those people achieved their goals.

The provider had taken steps to meet people's cultural needs by ensuring there were staff available to support people to access local amenities that supported people's religious beliefs.

A programme of social stimulation was in place and there was the staff resource to support this. For instance, there were a number of staff who were able to drive the service's mini-bus, which gave people access to visit country parks, music festivals and cinemas. Other activities take place in the service included but were not limited were arts, crafts and board games. One person told us, "I ask for wool for my knitting and they [staff] get it when I need it." We saw that people had painted pictures of their favourite subject and that they had donated some of these to be displayed in the service. People took part in theme days for example, records showed us how people had dressed up in Halloween costumes including spiders and skeletons and matching painted faces.

A sample of other activities, pastimes and interests included people placing the wreath that they had made at a Remembrance Day parade, playing a game of curling in the lounge. People were supported by staff to play board games. Although this could take time staff showed patience in the way they communicated with people how to play and hold general conversations. 55 volunteers from a well-known bank had helped paint the service in a way people had chosen. They had also assisted people to attend archery and other sports at a local country park. Pictures of the many social occasions we viewed showed us the difference this had meant to people by the smiles on their faces and the positives changes this had made to their lives. Arrangements for social activities and stimulation were innovative.

The activities co-ordinator told us, and records we viewed showed, how "people had filmed what they had done at the service and they were able to watch this on the big screen during a visit to Twickenham as well as thoroughly enjoying the rugby." One person communicated to us that it was "amazing". This showed us that the service played a key role in the local and wider community and was actively involved in building further links.

A group of people had attended a local Royal Air Force (RAF) station for Christmas lunch which included singing with a local school choir. Staff identified that one person had established some communication with the armed forces personnel. It became know that this person used to have a career in the RAF which was previously unknown. This broadened the choice of activities the person may like to take part in. Staff thought that an event similar to the Edinburgh military Tattoo would be a good starting point. They found a similar event that was being held in Birmingham. Staff had worked with the event organisers to ensure the service's vehicle was able to park near the event. This activity was thoroughly enjoyed by all who attended.

Staff made a special effort to address people's needs. People had taken part in planting some vegetables in

the garden. The activities staff member told us, "People who would not normally eat vegetables could not wait to eat what they had planted. We dug them up at 11am and served on people's plates at 12.30pm the same day." The activities staff also told us about, and we saw, a volunteer worker who they had found was able to play chess with a person who had a real passion for this board game. The person at times also played against a computer when the volunteer was not available. The person told us, "I can beat them [volunteer] but not the computer."

We saw that complaints had been used to drive change and improvements. We found that the provider's complaints process had been adhered to and used to the benefit of those people who had raised concerns. Where people had raised concerns about the meal options changes had been introduced to people's nutrition which a person had personally sourced and staff had obtained these for them. The registered manager told us that as a result of some concerns, "[Name] is a success story. We have literally bent over backwards to satisfy their concerns and we have had to be innovative using new approaches." An example the registered manager gave us of these approaches including the person writing their own care plan which the person wanted to be in significant detail. People could communicate their concerns by e-mail if this was their preference. People were involved in how their complaints were managed such as pictorial explanations of the procedure.

People were supported to make important decisions about their end of life care needs People could also choose not to make these decisions until they felt ready to do so. Where people had made advanced directives for their resuscitation then these were up-to-date and had involved the person, their relatives or advocacy. We saw that the registered manager had processes in place which followed national resuscitation guidance for where people were unable to express their choice. This process where required had created personalised recommendations for people's clinical care in a future emergency. People's end of life care wishes provided health and care professionals responding to emergencies with any recommendations to help them to make immediate decisions about that person's care and treatment.

Good

Is the service well-led?

Our findings

The registered manager continued to have systems in place to monitor and review the day-to-day culture within the service. We observed that staff worked well together and that they had the support they needed for their role. One staff member told us, "We have regular supervision, staff meetings, and spot checks by the [registered] manager as well as feedback on what we do well and also if anything needs further attention." Another staff member said, "When I started I had a lengthy induction to introduce me to people and to learn their individual needs. I also had on-going support coaching and working with experienced staff until I was confident." Staff adhered to the provider's values in supporting people to live fulfilling lives and to promote their independence. This had helped instigate a culture which empowered people to achieve the best outcome possible.

Areas of improvement included no longer using agency care staff and having on call staff who knew people well. This was due to an improvement in the terms of staff's employment and a successful recruitment drive. One person told us, "They [staff] are all good to me. [Registered manager] is always asking us if we need anything and checking on those people who can't speak." A social worker told us that the registered manager led their team well and they worked well together and that "they openly discuss concerns that have been raised about the care and felt confident they would deal with it professionally and efficiently. [They are] always very honest about the strengths of the Manor and also areas they can develop." The deputy manager said, "We [the registered manager] work together and we sing off the same hymn sheet as well as being open to each other's challenges." Another staff member said, "No matter how busy [registered manager] is, she always finds time to listen."

The registered manager had been in post since 12 June 2015. This helped provide a consistent approach to the quality of people's care. 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. We found that the registered manager was aware of their responsibilities. The registered manager told us that they had as much support as they needed and said, "I have a bi-monthly meeting with my area manager as well as regular telephone conversations. I have had the support I needed for [complex situations]." The registered manager kept up-to-date with care practices by attendance at the local registered managers' forum.

One staff member told us that they were held accountable for their decisions by saying, "We are empowered to support people. We have rules and guidance to follow but we can use our initiative." On the day of our inspection we saw how in the event of an emergency that staff responded straight away and in a collaborative way.

People, their relatives or representative, the management team and staff played a key role in developing the service to be the best it could possibly be. All these individuals had supported the registered manager in their successful bid to modernise and improve the building infrastructure. One person communicated to us that they "wished it could have been like this four years ago". The registered manager told us, "It has been

hard work to get where we are but it is so nice to have such wonderful facilities which we are already seeing huge improvements in what people can do which they could not have done here before." This was confirmed by people, relatives and social workers we spoke with.

Strong links were identified and made with the local community such as country park visits, shopping, going to church as well as attendance at music festivals, local military bases and sporting events. One person told us, "We ask to go somewhere or do something and generally this happens. It's great to meet people and do everyday things."

Systems were in place for staff to report any potential standards of care which did not live up to the provider's expectations. One staff member said, "If I blew the whistle on any staff member I am confident that [registered manager] would do the right thing, support me but most importantly make sure the person was safe and well cared for."

The quality assurance, information technology, audit and governance arrangements remained effective in identifying enhancements and the subsequent implementation of actions to drive sustained improvement. For example, care plans, the environment, accessing up-to-date details about people's health conditions and care, training and observations of care staff practices. We found that as a result of monitoring by the registered manager and feedback from a staff survey the structure of the staff team had been changed to better meet people's needs. Where incidents had occurred the provider had taken learning from this and put measures in place to help prevent any potential reoccurrence.

The registered manager and staff team worked well with other external agencies such as people's social workers, the local safeguarding authority and healthcare professionals. One social worker told us, "[The registered manager] is incredibly approachable, she replies to emails promptly and is always available to talk if needed." We found that this had benefitted people with new and different strategies to help deliver good quality care as far as practicable.