

J.A.N. Limited

# Inglenook House

## Inspection report

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## Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

# Summary of findings

## Overall summary

We carried out an unannounced comprehensive inspection on 25 March 2018.

Inglenook House provides care and accommodation for up to ten people with learning disabilities. On the days of our inspection there were seven people living at the care home. In relation to Registering the Right Support we found this service was doing all the right things, ensuring choice and maximum control. Registering the Right Support (RRS) sets out CQC's policy registration, variations to registration and inspecting services supporting people with a learning disability and/or autism.

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 did not have a registered manager; however the recently appointed manager was in the process of submitting their application to the Commission. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At the last inspection on the 19 December 2015, the service was rated Good. At this inspection we found the service remained Good.

Why the service is rated good:

People were not able to verbalise their views and staff used other methods of communication, for example pictures or sign language. We met and spoke with all the people during our visit and observed the interaction between them and the staff.

The Provider Information Return (PIR) states; "Our Director has owned the business for 30 years and has always promoted a positive culture that is open and person centred."

People remained safe at the service. People were protected from abuse because staff knew what action to take if they suspected someone was being abused, mistreated or neglected. Staff, were recruited safely, and checks carried out with the disclosure and barring service (DBS) ensured they were suitable to work with vulnerable adults. People had their needs met by suitable numbers of staff.

The Provider Information Record (PIR) states; "We hold monthly service user forums where we discuss abuse and bullying ensuring our service users know what the term "abuse" or "bullying" means and if they felt comfortable telling us if they felt they were being bullied."

People's risks were assessed, monitored and managed by staff to help ensure they remained safe. Risk assessments were in place to help support risk taking, and help reduce risks from occurring. People who had behaviour that may challenge staff or others had risk assessments in place which gave good guidance and direction to staff about how to support the person, whilst taking account of everyone's safety. People received their medicines safely by suitably trained staff.

People were supported by staff who had received training to meet their needs effectively. Staff meetings, one to one supervision of staffs practice and appraisals of performance were undertaken. Staff completed the Care Certificate (a nationally recognised training course for staff new to care). Staff confirmed the Care Certificate training included a section on the Equality and Diversity needs of people.

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's health was monitored by the staff and they had access to a variety of healthcare professionals. The provider worked closely with external health and social care professionals, to help ensure a coordinate approach to people's care.

People's end of life wishes were not currently documented, however the manager had plans to discuss this issue with relatives, advocates and involve people as much as possible.

People's care and support was based on legislation and best practice guidelines; helping to ensure the best outcomes for people. People's legal rights were upheld and consent to care was sought as much as possible. Care records were person centred and held full details on how people liked their needs to be met; taking into account people's preferences and wishes. Overall, people's individual equality and diversity preferences were known and respected. Information recorded included people's previous medical and social history and people's cultural, religious and spiritual needs.

People were treated with kindness and compassion by the staff who valued them. The staff, some who had worked for the company for a number of years, had built strong relationships with people who lived there. Staff respected people's privacy. People, or their representatives, were involved in decisions about the care and support people received.

The service remained responsive to people's individual needs and provided personalised care and support. People's communication needs were known by staff. Staff had received training in how to support people with different communication needs. The provider had taken account of the Accessible Information Standard (AIS). The AIS is a requirement to help ensure people with a disability or sensory loss are given information they can understand, and the communication support they need.

People were able to make choices about their day to day lives. The provider had a complaints policy in place and the manager said any complaints received would be fully investigated and responded to in line with the company's policy. Staff knew people well and used this to gauge how people were feeling. The policy was not provided in an accessible format for people. However, the provider and staff demonstrated they would always act on changes in people's presentation.

The service continued to be well led. People lived in a service where the provider's values and vision were embedded into the service, staff and culture. Staff told us the provider, who had been overseeing the service in the absence of a registered manager, was very approachable and made themselves available. The provider had monitoring systems which enabled them to identify good practices and areas of improvement.

People lived in a service which had been designed and adapted to meet their needs. The service was monitored by the provider to help ensure its ongoing quality and safety. The provider's governance framework, helped monitor the management and leadership of the service, as well as the ongoing quality and safety of the care people were receiving.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

This service remains good.

Good ●

### Is the service effective?

This service remains good.

Good ●

### Is the service caring?

This service remains good.

Good ●

### Is the service responsive?

This service remains good.

Good ●

### Is the service well-led?

This service remains good.

Good ●

# Inglenook House

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection was undertaken by one inspector on 24 March 2018 and was unannounced.

Prior to the inspection we looked at other information we held about the service such as notifications and previous reports. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. At our last inspection of the service in December 2015 we did not identify any concerns with the care provided to people.

During this inspection we met and spent time with all seven people who lived at the service. Most of the people living at the service had complex needs which meant they were unable to communicate and tell us about their experience of being supported by the staff team. Therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living in the service. We looked around the premises and spoke to the manager and three members of staff. Following our inspection we contacted two relatives of people who used the service, to obtain their feedback.

We looked at records relating to the individual's care and the running of the home. These included four care and support plans and records relating to medication administration. We also looked at how the provider ensured the quality monitoring of the service. This included feedback, audits and maintenance records.

# Is the service safe?

## Our findings

The service continued to provide safe care. People who lived in Inglenook were not able to express themselves verbally. However, we observed people appeared to be happy, relaxed and comfortable with the staff that were supporting them. Staff all agreed that people were safe. One relative said; "Yes they are safe living there."

People were protected from abuse because staff knew what action to take if they suspected someone was being abused, mistreated or neglected. Staff were confident the manager would take action, but also knew where to access the contact details for the local authority safeguarding team should they have to make an alert in the manager's absence.

People did not face discrimination or harassment. People's individual equality and diversity was respected because staff had completed training and put their learning into practice. Staff completing the Care Certificate (a nationally recognised qualification for staff new to care) covered equality and diversity and human rights training as part of this ongoing training.

People had their needs met by suitable numbers of staff to support them based on the activity they were undertaking. Throughout the inspection we saw staff supporting people, meet their needs and spend time socialising with them. Staff were recruited safely and checks carried out with the disclosure and barring service (DBS) ensured they were suitable to work with vulnerable adults.

People had the risks associated with their care assessed, monitored and managed by staff to ensure their safety. Risk assessments had been completed to ensure people were able to receive care and support with minimum risk to themselves and others. There were clear guidelines in place for staff to help manage these risks. People had risk assessments in place regarding their behaviour, which could be seen as challenging for others or the staff.

People's accidents and incidents were recorded and referrals were made to the local learning disability team for additional advice and support if required.

People received their medicines safely from staff who had completed training. Systems were in place to audit medicines practices and records were kept to show when medicines had been administered. People prescribed medicines to be taken when required (PRN), such as paracetamol had records in place to provide information to guide staff in their administration; such as what the medicines were for, symptoms to look for, alternative initial actions to try, the gap needed between doses or the maximum dose.

People lived in an environment which the provider had assessed to ensure it was safe and secure. The fire system was checked with weekly fire tests carried out. People had individual personal emergency evacuation procedures in place (PEEPs). People were protected from the spread of infections. Staff understood what action to take in order to minimise the risk of cross infection, such as the use of gloves and aprons and good hand hygiene to protect people.

The provider worked hard to learn from mistakes and ensure people were safe. The manager and provider had an ethos of honesty and transparency. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

## Is the service effective?

### Our findings

The service continued to provide people with effective care and support. Staff were competent in their roles and had a very good knowledge of the individuals they supported which meant they could effectively meet their needs.

People were supported by staff who had received training to meet their needs effectively. The manager had ensured staff undertook training the provider had deemed as 'mandatory'. This included moving and handling, epilepsy and fire safety. Staff completed an induction which also introduced them to the provider's ethos, policies and procedures. Staff were supported and received regular supervision and team meetings were held. This kept them up to date with current good practice models and guidance for caring for people with a learning disability.

People's care file held communication guidelines. Each documented how people were able to communicate and how staff could effectively support individuals. People had a "Hospital Passport" in place which would be taken to hospital in an emergency and provided details on how each person communicated. Staff demonstrated they knew how people communicated and encouraged choice whenever possible in their everyday lives. Pictorial images were displayed on the activities board to help ensure it was in a suitable format for everyone. This demonstrated the provider had taken account of the Accessible Information Standard (AIS). The AIS is a requirement to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

People were supported to eat a nutritious diet and were encouraged to drink enough to keep them hydrated. People identified at risk of choking due to consistency of food had been referred to appropriate health care professionals. For example, speech and language therapists. The advice was clearly recorded and staff supported people with suitable food choices.

People were encouraged to remain healthy, for example activities were undertaken, and included supporting people going for walks to support them to remain healthy. People's health was monitored to help ensure they were seen by appropriate healthcare professionals so their ongoing health and wellbeing was assured. People's care records detailed that a variety of external healthcare professionals were involved in their care.

Staff had completed training about the Mental Capacity Act 2005 (MCA) and knew how to support people who lacked the capacity to make decisions for themselves. Staff encouraged and supported people to make day to day decisions. Where decisions had been made in a person's best interests these were fully recorded in care plans. Records showed independent advocates and healthcare professionals had also been involved in making decisions. This showed the provider was following the legislation to make sure people's legal rights were protected.

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 MCA. The

procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had a policy and procedure to support people in this area. The provider had liaised with appropriate professionals and made applications for people who required this level of support to keep them safe.

People were not always able to give their verbal consent to care. However staff were heard to verbally ask people for their consent prior to supporting them, for example before assisting them with their care tasks. Staff waited until people had responded using body language, for example, either by smiling or going with the staff member to their rooms.

People lived in a service which had been designed and adapted to meet their needs. Specialist equipment including chair lifts meant people could access upstairs more easily.

## Is the service caring?

### Our findings

The staff continued to provide a caring service. People appeared relaxed and comfortable with the staff working with them. There was a busy, but happy atmosphere in the service. Many people had lived at the service for a number of years and had built strong relationships with the staff who worked with them. Relatives agreed the care provided was "very good."

People were supported by staff who were both kind and caring and we observed staff treated people with patience and kindness. We heard and saw plenty of laughter and smiles. Staff were attentive to people's needs and understood when people needed reassurance, praise or guidance.

People were given emotional support when distressed. For example, the staff offered reassurance to a distressed person, by giving them a cup of tea and by having a chat. The person responded well to staff intervention.

People had decisions about their care made with the involvement of their relatives or representatives. People's needs were reviewed regularly and staff who knew people well attended these reviews. People had access to independent advocacy services, and were supported to access these when required. This helped ensure the views and needs of the person concerned were documented and taken into account when care was planned.

Staff knew people well and understood people's verbal or nonverbal communication. Staff were able to explain each person's communication needs. For example, by the expressions they made to communicate if they were happy or sad or the words they used to describe particular items. Staff clearly understood people's nonverbal communication such as how they currently had concerns over one person's wellbeing by the "Pained look in their eyes". This person had been referred to the GP. Staff knew that other people made facial expressions and certain noises indicating they may be upset.

People's independence was respected. For example, staff encouraged people to participate in household tasks if they were able to. Staff did not rush people and support was given at the person's own pace. Staff were seen to be patient and gave people time while supporting their independence. Staff understood people's individual needs and how to meet those needs. They knew about people's lifestyle choices and how to help promote their independence.

People's privacy and dignity was promoted. Staff knocked on people's doors prior to entering their rooms. Staff used their knowledge of equality, diversity and human rights to help support people with their privacy and dignity in a person centred way. People were not discriminated against in respect of their sexuality. People's care plans were descriptive on people's needs and followed by the staff.

The values of the organisation ensured the staff team demonstrated genuine care and affection for people. This was evidenced through our conversations with the staff team. People, where possible, received their care from the same group of staff. This consistency helped meet people's behavioural needs and gave staff a

better understanding of people's communication needs. It supported relationships to be developed with people so they felt they mattered.

## Is the service responsive?

### Our findings

The service continued to be responsive.

People's care records were person-centred and held detailed information on how people wanted their needs to be met. They took account of their wishes and preferences, their social and medical history, as well as any cultural, religious and spiritual needs. Staff monitored and responded to any changes in people's needs. For example, they had contacted the learning disability team for advice and support over one person's recent change in their behaviour. Staff told us how they encouraged people to make choices. Staff said some people were shown visual items to help make choices.

People's individual care records were personalised to each person and held information to assist staff to provide care and support along with information on people's likes and dislikes. In addition to full care plans there was a one page profile which included easy access information on people's communication and behavioural needs. This meant new staff had the information on how to respond to people as they wanted and knew what was important to people. Staff had good knowledge of people they cared for and were able to tell us how they responded to people and supported them in different situations.

People received individualised one to one personalised care. People's communication needs were effectively assessed and met by staff. Staff told us how they adapted their approach to help ensure people received this individualised support. For example, picture or visual choices to assist people choose.

A complaints procedure was available; however people currently living in the service would not fully understand the procedure. The manager and provider understood the actions they would need to take to resolve any issues raised. They explained they would act in an open and transparent manner, apologise and use the complaint as an opportunity to learn. Staff told us that due to people's nonverbal communication they knew people well, worked closely with them and monitored any changes in behaviour. They would then act to try and find out what was wrong and address this. The manager told us, they would take action to review the policy to ensure it was in line with the Accessible Information Standard (AIS). The AIS is a requirement to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People had advocates appointed to ensure people who were unable to effectively communicate, had their voices heard.

People's end of life wishes were not currently documented, however the manager had plans to discuss this issue with relatives, advocates and involve people as much as possible. Staff confirmed they had not needed to support people with end of life care. Staff were aware of issues relating to loss and bereavement and the manager had completed the local hospice end of life care programme with another staff member due to complete this training.

The PIR records; "During our service users' forums we have begun to introduce the ideas about end of life, some service users have understood and are able to participate and for others it is going to take longer to introduce."

People took part in a wide range of social activities. People's family and friends were encouraged to visit and Skype (an online communication tool) was available if needed. Staff recognised the importance of people's relationships with their family/friends and promoted and supported these contacts when appropriate.

## Is the service well-led?

### Our findings

The service remains well-led. Staff spoke very highly of the provider. One staff member said; "They will always muck in to help" and "Always available over the phone and will help us out as they did when we had a lot of sickness recently."

The service did not have a registered manager; however the recently appointed manager was in the process of submitting their application to the Commission. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 lived in a service whereby the provider's caring values were embedded into the leadership, culture and staff practice.

The PIR records; "We aim to provide a responsive service by the way of ensuring that each person receives a person centred approach and a personalised care package." These values were clearly embedded into the culture and practice within the service and incorporated into staff training and staff received a copy of the core values of the service. As a consequence of this, people received a service that was safe, effective, caring responsive and well-led.

The provider was respected by the staff team. Staff told us they were approachable and always available to offer support and guidance. They had been working in the service regularly in the absence of a registered manager and were now supporting the recently appointed manager. The provider was open, transparent and person-centred. The provider was committed to the company and the service they ran, the staff but most of all the people. The manager told us how recruiting the correct staff was an essential part of maintaining the culture of the service. People also benefited from a provider and manager who kept their practice up to date with regular training. They worked with external agencies in an open and transparent way fostering and developing positive relationships.

Staff were motivated and hardworking. They shared the philosophy of the management team. Shift handovers, supervision, appraisals and meetings were seen as an opportunity to look at current practice.

Staff spoke of and we observed, the fondness they felt for the people they cared for and stated they were happy working for the company but mostly with the people they supported. The management monitored the culture, quality and safety of the service by meeting with people and staff to make sure they were happy.

People lived in a service which was continuously and positively adapting to changes in practice and legislation. For example, the recently appointed manager was aware of, and had started to implement the Care Quality Commission's (CQC's) changes to the Key Lines of Enquiry (KLOEs), and was looking at how the Accessible Information Standard would benefit the service and the people who lived in it. This was to ensure the service fully meet people's information and communication needs, in line with the Health and Social

Care Act 2014.

The provider's governance framework, helped monitored the ongoing quality and safety of the care people were receiving and the service overall. For example, systems and process were in place to check accidents and incidents, environmental, care planning and nutrition audits. These helped to promptly highlight when improvements were required. Action was then taken to continuously drive improvement.

The provider worked hard to learn from mistakes and ensure people were safe. The manager and provider had an ethos of honesty and transparency. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.