United Response

United Response - 14 Lingwell Approach

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

This was an unannounced inspection carried out on 25 February 2016.

We last inspected 14, Lingwell Approach in November 2013. At that inspection we found the service was meeting all the legal requirements in force at the time.

14, Lingwell Approach provides accommodation and personal care for up to four people who have learning disabilities and physical disabilities. Nursing care is not provided.

A registered manager was in place. 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.'

Due to their health conditions and complex needs people were not able to share their views about the service they received. People appeared content and relaxed.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Staff had received training and had a good understanding of the Mental Capacity Act 2005 and Best Interest Decision Making, when people were unable to make decisions themselves. There were other opportunities for staff to receive training to meet people's care needs. Staff received supervision and appraisal.

People received their medicines in a safe and timely way. People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed.

Staff knew the people they were supporting well and there were enough staff on duty to provide individual care to people. Care was provided with patience and kindness and people's privacy and dignity were respected. Care plans were in place detailing how people wished to be supported and people were involved in making decisions about their care.

People's nutritional needs were met and they received a choice of food. People were supported to be part of the local community. They were supported to maintain some control in their lives and they were encouraged to be involved in every day decision making.

Staff said the registered manager and management team were supportive and approachable. Communication was effective, ensuring people, their relatives and other relevant agencies were kept up to

date about any changes in people's care and support needs and the running of the service. There were effective systems to assess and monitor the quality of the service that people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being at all times. Regular checks were carried out to ensure the building was safe and fit for purpose. Appropriate checks were carried out before staff began work with people.

Staffing levels were sufficient to meet people's needs safely and flexibly. People received their medicines in a safe and timely way.

People were protected from abuse and avoidable harm as staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs.

Is the service caring?

Good

The service was caring.

Relatives said the staff team were caring and patient as they provided care and support.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

Staff spent time interacting with people and they were all were encouraged and supported to be involved in daily decision making.

There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

Is the service responsive?

Good

The service was responsive.

People received support in the way they wanted and needed because staff had detailed guidance about how to deliver their care.

People were provided with a range of opportunities to access the local community.

A copy of the complaints procedure was available for people.

Is the service well-led?

Good

The service was well-led.

A management team was in place who promoted the rights of people to live a fulfilled life within the community.

An ethos of individual care and involvement was encouraged amongst staff with people who used the service.

The registered manager monitored the quality of the service provided and introduced improvements to ensure that people received safe care that met their needs.

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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 was 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.

Before the inspection we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care. We spoke with the local safeguarding teams. We also contacted health and social care professionals who worked with the service. We received no information of concern from these agencies.

This inspection took place on 25 February 2016 and was unannounced. The inspection was carried out by an adult social care inspector.

Due to their health conditions and complex needs people were unable to share their views about the service they received.

During the inspection we spoke with the registered manager, the area manager and two support workers. After the inspection we telephoned one relative to obtain their views of the care provided. We observed care and support in communal areas and looked in the kitchen and peoples' bedrooms. We reviewed a range of records about people's care and how the service was managed. We looked at care plans for three people, the recruitment, training and induction records for four staff, two peoples' medicines records, staffing rosters, staff meeting minutes, maintenance contracts and the quality assurance audits that the registered

manager completed.

Good

Is the service safe?

Our findings

Due to people's complex communication needs they were not able to communicate verbally with us. People appeared calm and relaxed as they were supported by staff. A relative commented, "I think (Name) is safe, the staff know them well."

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were able to describe various types of abuse. They could tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. Records showed and staff confirmed they had completed safeguarding adults training. Staff members' comments included, "I'd complete a safeguarding alert form for the local authority," and, "I'd report any concerns to the registered manager, or person in charge." Staff told us they currently had no concerns and would have no problem raising concerns if they had any in the future. They told us safeguarding was discussed regularly at their supervision sessions in order to emphasise its importance and keep it fresh in their mind. No safeguarding incidents had needed to be raised since the last inspection.

We checked the management of medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration. Medicines were appropriately secured in a locked cabinet in a locked room. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. We were advised the community pharmacist had informed staff at a recent medicine audit that a drug that had been previously classified as a controlled drug did not need to be stored as a controlled drug due to the small dosage that was prescribed. We advised the registered manager to follow the guidance in their medicine's policy and continue to store and treat the drug as a controlled medicine in order to provide an accurate account of its administration and to ensure there was no potential for misuse. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and they were sufficiently skilled to help people safely with their medicines.

Medicines were given as prescribed. We observed a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. We had concerns as we observed one person had their medicine administered on top of a spoonful of their food, as they were assisted to eat their lunch. This was rather than the medicine being administered on its own. We were told this was because of a person's swallowing difficulties. A record was not in place that showed the decision making process as the person lacked mental capacity to be involved in their own decision making. There was a letter available from the General Practitioner but it did not show who had been involved in the decision making and why the medicine needed to be administered this way. We regarded the method of placing a tablet in food should be treated the same way as the administration of covert medicine (covert medicine refers to medicine which is

hidden in food or drink). The 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people. NICE guidelines state, "A best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests."

A member of staff told us that staff had received training with regard to administering a specialist medicine for severe seizures in order to provide the necessary care to a person in an emergency situation until the required medical assistance arrived at the service. They also told us there had been no need to administer the medicine this way as yet.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for epilepsy, moving and assisting and distressed behaviour. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

Staff were aware of the reporting process for any accidents or incidents that occurred. These were reported directly to the registered manager. We were told all incidents were audited and action was taken by the registered manager as required to help protect people. The registered manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to distressed behaviour a person would be referred to the psychologist and behavioural team when a certain amount of incidents had occurred and a meeting would be held.

There were sufficient numbers of staff available to keep people safe. We were told staffing levels were determined by the number of people using the service and their needs. At the time of inspection there were three people using the service as one person was away staying at their parent's home. We were told and staffing rosters confirmed there were usually three members of staff during the day to support the four people who lived at the service and two staff members were on duty overnight. On the day of inspection there were two staff members on duty as a person was at home. These numbers did not include the registered manager.

Staff had been recruited correctly as the necessary checks to ensure people's safety had been carried out before people began work in the service. We saw relevant references had been obtained before staff were employed. A result from the Disclosure and Barring Service (DBS), which checks if people have any criminal convictions, had also been obtained before they were offered their job. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

The registered provider had arrangements in place for the on-going maintenance of the building. Routine safety checks and repairs were carried out by the handyman such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. We also saw records to show that equipment used at the service was regularly checked and serviced, for example, the specialist bath and moving and assisting

equipment.

We recommended the registered manager considered the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

Good

Is the service effective?

Our findings

Staff were positive about the opportunities for training to understand people's care and support needs. Staff comments included, "We do face to face and e-learning training where we complete booklets," "I have National Vocational Qualifications (NVQ) (now known as the diploma in health and social care) and, "Training is brilliant."

We spoke with members of staff who were able to describe their role and responsibilities clearly. Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. Staff members comments included, "I had an induction when I started." The provider's information return, (PIR) stated, "Staff have a full four week shadowing as part of their induction before they work on their own with a person."

The staff training records and staff training matrix showed staff were kept up-to-date with safe working practices. The registered manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as, Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS), equality and diversity, distressed behaviour, epilepsy, autism awareness, postural management, dementia and Percutaneous Endoscopic Gastrostomy (PEG) training. PEG is a tube which is placed directly into the stomach and by which people receive nutrition, fluids and medicines.

The registered manager and staff told us and staff training records showed staff had received PEG feed training from professional nurses from the PEG feed provider and they had been signed off as being clinically competent to administer the feed. However, we had concerns as we were told future arrangements were for a senior staff member, who was not a nurse but who had received more intensive training, to cascade the training in the future to staff at the home. We informed the registered manager arrangements should remain in place to ensure staff continued to receive the training from qualified nursing staff who could sign to confirm that staff were clinically competent to administer the person's food and medicines to ensure it continued to be dealt with safely and effectively. The registered manager contacted the nursing staff with the manufacturer of the PEG equipment to ensure this was addressed.

Staff told us and their training files showed they received regular supervision from the registered manager or senior support staff to discuss their work performance and training needs. One person said, "I have supervision every two months." Staff told us they were well supported to carry out their caring role. They said they had regular supervision to discuss the running of the service and their training needs. They said they could also approach the registered manager at any time to discuss any issues. They also said they received an annual appraisal to review their work performance.

Staff told us communication was effective. Staff members' comments included, "Communication is very good," "We all work well together." We were told a handover session took place to discuss people's needs

when staff changed duty, at the beginning and end of each shift. A formal verbal exchange of information took place about all people to ensure staff were aware of the current state of health and well-being of each person. Staff told us the diary and communication book also provided them with information.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). 14,Lingwell Approach records showed one person was legally authorised and three applications were waiting for assessment by the local authority.

Records showed assessments had been carried out, where necessary of people's capacity to make particular decisions. Records contained information about the best interest decision making process, as required by the Mental Capacity Act. Best interest decision making is required to ensure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. Information was available to show if people had capacity to make decisions and to document people's level of comprehension. For example, records stated, "I have very limited understanding of any verbal communication and can show an understanding of basic, simple words such as my name or an object I know well," "I have a Deprivation of Liberty in place and it is believed I cannot understand and retain information long enough to make a substantial decision about my life," and, "The best time to ask me to make a decision is when I'm calm and settled and when I'm not tired, approach me after I have been to an activity as I'm not distracted and waiting to go out."

We found that systems were in place to ensure people had food and drink to meet their nutritional needs. People identified as being at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Staff completed daily 'food and fluid' balance charts for some people. Risk assessments were in place to identify if the individual was at risk when they were eating or had specialist dietary requirements. Care plans for people's nutrition were in place and they provided guidance about how staff were to support the person. For example, one person's care plan stated, "I can hold my cup with hand over hand support, staff to help me tip my cup," another person's care plan stated, "Staff must give me full support with all my food and drinks," and, "Be very patient with me and allow me time to swallow my food before you offer me any more." Care plans for people's nutrition contained information where there was a need for a modified diet where required. We observed the specialist equipment obtained by the speech and language therapist. A 'saddle seat' was used to assist a person to be well-supported posturally at the table and so increase their nutritional intake.

Records showed the health needs of people were well recorded. Information was available in their records to show the contact details of any other professionals who may also have been involved in their care. Care records showed that people had access to a General Practitioner (GP), dietician, speech and language therapist, district nurse, physiotherapist and other health professionals. The relevant people were involved to provide specialist support and guidance to help ensure the care and treatment needs of people were met. . For example, speech and language therapist and dietician. One person's care plan stated, "….. dietician input when required and occupational therapist and speech and language therapists for advice." A health care professional we contacted before the inspection commented, "Staff have followed advice given and contacted our team at appropriate times for people's needs."

Good

Is the service caring?

Our findings

Relatives were complimentary about the care and support provided at the service. Their comments included, "The staff are very caring, I can't fault them," and, "The care is excellent." A professional commented, "I have always found the staff to be caring and person-centred."

During the inspection there was a relaxed and pleasant atmosphere in the service. Staff interacted well with people. Staff were warm, kind, caring and respectful with people and people appeared comfortable with them. Staff were patient in their interactions and took time to observe people's non-verbal communication. Staff asked people's permission before carrying out any tasks and explained what they were doing as they supported them. This guidance was also available in people's support plans which documented how people liked and needed their support from staff. For example, a nutritional support plan stated, "My food needs to be chopped into very small pieces with plenty of sauce or gravy. This enables me to swallow my food more comfortably," and, "Always use hand-over-hand support but don't be afraid as I can sometimes do the task myself, never assume because I did it yesterday I can do it today." Staff we spoke with were able to give us information about people's needs and preferences which showed they knew people well.

People were unable to fully express their views verbally. Support plans provided information to inform staff about how a person communicated. For example records stated, "I will pout my lips and refuse to open my mouth, sometimes this means I have had enough to eat or I do not like what is being offered to me," "I will spit my food out if I do not like it, or like the texture," and, "Keep verbal communication short and to the point. For example, (Name) your coat or (Name) drink. Back up your verbal communication with hand gestures and prompts."

Staff respected people's privacy and dignity and provided people with support and personal care in the privacy of their own room. People were able to choose their clothing and staff assisted people, where necessary, to make sure that clothing promoted people's dignity. For example, one care plan stated, "I like to choose my own clothes for the day, I need to be shown two outfits and asked which one. I am particularly fond of red."

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the registered manager or senior staff any issues or concerns. The registered manager told us people who did not have relatives to provide advice and support to them would be supported by an advocate. Advocates can represent the views for people who are not able to express their wishes. The registered manager told us of situations where staff had advocated for people to ensure they received the medical treatment they were entitled to receive. For example, for an operation.

Good

Is the service responsive?

Our findings

People were supported to access the community and try out new activities as well as continue with previous interests. Records showed there were a wide range of other activities and entertainment available for people. For example, "My favourite day out is going on the train." We were told people enjoyed having pamper sessions, trampolining, shopping, walking, musicals, eating out, arts and crafts and using the sensory equipment to help stimulate or relax people. Transport was available so people enjoyed trips to the country, coast and nearby towns. People were supported by staff to go on holiday and we saw some people had been to Filey. One person's records showed they were planning to go to Disneyland with staff.

Relatives we spoke with said they were involved in discussions about people's care and support needs. One relative commented, "I'm kept involved and we meet to discuss (Name)'s support needs." They also said, "About twelve of us meet every year, all the professionals, to discuss (Name)'s care and treatment." Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends. Most people had visitors and some people went to spend time at their family home. One person's care plan stated, "I love to see my Mum and hear her voice on the telephone," and, "I like to have photographs taken at the visits with my Mum so I can look at them later to remind me of my time with my Mum."

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. Records showed pre-admission information had been provided by relatives and people who were to use the service. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, mobility and communication needs.

We were told a new care plan system was in the process of being introduced to ensure person-centred care was provided to the individual and that their records reflected the care provided by staff. People's care records were up-to-date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. For example, "When I am in a park I can become very excited and lose my concentration," "I like to wear jeans but my support worker always needs to ensure I wear a belt on to keep them up," and, "(Name) likes to watch musical DVDs in their bedroom with their sensory lamps on."

Care plans provided instructions to staff to help people learn new skills and become more independent in aspects of daily living whatever their needs were. For example, a care plan for personal hygiene stated, "I need full support to wash my body, but to learn about skills my support worker should try to offer hand over hand support with me holding the face cloth," and, "I am unable to fasten zips or buttons so will need them fastened for me."

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised

service. For example, a member of staff described how they offered choice to a person who may not communicate if they wanted a lie in bed each day. They told us, "If (Name) is lying down awake they aren't ready to get up but if they are propped up leaning on an elbow they are ready to get up." Records also provided information to ensure people were offered choice. For example, one record detailed with regard to hot and cold drinks, "Show (Name) a beaker or a cup and they will point and that shows if they want a hot or a cold drink," and, "Show (Name) a jar of coffee and a tea-bag and (Name) will indicate their choice." Care plans detailed other objects of reference to show the person to let them make a choice for example, a riding hat if they wanted to go riding or a football if they wanted to play football in the garden.

A daily record was available for each person. It was individual and in sufficient detail to record their daily routine and progress in order to monitor their health and well-being. This was necessary to make sure staff had information that was accurate so people could be supported in line with their current needs and preferences.

People had a copy of the complaints procedure that was written in a way to help them understand if they did not read. A record of complaints was maintained. No complaints had been received since the last inspection. A relative commented, "I'd have no problem speaking to staff if I had any concerns."

Good

Is the service well-led?

Our findings

A registered manager was in place who had been registered with the Care Quality Commission since February 2015. The registered manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities.

The culture promoted person centred care, for each individual to receive care in the way they wanted. Information was available to help staff provide care the way the person may want, if they could not verbally tell staff themselves. There was evidence from observation and talking to staff that people were encouraged to retain control in their life and be involved in daily decision making.

The atmosphere in the service was friendly. Staff said they felt well-supported. Comments included, "I love it here," "The service is very well run," and, "Management are approachable."

Staff told us staff meetings took place every two months. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Minutes showed staff had discussed service issues, health and safety, training, the needs of people who used the service and feedback from people from head office who monitored the quality of care provision. Staff told us meeting minutes were made available for staff who were unable to attend meetings

Records showed audits were carried out regularly and updated as required. Daily audits included checks on medicines management and the environment. Weekly checks also took place that included health and safety, medicines, security, fire safety and documentation. Monthly and three monthly audits were carried out and they included health and safety, finances, documentation, risk awareness and staff awareness of safeguarding. The results were sent to the line manager who had direct operational responsibility for the service. The registered manager told us a peer audit was carried out by another registered manager to provide an independent view of the service. Their monthly visit was to speak to people and the staff regarding the standards in the service. They also audited a sample of records, such as care plans and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to staff, family members and professionals who supported people who used the service. We saw the survey results for 2015. They had been aggregated for the three services in the Leeds and Harrogate area and information was not available with regard to Lingwell Approach. We had concerns the survey results were not individual to the service so any required action could be taken by the registered manager immediately to improve the service provision at the home. This would help contribute to the quality monitoring of home's service. The registered manager told us this would be addressed