The Melanie Ann Trust

The Melanie Ann Trust Residential Home

Inspection report

251 Saltings Road
Snodland
Kent
ME6 5HR

Tel: 01634320894

Date of inspection visit:
08 January 2018

Date of publication:
07 February 2018

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

The inspection took place on 08 January 2018. This inspection was announced.

This service 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. There were three people using the service at the time of our inspection. People had a learning disability, autism or visual impairment.

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

The registered manager was employed at the service. 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.

At the last Care Quality Commission (CQC) inspection on 08 December 2015, the service was rated as Good in all of the domains and had an overall Good rating.

At this inspection we found the registered manager and provider had consistently monitored the quality of their service to maintain a rating of Good.

Melanie Ann Trust Residential Home is a charitable trust and continued offering an inclusive service. The staff followed policies about Equality, Diversity and Human Rights and continued to receive training about this.

The registered manager was consistent in measuring the quality of people's experiences when they lacked developed communication skills and continued to work at putting people at the heart of the service. They continued to ask relatives, staff and external health and social care professionals for their views about the service.

We observed friendly caring staff who addressed people with respect and care.

The quality outcomes promoted in the providers policies and procedures were monitored by the registered manager. There continued to be multiple audits undertaken based on cause and effect learning analysis, to improve quality. Staff understood their roles in meeting the expected quality levels and staff were empowered to challenge poor practice.

The registered manager consistently understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA).

The registered manager checked staff's suitability to deliver personal care during the recruitment process.

The registered manager continued to train staff so that they understood their responsibilities to protect people from harm. Staff understood the risks to people's individual health and wellbeing and risks were clearly recorded in their care plans. People's medicines continued to be managed and administered safely.

There continued to be enough staff deployed to meet people's physical and social needs. Emergency backup systems continued to be operated to allow care to continue at all times. Staff consistently received training that matched people's needs effectively and staff were supported with supervision and with maintaining their skills.

People had access to many different activities of their choice outside of the service and were supported to pursue and maintain these. Within the service, people were supported to take part in activities they said they wanted to do individually or together.

People were consistently supported to eat and drink according to their assessed needs. Staff supported people to maintain a balanced diet and monitor their nutritional health. Most people chose to have communal meals where they ate together. When people decided they did not want to eat their meal with the rest of the group or at the same time this was respected and supported. People were supported to access health care when they needed it and assisted to maintain their health.

Risks assessments continued to be updated and in place for the environment, and for each individual person who received care. Assessments identified people's specific needs, and showed how risks could be minimised. Management systems were in use to minimise the risks from the spread of infection, staff received training about controlling infection and carried personal protective equipment like disposable gloves and apron's.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

The Melanie Ann Trust Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned, to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection. We re-inspect services that have been rated as Good within 24 months of the report publication date.

The inspection took place on 08 January 2018 and was announced. We gave notice of the inspection so that people may be less anxious by our presence in their home. The inspection was carried out by one inspector.

Before the inspection, we asked the provider to complete 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. We also reviewed the information we held about the service including previous inspection reports. We looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We observed the care provided for people. We spoke to one person who used the service and one relative on the telephone to gain their views of the service. We spoke with three staff including the registered manager, one senior care worker and one care worker. We requested feedback about the service from two health and social care professionals.

We looked at records held by the provider and care records held in the service. This included care plans, daily notes; a range of the providers policies including safeguarding, medicines and the complaints policy; the recruitment and training records of the member of staff employed since our last inspection; the staff training programme and health, safety and quality audits.

Good

Is the service safe?

Our findings

People were protected by staff who understood how each person communicated if they were in pain, anxious, upset or unhappy. We observed how this happened by witnessing two members of staff communicating by touch, using sign language and hand on hand support. One person told us, "I feel really safe with staff, they are lovely people."

A relative told us they could not fault the staff. They said, "The staff do everything possible to help people."

People were consistently protected from the risks of potential abuse. Information about safeguarding issues was presented to people in a format they may understand, using pictures of people. Staff clearly understood how each person would communicate that they were unhappy, scared or worried. There were no identified concerns about safety. The provider had maintained a safeguarding policy that informed staff about their responsibilities to safeguard people and what constituted abuse. Staff received training in safeguarding, knew what signs to look out for and felt confident the management team would listen to and act on any concerns they raised. Staff told us they understood how abuse could occur and how they should report abuse. Staff we spoke with were confident they could challenge any poor practice within the service and report it appropriately. Staff had read and understood the provider's policies, for example the whistleblowing policy. The registered manager asked staff to sign to acknowledge this. Staff knowledge of safeguarding was discussed during recorded supervision meetings with the registered manager. The registered manager had access to the 'Multi-agency safeguarding vulnerable adults: Adult protection policy, protocols and guidance for Kent and Medway.' (This document contained guidance for staff and managers on how to protect and act on any allegations of abuse).

There continued to be a policy about dealing with incidents and accidents. Staff received training about how to report accidents and incidents to the registered manager. There were no recorded incidents. However, the registered manager described how they would act within the provider's policy if any were reported. For example they would ensure these were recorded, and investigated to reduce the risk of future incidents.

People continued to receive their medicines safely to protect their health and wellbeing. Staff followed the provider's medicines policies and the registered manager checked that this happened by a system of spot-checking staff when they were providing care and administering medicine. (Spot checks are observational supervisions of staff.) When staff assisted people with their medicines they followed an up to date medicines administration procedure. All staff were provided with training so that if they were asked to take on the administration of medicine's for people they could do this safely. We observed medicines being administered and staff we talked with gave us details of how they supported people safely when dealing with medicines.

People were protected by staff who understood their responsibility to record the administration of medicines. The medicine administration record (MAR) sheets showed that people received their medicines at the right times and as prescribed. The system of MAR records allowed for the checking and recording of

medicines, which showed that the medicine had been administered and signed for by the staff. We sampled recent MAR sheets and these were being completed correctly by staff. Medicines management included a policy regarding the safe management of 'As and When Required Medicines' (PRN), for example paracetamol. Medicines were audited systematically by the registered manager as part of their quality systems.

The registered manager continued assessing risks to people's individual health and wellbeing. For example, they assessed people's care needs, mobility, nutrition and communication. Audits of medicines and specific risk to people from the care being delivered were in depth and frequent to ensure people's safety. Where risks were identified, people's care plans described the equipment needed and the actions care staff should take to minimise the risks. The registered manager asked staff to sign to acknowledge this. Staff knowledge of managing risks was discussed during recorded supervision meetings with the registered manager. Staff explained to us how they followed risk assessments to maintain people's safety when they delivered care. For example, when planning a holiday or community activity.

Staff were deployed with the right skills and in the right numbers to meet people's care needs. Between 8 am and 10 pm people had one to one staff care and support. At night a member of staff remained on site. The staff roster confirmed the staffing levels. There were no recently recruited staff. Most staff had been working at the service for many years. The provider's recruitment policy continued to ensure risks to people's safety were minimised. This protected people from new staff being employed who may not be suitable to work with people who needed safeguarding. All applicants had references, full work histories and had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

Care plans and care records were kept securely. Detailed daily care records were kept by staff. Records included personal care given, well-being and food and fluids taken; when required. Staff understood their responsibility to maintain people's confidentiality.

The provider continued to maintain fire safety. Fire systems were maintained and tested. Each person had a personal emergency evacuation plan (PEEP) with detailed information about their ability to escape fire and the support they needed from staff to do this safely. In house test and practice evacuations were recorded.

The provider had continually checked that the work environment was safe for people and staff. Safe working practices and the risks of delivering the care were assessed and recorded to keep people safe. Environmental risks were assessed and equipment was serviced and checked by the provider and staff. Other environmental risks were monitored to protect people's health and wellbeing. These included water temperatures checks. There were up to date safety certificates for gas appliances, electrical installations, portable appliances and the fire systems. The registered manager showed us a detailed maintenance plans and we saw that these were being followed. For example, the main bathroom had been refurbished and the downstairs hall had been re plastered and painted.

The registered manager continued to plan consistent care. The provider had a policy that enabled care to continue in other places, for example a nearby hotel. This meant that people's care could continue if there was disruption to the service, for example in periods of extreme weather conditions or if the home could not be accessed. The registered manager had a 24 hour emergency back up on call system in place.

People continued to be protected from potential cross infection. There was a cleaning system in place that allowed for daily, weekly and deep cleaning to take place. Records of cleaning were kept. Staff confirmed

they understood their responsibility to assist people to maintain the cleanliness in the service. Staff received food hygiene and infection control training. Staff told us they always had access to personal protective equipment [PPE] when appropriate, such as disposable gloves and aprons.

Good

Is the service effective?

Our findings

Staff understood people's needs, followed people's care plan and were trained for their roles. One person said, "Yes the staff get training, they help me do things I like."

We carried out observations of people's care in the kitchen and lounge. People were supported with their agreed and recorded daily routines by staff. People's health needs were monitored by staff and comprehensive information was provided about people's conditions.

The registered manager continued to carry out an assessment with people before care was delivered. The assessment checked the risks and the care and support needs of each person so the registered manager could make sure staff had the skills to care for the person appropriately. At the assessment stage and during reviews people were encouraged to discuss their sexuality or lifestyle preferences as well as their rights, consent and capacity. The registered manager involved people and their family members in the assessment process when this was appropriate.

The initial assessment led to the development of the care plan. Individual care plans were detailed, setting out guidance to staff on how to support people in the way they wanted. Care plans focused on people's strengths and were adjusted to maintain people's interest and reduce anxiety. For example, tasks like shopping were broken down into smaller steps. Staff were required to record the care they had provided to people by recording how they had met people's needs in their care plan records. Staff told us they had all the information they needed within the care plan to support people well. People's nutritional risk and allergy needs were shared with staff if they prepared meals. People were involved in the preparation of their meals and menu choices. Most foods were freshly prepared. People were helping to choose the menu for the week and people got involved in step by step shopping and food preparation. People's likes and dislikes in respect of food and drink and the menus had been planned taking their preferences into account. Staff recorded if certain foods were eaten or rejected as an indicator of food preferences. A range of diet choices were catered for. Members of staff were aware of people's dietary needs and food intolerances. People had chosen different menu options with consideration to their health needs and allergies. Staff recorded what people ate and drank in the daily records. This meant that key areas of people's health and wellbeing could be monitored as an indicator of their health.

Staff continued to understand how to protect people's health and wellbeing in partnership with other health and social care professionals. People were assisted to access other healthcare services to maintain their health and well-being, if needed. Records confirmed that people had been seen by a variety of healthcare professionals, including a GP, nurse and dentist.

To assist people in making choices about consent, staff respected and empowered people to make decisions before care and support was delivered. We saw records of relatives taking part in the planning of care and best interest decision making. Staff told us of ways in which they gained consent from people, demonstrating how they communicated with people who could not verbalise their wishes. Staff explained that if needed, they used non-verbal methods of communication using gestures, signs and showing people

items to enable them to give consent and make choices. Our observations confirmed that these methods were used effectively to gain consent and understand people's needs.

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

We checked whether the service was working within the principles of the MCA 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. We found that this process protected the person's rights.

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 2005. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

Staff feedback about the standards of training and supervision was consistently good. The registered manager planned training in advance. This meant that they could book staff on refresher training in good time. Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. Since our last inspection, records showed staff had undertaken training in all areas considered essential for meeting the needs of people who needed personal care. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people.

The registered manager supported staff to have the skills and support they needed to do their jobs well. Staff received an induction when they started working for the service. New staff inductions included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. Staff then started to work through the training to Care Certificate standards which was recorded in their staff files. The Care Certificate includes assessments of course work and observations to check staff met the necessary standards to work safely unsupervised.

The registered manager planned staff supervisions in advance. The registered manager checked how staff were performing through an established programme of regular supervision (one to one meeting) and an annual appraisal of staff's work performance. The supervisions included sessions to update and test staff learning from training. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff confirmed to us that they had opportunities to meet with their manager to discuss their work and performance through supervision meetings. Staff supervisions were recorded.

Good

Is the service caring?

Our findings

Staff saw their roles as enablers for people. We observed staff were assisting and encouraging independence rather than just doing things for people. For example, we saw a member of staff gently encouraging a person to wash their plate and hands after lunch. We observed them using hand on hand positive engagement.

The care people received continued to be person centred and met their most up to date needs. People's likes and dislikes had been recorded in their care plans. Staff encouraged people to be as independent as possible.

The provider had a range of policies setting out their approach to dignity, equality, diversity and human rights (EDHR). These were accessible to staff at any time and included in people's initial assessments. Staff received training about the culture of the organisation in promoting dignity and human rights. Staff knowledge of EDHR was discussed at recorded supervisions meetings with the registered manager. Staff we spoke with and observed demonstrated to us how they delivered care respectfully.

We observed staff that were smiling, friendly and happy to provide care. Staff were tested on their attitude to care when they applied to work at the service. All of the staff we spoke with displayed a caring attitude. We found that people continued to be supported by caring staff that were sensitive in manner and approach to their needs. Staff described how they delivered friendly compassionate care. We observed how they made sure that people were comfortable and relaxed in their presence. Staff described how they made sure people had all they needed. For example, personalisation in the service was fully inclusive with people choosing the décor, furnishing, who their key worker was and how their bedrooms were decorated to their lifestyle choices. Each person had a named key worker. This was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their dreams and aspirations.

The staff we spoke with were aware of what was important to people and were knowledgeable about their preferences, hobbies and interests. They had been able to gain information on these from the 'Person centred care plans', which had been developed through talking with people and their relatives. This information enabled staff to provide care in a way that was appropriate to the person.

The registered manager continued to ensure people's individual records provided up to date information for staff on how to meet people's needs. This helped staff understand what people wanted or needed in terms of their care and support.

Good

Is the service responsive?

Our findings

People's needs had been fully assessed and care plans had been developed on an individual basis. Person centred care planning (PCP) was in use. PCP is a way of thinking and doing things that sees the people in the service as equal partners in planning, developing and monitoring care to make sure their needs and preferences were met.

Records showed that people, relatives and staff had consistently been asked their views about their care. People told us they had been fully involved in the care planning process and in the reviews of those plans. Reviews of the care plan could be completed at any time if the person's needs changed. We could see that care plan reviews had taken place as planned and that these had been recorded.

Staff read people's daily reports for any changes that had been recorded and the registered manager reviewed people's care notes to ensure that people's needs were being met. Staff acknowledged their awareness of people's care plans and needs by signing them to this effect. When we spoke with staff they showed that they knew people well and what was important to them. This was evidenced by the knowledge and understanding they displayed about people's needs, preferences and wishes. The staff were able to tell us how they provided people with care that was flexible and met their needs.

People continued to receive personalised support which met their specific needs. Each person had an up to date care plan which set out for staff how their needs should be met. Care plans were personalised and contained information about people's likes, dislikes and their preferences for how care and support was provided. Where changes were identified, people's plans were updated promptly and information about this was shared with all staff.

The activities people were involved in were tailored to their choice and lifestyle to encourage participation and reduce social isolation. People had a routine for one-to-one staff support in the community. This included participating in leisure activities, going to the pub for lunch and personal shopping. Staff were allocated to people's activities based on their skills and experience. Activities were recorded. This meant staff could understand and meet this person's individual needs.

People attended work experience and learning activities such as helping with horse care, assisting riding sessions and gardening projects. People also attended structured learning venues which aimed to give people with learning disabilities or physical disabilities a positive outlook on life, gain new experiences, make new friends and develop their personal, social, and negotiating skills through various activities. People had routinely been on holidays, for lunch out, attended social events and visited places that may interest them. Staffing was provided based on the assessment of risks the activity to be undertaken may have. Activities were introduced to people slowly so that staff could learn by the persons known responses and behaviours if they liked the activity or if they wanted to do something else.

Person centred reviews took place with health action plans and communication passports in place. Health action plans are recommended for people with learning disabilities by the department of health to promote

people's health and their access to health services. Communication passports are easy to follow person-centred booklets for those who cannot easily speak for themselves when they need to use other services. For example, if they were admitted to a hospital.

There continued to be a general policy about dealing with complaints that the staff and registered manager followed. The complaints procedure was made available in the service. For people living in the service the staff used analysis of behaviours and reactions to gain information about people to gauge what had made them unhappy and why. Any concerns were recorded in people's care plans and discussed within the team meetings. The service staff had also received a number of compliments in the last year.

Good

Is the service well-led?

Our findings

One person said, "I really like the Melanie Ann Trust, I like living there." A relative told us they thought the service was well managed.

The aims and objectives of the service were set out and the registered manager of the service staff followed these. For example, to provide the best individualised support to people. Staff received training and development to enable this to be achieved. The registered manager had a clear understanding of what the service could provide to people in the way of care and meeting their learning disabilities needs.

The registered manager and their staff team were well known by people. We observed staff being greeted with smiles by people. The registered manager had extensive experience of delivering person centred care to people with learning disabilities and complex needs. It was clear from our discussions with them that they had the skills and motivation to lead the staff team in the delivery of positive outcomes for people. The values of the organisation were clearly noted and identified within the organisational policies and the provider statement of purpose. The provider's vision was based on enabling people with learning disabilities to take control of their lives and be less isolated in their communities and to live in a homely environment. Staff told us that they learnt about the values of the organisation from day one of their employment. Staff were committed and passionate about delivering person centred care to people living with learning disabilities and autism.

Staff we spoke with told us that the management in the service expected staff to do a good job. They told us they felt well supported by the managers in the organisation. All the staff we spoke with told us how much they enjoyed their job. Staff said they felt well supported by the management team. Staff told us they felt listened to and described the management team as approachable.

The registered manager provided leadership in overseeing the service and provided support and guidance where needed. They also delivered care shifts which gave them good levels of contact with people and staff.

The provider had clear values which was promoted by the registered manager to all staff. The culture of the service was open and inclusive. Staff we spoke with consistently demonstrated the provider's values. Staff went through the care values of The Melanie Ann Trust Residential Home during their induction and this was followed up at supervisions so that they understood them.

Feedback from staff, people and relatives had been sought via surveys, meetings and telephone calls.

The registered manager had carried out quality audits of the service. These audits assisted the registered manager to maintain a good standard of service for people and to consistently meet the legal requirements and regulations associated with the Health and Social Care Act 2008, and Care Act 2014. The registered provider continued to monitor the quality of service provision.

We looked at the arrangements in place for quality assurance and governance in all areas. Quality assurance

and governance processes are systems which help providers to assess the safety and quality of their services. We saw the registered manager checked people's care plans, risk assessments and daily logs to ensure they were up to date and completed to a good standard. This meant that the delivery of care to people's assessed needs could be checked and monitored.

There were systems in place to check the staff training records to make sure staff training was up to date and staff were equipped to carry out their role and responsibilities and any training needed was booked. These were effective. Records showed that all staff training was in date.

We reviewed some of the registered provider's policies and procedures and saw these were updated on a regular basis to ensure they reflected current legislation. The registered manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008. The policies and procedures were available for staff to read and staff were expected to read these as part of their training programme.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had shared their last rating and this was displayed in the service.