Royal Mencap Society

Hales Lodge

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

Hales Lodge is a residential home that provides care, support and accommodation for up to eight people who have learning and physical disabilities. At the time of our inspection the home was fully occupied.

The home had a registered manager in post. 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 and associated Regulations about how the service is run.

People were safe and lived in a safe environment because there were enough well trained staff to support people and appropriate recruitment checks were carried out before staff began working in the home. The premises were well maintained and any safety issues were rectified promptly.

Identified risks to people's safety were recorded on an individual basis. There was guidance for staff to be able to know how to support people safely and effectively.

Medicines were managed and administered safely in the home and people received their medicines as prescribed.

People were supported effectively by staff who skilled and knowledgeable in their work. All new members of staff completed a full induction and staff were supported well by the manager.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and to report on what we find. These safeguards protect the rights of adults using the services by ensuring that, if there are restrictions on their freedom and liberty, these are assessed by professionals who are trained to assess whether the restriction is needed. DoLS applications had been made for all eight people currently living in Hales Lodge.

People were supported to eat and drink sufficient amounts and people's intake of food and drinks was monitored and recorded. Prompt action and timely referrals were made to relevant healthcare professionals when any needs or concerns were identified.

Staff in the home were caring and attentive. People were treated with respect and staff preserved people's dignity. Relatives were welcome to visit as and when they wished and people were encouraged and supported to be as independent as possible. People were also able to undertake activities or hobbies of their choice.

Assessments were completed prior to admission, to ensure people's needs could be met. People were involved as much as possible in planning their care and received care and support that was individual to their needs. Risk assessments detailed what action was required or had been carried out to remove or

minimise identified risks.

People were supported to raise concerns or make a complaint if needed and were listened to, with appropriate responses. Action was taken where possible.

The service was being well run and people's needs were being met appropriately. The manager was approachable and open to discussion. Communication between the staff, management and people living in the home was frequent and effective.

There were a number of effective systems in place in order to ensure the quality of the service provided was regularly monitored. Regular audits were carried out by the manager and the provider's operations managers, in order to identify any areas that needed improvement.

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.

Risks to people were identified and minimised appropriately. Staff knew how to recognise signs of possible abuse and understood the correct reporting procedure.

Staffing levels were sufficient to meet people's needs and appropriate recruitment procedures were followed to ensure prospective staff were suitable to work in the home.

People were supported to safely take their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff were supported by way of relevant training, supervisions and appraisals to deliver care effectively.

People's consent was sought and nobody was being unlawfully deprived of their liberty.

People had sufficient amounts to eat and drink in the home and prompt action and timely referrals were made to relevant healthcare professionals when any needs or concerns were identified.

Is the service caring?

Good

The service was caring.

Staff were caring and attentive. People were treated with respect and staff preserved people's dignity.

Relatives were welcome to visit as and when they wished and people were encouraged and supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Assessments were completed prior to admission, to ensure people's needs could be met. People were involved in planning their care as much as possible.

People were able to choose what they wanted to do and where they wanted to spend their time.

People were supported to raise concerns or make a complaint if needed and were listened to with appropriate responses and action taken where possible.

Is the service well-led?

Good

The service was well led.

The service was being well run and people's needs were being met appropriately.

The manager was approachable and open to discussion. Communication between the management, staff and people living in the home was frequent and effective.

There were a number of systems in place in order to ensure the quality of the service provided was regularly monitored. Regular audits were carried out to identify any areas that needed improving.

Hales Lodge

Detailed findings

Background to this inspection

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

This inspection was carried out by one inspector on 18 March 2016 and was unannounced.

Before our inspection we looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

As some people were not able to tell us in detail about their care, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During this inspection we met seven of the eight people who were living in the home. We also spoke with the manager and five support workers. We looked in detail at the care records for three people and a selection of medical and health related records.

We also looked at the records for two members of staff in respect of training, supervision, appraisals and recruitment and a selection of records that related to the management and day to day running of the service.

Good

Is the service safe?

Our findings

People were not able to tell us directly whether they felt safe but we saw that they were relaxed and comfortable in the presence of all staff. We saw that people were supported and cared for safely and that risks to their health, welfare and safety were minimised.

The manager and staff demonstrated that they understood what constituted abuse and that they knew the correct reporting procedure. The manager said they were confident that all the staff would report anything they were concerned about straight away. We saw that staff had completed training sessions in safeguarding and noted that staff had received a safeguarding update during their team meeting in January 2016. This had included understanding different types of abuse, how to report concerns and who to report them to.

We saw that individual and 'person centred' risk assessments had been completed in respect of all aspects of people's everyday lives. Where new or potential risks were identified, the information and guidance for staff was updated promptly to reflect the relevant changes. For example, assessments explained how to support people safely with their food and fluid intake, transferring people by using a hoist, how to know when people were experiencing pain and how to minimise the risk of acquiring pressure ulcers. Risk assessments had also been completed for the social and emotional aspects of people's lives.

We saw that there were consistently enough staff on duty to support people and the manager showed us how the rota was often adjusted in order to meet people's individual needs. For example, if someone wanted to go out in the evening. Staff and the manager also told us that there was always a designated 'on-call' member of staff, which meant they were on standby to cover any shortfalls in staffing levels for each shift. If agency staff needed to be used, we were told that these were always from the same agency and knew the service and the people living there.

The manager also explained that people's dependency was continually assessed, to ensure that the staffing levels remained sufficient and appropriate. Our observations during this inspection showed that staff responded to people's needs in a timely fashion. It was also evident from our discussions and observations that one of the main priorities in the home was to ensure that people were able to safely carry out their daily routines. For example, activities, attend appointments or have one-to-one staff support, as they required.

The staff records and staff we spoke with confirmed that appropriate recruitment procedures were followed to make sure that new staff were safe to work with people who lived in the home. All staff were police checked for suitability with the Disclosure and Barring Service and appropriate references were obtained before they started working in the home.

Medicines were managed and administered safely in the home and people received their medicines as prescribed. The manager told us that all staff were appropriately trained to administer people's medicines. We saw that people's medicines were appropriately stored in lockable facilities in people's rooms. People's records, including the medicine administration records (MAR), were clear, up to date and completed

appropriately.

Records we looked at and a discussion with the manager also confirmed that people had regular reviews of their medicines. This ensured they remained appropriate for people's clinical needs.

Good

Is the service effective?

Our findings

People living in the home were not able to speak with us directly but we saw that they were supported effectively by staff who were skilled and knowledgeable in their work.

All new members of staff completed a 'home specific' induction process, which included completing essential training courses that were relevant to their roles. Some staff were new to working in care but told us that their training had been, "Brilliant". They also said that they felt very well supported by more experienced staff and the manager. Specific training was also provided in order for staff to be able to understand and meet people's individual and sometimes complex support needs. For example, training in epilepsy, autism and PEG (Percutaneous Endoscopic Gastrostomy) feeding and site care. PEG is a procedure that enables nutrition, fluids and medicines to be put directly into a person's stomach, bypassing their mouth and oesophagus.

The manager confirmed that one-to-one supervisions were carried out with staff on a regular basis. Annual appraisals were scheduled to be carried out in April 2016.

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 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.

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 Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that the manager ensured the service operated in accordance with the MCA and DoLS procedures and noted that training on this subject was ongoing and had recently been delivered to staff.

Mental capacity assessments had been completed for people, where their capacity was in question. We saw that the areas in which a person lacked capacity were clearly recorded, together with explanations of how each person could make decisions for themselves. Where people lacked capacity, we saw that best interests decisions were made with the involvement of as many relevant people as possible. For example, the people themselves, their family or advocates, staff, health professionals and social workers.

The manager told us that a DoLS application had been made for each of the people currently living in the home. They explained how each application had been completed individually for each person and confirmed that these were not just routine or 'blanket' applications. We saw that, due to the nature and complexities of people's learning and physical disabilities, these applications were appropriate.

People were supported to have enough to eat and drink and our observations during lunch time showed people enjoying their meals. People's needs and abilities to eat and drink were very varied and we saw that staff catered for each person on a very individual basis. For example, one person indicated what they wanted when staff offered them a choice, by using facial and body gestures. Another person needed full support to eat their meal, which we saw they received. We noted that one person, who liked a hot meal for lunch, took a microwaveable meal to the day centre they attended.

Two people received their food and drink by PEG. One person had this due to their persistent refusal to eat or drink anything by mouth. For this person, we saw that there had been a lot of input from relevant health professionals to ensure their health and wellbeing was maintained. We also saw that staff followed a detailed care plan which encouraged this person to be involved in meal preparations and baking. This was proving successful with regard to finding some things that the person was able to enjoy eating and drinking.

People's intake of food and drink was monitored and recorded; showing clear descriptions of what people had actually eaten, drank, or refused. Staff consistently audited this information, so that prompt action could be taken when people were not eating or drinking sufficient amounts, to help ensure they stayed well. The records we saw for two people were completed properly and up to date.

Information in people's care records showed that prompt referrals were made to healthcare specialists when any concerns were identified. For example, to the dietician and speech and language team, when there were concerns about people's weights and nutritional intake or if people had any difficulties with swallowing.

People's general health and wellbeing was continually reviewed on a daily basis and their care records were kept up to date regarding their healthcare needs. People were also able to access other relevant healthcare professionals as needed, such as the GP, district nurse, epilepsy specialist nurse, physiotherapist, psychiatrist, dentist and optician.

We also saw evidence, by way of observations and information in the care records that staff worked in accordance with guidance provided by external professionals. This ensured that people continued to be supported and cared for effectively.

Good

Is the service caring?

Our findings

People living in the home were not able to tell us directly whether the service was caring but we saw that staff treated people kindly and in a caring and friendly manner. Staff interacted with people to levels that were individual to each person's wishes. We also saw that people were comfortable in the presence of all the staff they were being supported by.

We noted that staff were very perceptive to people's wants, needs and feelings. Staff actions, combined with people's body language and facial expressions demonstrated that staff knew people and their needs very well.

People's care records showed that people were fully involved in planning and agreeing the way in which their care and support was provided. Where people were unable to communicate verbally or in a formal way we saw that staff used methods that were individual to each person. This helped people make their own decisions and choices as much as possible. For example, some people understood and responded to photographs of things such as food, places or activities. Some other people needed to see physical objects such as car keys, a mug or a bath sponge to be able to understand what was being offered.

On one occasion we saw it recorded that when one person had been offered a bath, they had refused by way of shaking their head and scratching the support worker's hand. This was their recognised and accepted method of giving a negative response. It was also recorded appropriately that the person's choice had been respected.

Most people had regular contact with family members and visitors, who were known to people, were welcome without restrictions. Where people were unable to make decisions for themselves, we saw that a detailed decision making process was followed in people's best interests. This involved as many relevant people as possible. For example, the people themselves, their family or advocates, staff, health professionals and social workers.

Our observations throughout this inspection showed that people were treated with dignity and respect at all times and their right to privacy was consistently upheld. For example, one person indicated that they needed assistance with some intimate personal care. We saw that staff discreetly acknowledged this person's request and, in a dignified manner, escorted them to their room.

People were also encouraged and supported to be as independent as possible. For example, by being provided with assistive equipment for mobilising or eating and drinking and being able to choose how and where they wished to spend their time.

People were supported to maintain strong links with the community and were often out and about; pursuing their interests and maintaining their friendships. Some people accessed regular day services and staff maintained frequent contact with other health and social care professionals. During this inspection we observed people going out for a walk with staff into the village, during which, one person also met up with a

family member.

Good

Is the service responsive?

Our findings

People were involved in planning their care as much as possible and received care and support that was individual to their needs. We observed staff continually making sure that people were doing what they wanted and were where they wanted to be. When anybody needed assistance, we saw that staff were very quick to respond.

Information in people's care records showed that detailed assessments had been completed, to ensure the service could meet their needs. These assessments formed the basis of people's care plans and were reviewed and updated on a regular basis. People's risk assessments were also regularly reviewed and updated as needed.

All our observations during this inspection confirmed that people were recognised and treated as individuals and that the care and support provided was person centred. The contents of the care plans were also very personalised and gave a full description of each person's individual support needs. For example, one person needed support from two members of staff when receiving personal care. Another person liked to go out somewhere with staff when they were being provided with their allocated personal one-to-one time. People's individual methods of communication were also clearly described. Other information we saw included pen pictures, personal histories, likes, dislikes and aims and goals for the future.

People living in the home were able to lead lifestyles that they enjoyed. For example, some people regularly attended day centres, where they could socialise and take part in a range of activities. We also noted that people were supported by the staff in the home to do the things they liked. These included pamper sessions, sports, going for a walk, watching films, art work, going to discos, dancing and shopping. In some cases, people also helped with household chores such as cleaning and cooking.

One person's notes showed that, although they could not speak to their family on the telephone, they liked to listen when staff put the telephone to their ear. Another person used 'Face-Time' to communicate with their parents on occasions.

The manager told us how one person often liked to be involved in interviewing potential staff. This person enjoyed asking particular questions to see what sort of response they received. This helped to decide whether the potential staff member would be suitable. For example, questions like, "If I decided I wanted purple hair, what would you do?" This person also liked to carry out the regular checks of their money tins with staff and had achieved a finance training certificate. In addition, they also enjoyed doing the routine checking of the first aid box contents with staff and were actively involved in the administration of their own medication. This showed that people were encouraged and supported as much as possible to enhance their life skills and be as independent as possible.

We saw that the home had an appropriate complaints procedure, which contained detailed information about the steps to be taken in the event of a complaint being received. People living in the home were supported by staff on an individual basis to make a complaint or raise any concerns if they had any. We saw

that any concerns were listened to and responded to appropriately. No formal complaints had been received but we saw positive feedback from people's relatives.

Good

Is the service well-led?

Our findings

We observed that people living in the home, their family, visitors and staff were all considered to be an important factor in the way the home was run. Any suggestions for improvements were welcomed, listened to and action was taken where appropriate or necessary.

There was a registered manager in post and the information we held about Hales Lodge showed that notifiable events had been reported as required. When we spoke with the registered manager about this, they demonstrated an understanding of what events they were required to report and to whom. The registered manager also told us they felt very well supported in their role.

Communications between staff and management were frequent and effective. Regular team meetings took place and detailed minutes were taken each time. These meetings covered all aspects of the service. For example, health and safety issues, staffing levels, staff training, areas of responsibility and the individual support requirements for people living in the home.

There was an open, positive culture in the home and staff told us the manager was approachable and open to discussion. All the staff we spoke with said they enjoyed working in Hales Lodge. One member of staff said, "I love it here. I haven't been here long but it feels like I've been here forever; it's brilliant." Another staff member said "It's completely different from what I was doing before but I'm loving it."

Record keeping and management systems were in good order, with effective auditing and follow up procedures in place. There were a number of systems in place in order to ensure the quality of the service provided was regularly monitored. For example, care plans and people's individual assessments in respect of risk, were audited, reviewed and updated regularly. We also noted that the staff team as a whole consistently reviewed and considered people's physical and emotional health and wellbeing.

The manager showed us a detailed action plan that had been compiled in 2015 with the provider's operations managers. This had followed a full audit that was carried out shortly after the manager's appointment at the service and covered all elements of the service. We saw that positive progress had been made to areas that had been identified as requiring improvement. Outstanding actions were noted to be work in progress and the action plan continued to be monitored closely.

This confirmed to us that the service was being well run and that people's needs were being met appropriately.