Bethphage

Plas Newydd

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?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on 23 April 2018. At our previous inspection in February 2018 we had no concerns in the quality of care and had rated this service as good. At this inspection we found the service being provided was still good. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Plas Newydd is a care home for a maximum of five people who have a learning disability. It provides a service to younger adults, older people, people learning disabilities or autistic spectrum disorder, people with a physical disability and people with a sensory impairment. At the time of our inspection four people were using the service.

No registered manager was in post at the home at the time of our inspection. 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.

People's bedrooms are on the ground and first floors of the home, with bathrooms and toilets on both floors. Due to people's reduced mobility the passenger lift is used to access the first floor rooms.

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. 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.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and we reviewed both areas during this inspection.

There were systems and processes in place to protect people from harm. Risks to people's health and well-being were identified, planned for and managed. People had their medicines administered safely. There was sufficient suitably trained staff on duty to provide people with safe care and support when they needed it. Where incidents had happened, there was learning from these and this was used to help improve staff practice.

People's needs were assessed and staff and other healthcare professionals worked together to ensure good outcomes for people. Staff were trained to support people with their individual needs and were supported in their roles. People were supported to maintain good health and had access to health and social care professionals when necessary.

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

People were supported by staff who treated them with kindness, compassion, respect and dignity. People were supported by staff to express their views where they were able to and have choice over their day to day care.

People received care and support that was centred around them and was individual to their specific needs and preferences. Staff supported people to take part in social activities and lead full and varied lives. Systems were in place which enabled staff to raise concerns on behalf of people. Relatives were able to speak with staff and management about any concerns they had.

The culture of the home was person centred. Staff cared about the people they supported, were knowledgeable about people and they had formed positive relationships with them. The quality and safety of the service was monitored, assessed and when needed, improvements were made.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? 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 was not always well-led. No registered manager was in post although the manager confirmed they would be applying to register with us for this role. Poorly maintained equipment had not been addressed through the provider's quality assurance processes and duty of candour requirements had not been met following one incident. The culture of the home was person centred and staff were clear on what was expected from them.	**Requires Improvement**

Plas Newydd

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 took place on 23 April 2018 and was unannounced. It was completed by one inspector.

Before our inspection visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law.

We also contacted the local authority and Healthwatch for any information they had, which would aid our inspection. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services.

We were not able to speak with people who lived at the service in order to obtain their views and experiences of the care they received due to their communication difficulties. We observed people's care and support in the communal areas of the home and how staff interacted with people. 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 our inspection we spoke with two relatives. We spoke with seven staff which included support staff, team leader, the manager and the area manager. We viewed the care records for two people which included care plans, daily support records, medicine records, consent and the assessment of risk. We also looked at records relating to the management of staff and the service.

Good

Is the service safe?

Our findings

Relatives we spoke with continued to be happy their family member was kept safe and their rights respected by staff. People continued to be protected from the risk of injury or harm by the systems and practices the provider had in place.

Staff confirmed they had received training in safeguarding people from potential abuse. They were able to describe how they would report suspected abuse and how they would be able to recognise it. One staff member said, "They (people) are even more vulnerable because they can't speak out. We have to do this for them and speak up." Staff were confident any concerns would be taken seriously and acted on by the managers. The provider had processes in place in order to report and investigate, where allegations or actual abuse was reported.

People were supported by staff who understood the risks they faced. Risk assessments were in place which gave staff clear direction on how to help keep people safe within and outside the home. One person had recently experienced a number of falls and we saw risk assessments were kept under review and updated to ensure the person was kept as safe as possible.

The provider took action where an incident had occurred that could have or had caused harm to a person. We saw evidence of lessons learnt and improvements put into place following one recent incident. Disciplinary action would be taken where systems and processes were not followed by staff and people were put at risk of harm.

People were supported by sufficient numbers of suitably qualified staff who were able to meet people's needs safely. The amount of staff needed to keep people safe was determined based on each person's individual needs. Where people required additional support, the provider worked with the local authority to ensure this was possible. The provider had recently introduced an "urgent response team" who could provide staffing cover and help to reduce agency use. Staff told us there had been an increase in the use of agency staff over the last year as staff had left employment. The manager confirmed that new staff had been recruited and were waiting to start work.

The provider's recruitment practices continued to protect people from the risk of being supported by unsuitable staff. The area manager confirmed that once recruited, staff's DBS checks would be re-done every three years.

People continued to receive their medicines as prescribed and were supported by staff who underwent checks to assess and monitor their practice. Staff administering medication supported people in a dignified and respectful manner. Staff had access to information about the safe management of people's individual medicines and the support they needed. Medicines were stored securely within people's rooms and staff maintained appropriate records to show when medicines had been given to people.

The cleanliness of the home was maintained by staff. We saw areas of the home were clean, including

communal areas, the bathrooms and toilet. There were appropriate hand washing facilities and staff wore personal protective equipment, such as disposable gloves, as necessary.

Good

Is the service effective?

Our findings

Relatives we spoke with confirmed they were involved in their family member's care and care planning. They confirmed that they were notified promptly about any changes in their family member's care needs and that access to health care professionals was always prompt when needed. Assessments of people's needs were completed to ensure their needs could be met by staff and the home's environment. People's physical and mental health, nutrition, personal care, communication and mobility were assessed and support plans put in place. Health action plans were kept which identified what was needed for each person to remain healthy, including the support which a person may require. People's diversity was acknowledged and assessments took into account people's daily care needs, their social needs, choices and preferences. Effective use of technology at the home meant that people benefitted from increased independence and privacy. Room and bed sensors helped to ensure one person's safety when they were in their room. We saw advice from other healthcare professionals had been sought as required, and that this had been incorporated into people's care plans to promote a consistent and effective approach.

People and their relatives felt that staff had the skills and knowledge to meet their needs. One relative said, "[Person's name] has no verbal communication so can be hard to understand. But staff understand them very well and work with them to make sure they have what they need. They do a good job."

People were supported by staff who had completed training and received appropriate support for their roles. On commencing work at the service new staff were required to undergo a structured induction where training and their practice was kept under review. Staff told us the training they completed was specific to the people they supported and included training to manage people's associated health conditions.

People needs were met by the adaptation and design of the premises; however, the decoration of the home required some updating, which was acknowledged by the manager and area manager. One bedroom was based on the ground floor with an adjacent wet room. Other bedrooms and a communal bathroom were on the first floor and were accessible via the passenger lift. There was enough space within the home for staff to safely manoeuvre wheelchairs and hoists. The home had a communal lounge which was large enough to accommodate all people and staff on duty.

The provider had effective arrangements in place to support people with their nutritional needs and preferences. Any associated risks continued to be monitored and reviewed regularly. Professional advice and assessment, such as Speech and Language Therapy, was sought where required. Staff understood how to support people's individual dietary needs to ensure they maintained a balanced diet and had the support they needed with eating and drinking.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can

only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider followed the requirements in the DoLS and had submitted, as required, applications to the supervisory body for authorisation. The manager told us where these had been authorised there were no conditions attached.

We saw the requirement of the MCA was followed when it came to decision-making. Staff understood how to comply with the MCA and ensure all decisions were made in people's best interests. One staff member told us, "We have to go with what's in their best interests. Thinking about what's best for them." Where people did not have capacity to make specific decisions about their care, appropriate persons, such as family members and healthcare professionals, were consulted. Records associated with decision making on behalf of people were decision specific and timely.

Good

Is the service caring?

Our findings

People continued to be treated with kindness, respect and compassion. One relative told us, "Staff have patience with [person's name]. They know what they like and don't like and treat them with respect and dignity." We saw that all staff interactions with people were positive, caring and meaningful. A core group of staff had worked at the home for a number of years during which time they had got to know people well and had formed positive and trusting relationships with them. Staff knew people's likes, dislikes, wishes and preferences and supported new staff to understand these.

People were supported to express their views where they were able. One relative said, "They (staff) keep me involved. I feel involved and I am kept updated on [person's name] care." Although people at the home had no verbal communication, staff supported them to be involved in day to day decisions as each person had a communication plan which detailed how staff could best support them to express their views and be understood. One staff member said, "Even though they (people) don't have verbal communication, we can still support choices such as picking what music they want to listen to." Staff used gestures and objects to assist with communication. We saw staff support two people to make decisions around what food and drink they wanted. Simple questions were asked and people shown options. One person confirmed they wanted more breakfast and was supported to choose what they wanted by being shown the food boxes. Staff told us they watched people's body language and vocalisation to identify their emotions. One person expressed happiness through vocalisation and would push away from something they did not want. Another person led staff to what they wanted or where they wanted to go within the house.

People were supported to maintain relationships which were important to them such as with friends and family. Staff helped people to visit friends and family and to send cards and presents. One person had an advocate who visited. An advocate acts on behalf of the person to ensure their wishes are respected and decisions made are in their best interests. People's relatives told us when they visited the home, staff were friendly and welcoming.

People's rights to privacy, dignity and independence were supported by staff. Staff ensured people received personal care in the privacy of their own rooms and bathrooms, with doors closed. Signs were hung on bathroom doors to alert staff the room was occupied. Staff told us people's independence was promoted by supporting people to do things for themselves where they could. They were supported hand over hand with some tasks such as making toast or putting a tea bag in their cup. One person was encouraged and supported to hoover their own room and we saw another person encouraged to take their plate to the kitchen sink. Some people had adapted cutlery and crockery to aid their independence.

Good

Is the service responsive?

Our findings

People continued to receive personalised care that was responsive to their needs. Relatives told us staff understood their family member's emotional and physical needs, along with their preferences, interests and personalities. They were happy the care provided by staff was current and relevant to people's care and support needs.

People's strengths and levels of independence were identified through the care planning and review process and appropriate social activities were planned. Staff supported people to lead fulfilled lives in the least restrictive way. One staff member told us they had grown to understand what people liked and did not like because they had worked with them for a number of years. They told us about the wide variety of community-based activities people took part in, which included day trips, social clubs, discos, shopping and trips to the cinema which were autism friendly and organised by a leading learning disability charity.

People's care and support needs were understood by the staff working at Plas Newydd. This was reflected in people's support plans and individual risk assessments and in the attitude and care of people by staff. One staff member said, "We build up a picture of the person and get to know them. We will trial new ideas for what they may want to do. We match staff with people and their interests, this is important for people." Another staff member told us, "We have to work in a very non-judgemental way; we're here for them (people) not for us. It's not what we want it's what is best for them."

People's support plans were reviewed monthly. Each person had allocated staff who worked closely with them to review and update their needs, goals and achievements. We saw staff also reviewed people's health needs and identified appointments that would require booking. One staff member told us they also looked at what was working well for the person and what was not working.

No-one was receiving end of life care at the time of our inspection. We saw staff had started to identify who was to be involved in making decisions around people's care and wishes but this was not completed for everyone. The area manager confirmed that end of life planning had been identified as a required action following a quality audit. They told us they would work with relatives, relevant health professionals and the person's keyworker to ensure people's wishes were identified and respected.

Relatives were confident to raise concerns and complaints and believed that they would be responded to effectively, although they told us they did not need to. They told us they had opportunities to talk to staff and the manager on a regular basis. They also confirmed that staff kept in touch with them and updated them on their family members care and support. People who lived at the home were unable to raise concerns themselves. They therefore relied on staff to act as their advocate and do this on their behalf through the provider's 'feedback policy'. Staff told us they used people's body language to identify their moods and whether they were happy or unhappy. We saw evidence where staff had spoken up on behalf of people to raise concerns around the way their support was delivered. Any complaints received would be responded to in line with the provider's complaints processes.

Requires Improvement

Is the service well-led?

Our findings

The provider is required to have a registered manager in post but they had left employment in February 2018. A new manager had been in post since this time and confirmed they will be applying to register as the registered manager in the near future. They had recently applied for their enhanced DBS and was waiting for this to be completed. 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.

Relatives we spoke with were aware of the change of management within the home. The new manager completed a structured induction period which included shadowing and building links with other Bethphage registered managers. They had been supported in their role by the area manager who undertook regular support visits.

Since our last inspection the home has had three different managers. Staff told us this had been difficult, especially with some long term staff leaving but they now felt the new manager had bought stability back to the home. One staff member told us, "I've noticed a massive improvement in the culture since [manager's name] has come." Another staff member said, "Things are on the up now, it's what we needed."

There continued to be a positive culture at the home which was centred around the people who lived there. The atmosphere was inclusive, relaxed and friendly. This was demonstrated through our observations and discussions with staff.

During our inspection visit we found two cupboards containing hazardous substances were left unlocked by staff. We also found a fridge with one food item out of date and a bowl of prepared food which had no date on it. At the time no people were present in the house and the risk to people was minimal because they were not able to access this area unaccompanied. We also found rust and chipped paint on a shower chair and toilet frame and a soiled shower sling in one bathroom. Defects such as these have the potential to harbour germs. The manager took immediate action to address these issues. They assured us a new shower chair and toilet frame would be ordered as a priority. We were therefore assured there was no on-going risk to people. Following our visit, the Operations Director confirmed the replacements had been ordered.

The provider had systems in place to assess, monitor and report on the quality of care provided at the home. Staff and the manager had responsibility for completing regular audits around the home. These audits covered all aspects of service delivery including care plans and associated records, medicines, health and safety of the environment, equipment and monitoring staff performance. However, they had not identified or addressed the infection control risk from the poorly maintained bathroom equipment. The provider's senior managers completed visits and quality checks at the home. Areas for improvement were identified and actioned in a timely way. The manager had identified improvements were needed in record keeping and this was evident from some records we viewed.

We also became aware where the provider had not followed the requirements for duty of candour following an incident at the home. This had occurred before the current manager had started employment. The manager and area manager confirmed this was an oversight and told us, "This is not common practice." The manager took action during our inspection visit to rectify this and we were satisfied with the actions taken. The provider and board of trustees were kept up to date on key information about the service which was collated and shared on a regular basis through reports and meetings. A board of trustees act collectively to help govern charities and take decisions. The board of trustees for Bethphage are also directors of the company.

Where required statutory notifications had been sent to us to keep us informed of specific events that have happened at the service. The registered persons are required by law to submit these statutory notifications. These ensure that we are aware of important events and play a key role in our on-going monitoring of services. We saw the last inspection report was displayed at the home as required.