Community Integrated Care

Gordon House Care Home

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 unannounced inspection was conducted on 16 May 2016.

Situated in North Liverpool and located close to public transport links, leisure and shopping facilities, Gordon House is registered to provide accommodation for up to 20 younger adults with severe or enduring mental health conditions. At the time of the inspection 18 people were living at the home. The location is a purpose-built, single storey property with single bedrooms and shared bathroom facilities.

A registered manager was in post. 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. The registered manager was not available on the day of the inspection; however operational management responsibilities were shared with a colleague who was available throughout.

All of the people that we spoke with told us that they felt safe living at Gordon House. We saw that people were kept safe because staff were vigilant in monitoring behaviours and indicators of abuse.

People living at the home had detailed care plans which included an assessment of risk. These were subject to regular review and contained sufficient detail to inform staff of risk factors and appropriate responses. In the care records that we looked at risk had been recently reviewed.

Throughout the inspection we saw that, in accordance with their care plans, people were free to leave the building and return as they chose. There was no requirement for people to sign in or out of the building or inform a member of staff. This meant that staff could not be certain who was in the building at any given time.

The home had conducted regular fire drills and testing of fire alarms and other emergency equipment. Emergency equipment was serviced annually in accordance with requirements. The fire risk assessment had been reviewed annually. Safety checks were also completed regularly on water temperatures, legionella and gas and electrical safety.

Staffing were recruited safely and deployed in numbers which were generally adequate to meet the care needs of people living at the home. However it was apparent that people were left without obvious access to staff support at various points throughout the inspection.

People's medication was stored and administered in accordance with good practice. We spot-checked medicines administration records and stock levels for each of the people living at the home. We saw that records were complete and that stock levels were accurate.

Staff were suitably trained and skilled to meet the needs of people living at the home. The staff we spoke with confirmed that they felt equipped for their role. The training matrix and staff certificates showed that training was in date.

The records that we saw showed that the home was operating in accordance with the principles of the MCA. Capacity assessments were decision-specific and were focused on the needs of each individual. None of the people living at the home at the time of the inspection was being deprived of their liberty although staff demonstrated that they understood the MCA and DoLS well.

Food was prepared from fresh ingredients, well presented and nutritionally balanced. People's preferences, allergies and health needs were recorded and used in the preparation of meals, snacks and drinks.

The people that we spoke had a good understanding of their healthcare needs and were able to contribute to care planning in this area. All staff spoke of having good links with community mental health teams, crisis services and psychiatrists and there was evidence seen in the care records of regular meetings taking place with the views of the person clearly recorded.

Throughout the inspection we saw staff engaging with people in a positive and caring manner. Staff took time to listen to people and responded to comments and requests. Staff spoke with people before providing care to explain what they were doing and asked their permission.

Each of the people living at the home that we spoke with said that they were encouraged and supported to be independent. Throughout the inspection we saw people moving around the building independently and engaging in activities of their own choosing.

Each of the people living at the home that we spoke with told us they received care that was personalised to their needs. We saw that staff delivered care in a different way to each person. People's preferences and personalities were reflected in the décor and personal items present in their rooms.

Each of the people that we spoke with confirmed that they had been involved in their own care planning and felt that they were able to make decisions about their care. We saw clear evidence in care records that people had been involved in the review of care.

People were supported to follow interests and access activities on an individual basis as part of their care. Staff also organised group activities to reduce social isolation.

Information regarding compliments and complaints was clearly displayed and the provider showed us evidence of addressing complaints in a systematic manner. All of the people that we spoke with said that they knew what to do if they wanted to make a complaint.

Staff were able to access bi-monthly team meetings where important topics were discussed. We saw evidence that discussions regarding quality and feedback from people living at the home had taken place.

The home had a clear vision and values. Each member of staff that we spoke with was able to explain that the home existed to provide a safe place for people to live and to provide a platform for recovery.

Staff were motivated to provide good quality care and were well supported by the provider. They understood their roles and responsibilities and what was expected of them regarding the provision of care and general conduct.

The provider had systems in place to monitor safety and quality and to drive improvements. We saw evidence of a quality assurance programme which detailed requirements and themes for each month. The registered manager and other senior managers completed a series of audits which included information that was fed-back to the staff team.

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 living at the home had detailed care plans which included an assessment of risk. These were subject to regular review and contained sufficient detail to inform staff of risk factors and appropriate responses.

Staff were recruited following a robust process and deployed in sufficient numbers to meet the needs of people living at the home.

Medicines were stored and administered in accordance with best-practice guidelines.

Is the service effective?

Good

The service was effective.

Staff were trained in topics which were relevant to the specific needs of the people living at the home and were supported through regular supervision.

People were provided with a balanced diet and had ready access to food and drinks. Staff supported people to maintain their health by engaging with external healthcare professionals.

Is the service caring?

Good

The service was caring.

We saw that people were treated with respect and compassion throughout the inspection.

Staff knew each person and their needs and acted in accordance with those needs in a timely manner. People's privacy and dignity were protected by the manner in which care was delivered.

People were involved in their own care and were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People living at the home were involved in the planning and review of care on a regular basis.

People's preferences for the provision of care were recorded and reviewed on a regular basis.

Procedures for the receipt and management of complaints were robust.

Is the service well-led?

Good

The service was well-led.

The home had a clear vision and values which were understood by a motivated staff team. Care was provided in accordance with the vision and values.

The provider had systems in place to monitor safety and quality and to drive improvements. They completed regular audits which included information to feedback to the staff team.

The home maintained records of notifications to the Care Quality Commission and safeguarding referrals to the local authority. Each record was detailed and recorded outcomes where appropriate.

Gordon House Care 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 inspection took place on 16 May 2016 and was unannounced.

The inspection team consisted of an adult social care inspector, a specialist advisor in nursing care and an expert by experience in mental health. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the local authorities who commission services at the home. We used all of this information to plan how the inspection should be conducted.

We observed care and support and spoke with people living at the home and the staff. We also spent time looking at records, including four care records, four staff files, 18 medication administration record (MAR) sheets, staff training plans, complaints and other records relating to the management of the service. We contacted social care professionals who had involvement with the service to ask for their views.

On the day of the inspection we spoke with seven people living at the home and three relatives. We also spoke with an operational manager, one nurse and three other staff.

Good

Is the service safe?

Our findings

All of the people that we spoke with told us that they felt safe living at Gordon House. One person said they felt safe because their mental health had improved so much since moving to the home. The relatives that we spoke with were equally positive. When asked about safety one family member said, "[Relative] is now in a good environment that can manage [their] needs and care."

We saw that people were kept safe because staff were vigilant in monitoring behaviours and indicators of abuse. Staff had received training to help them recognise when people were becoming more anxious and to de-escalate situations. Staff had also received training in safeguarding and were able to demonstrate a good understanding of local safeguarding procedures. The home displayed information regarding safeguarding and whistle-blowing in different parts of the building.

We asked people living at the home what they would do if they were being treated unfairly or unkindly. They each said that they would complain to the manager or the senior staff. Relatives also told us that they would speak to senior members of staff or the manager if they had any concerns. The home displayed a range of information which encouraged people to speak-out if they were concerned about any aspect of their care.

People living at the home had detailed care plans which included an assessment of risk. These were subject to regular review and contained sufficient detail to inform staff of risk factors and appropriate responses. In the care records that we looked at risk had been recently reviewed. We saw that risk assessments had also been reviewed and care plans amended following incidents. There was clear evidence that people had been involved in the review of risk in each of the care records that we saw. There was also evidence that the provider sought advice and input from other healthcare professionals to help manage health conditions and reduce risk. When asked how the home kept people safe the operational manager said, "We make sure staff are well-trained, we assess prior to people moving in then it's about good support planning, good handovers and good communication."

Throughout the inspection we saw that, in accordance with their care plans, people were free to leave the building and return as they chose. There was no requirement for people to sign in or out of the building or inform a member of staff. This meant that staff could not be certain who was in the building at any given time. This could prove dangerous if people failed to return or in the event of a fire. We spoke with the joint operational manager and the assistant service manager about the risks that this practice presented to the people themselves and the staff team. They explained that while they understood the risks, people were unlikely to respond positively to any request to sign in and out of the building. They told us that they would look at ways to monitor people's presence in the building more effectively.

Accidents and incidents were accurately recorded and were subject to assessment to identify patterns and triggers. Records were maintained on an electronic database which automatically shared important information with senior managers. Records were detailed and included reference to actions taken following accidents and incidents.

The home had conducted regular fire drills and testing of fire alarms and other emergency equipment. Emergency equipment was serviced annually in accordance with requirements. The fire risk assessment had been reviewed annually. The home had a dedicated smoking room with good ventilation. Staff were vigilant in monitoring one person who was known to smoke in their room. The home had been assessed as compliant for fire safety by Merseyside Fire and rescue Service in January 2015. The original assessment had identified one minor concern which had been addressed by the home within seven days.

Safety checks were also completed regularly on water temperatures, legionella and gas and electrical safety. Gas and electrical safety was checked by qualified engineers as required.

Staffing numbers were adequate to meet the care needs of people living at the home. The provider based staffing allocation on the completion of a dependency tool. We observed staff providing care and saw that there were usually sufficient numbers of staff available to keep people safe and respond to their needs. However, we saw that people were left with minimal levels of staff supervision and support at various points throughout the inspection. We spoke with the joint operational manager and assistant service manager about this. They explained that people's safety was not compromised because all of the people living at the home had a high degree of independence and staff were available in other parts of the building. We checked and confirmed this was in accordance with their care plans and risk assessments.

The home recruited staff following a robust procedure. Staff files contained a minimum of two references which were obtained and verified for each person. There were Disclosure and Barring Service (DBS) numbers and proof of identification and address on each file. DBS checks are completed to ensure that new staff are suited to working with vulnerable adults.

People's medication was stored and administered in accordance with good practice guidelines. We spot-checked medicines administration records and stock levels for each of the people living at the home. We saw that records were complete and that stock levels were accurate. We were told that nobody currently living at the home required covert medicines. These are medicines which are hidden in food or drink and are administered in the person's best interest with the agreement of the prescriber. Controlled drugs were stored safely and associated records were completed correctly. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation. We saw evidence of good PRN (as required) protocols and records. PRN medications are those which are only administered when needed for example for pain relief. We saw that the provider used body charts to indicate where topical medicines (creams) should be applied. Records relating to the administration of medicines were detailed and complete. A full audit of medicines and records was completed regularly.

Good

Is the service effective?

Our findings

Staff were suitably trained and skilled to meet the needs of people living at the home. The staff we spoke with confirmed that they felt equipped for their role. The training matrix and staff certificates showed that training was in date. The completion rate for training required by the provider was recorded as 100%. Staff were given additional training which related to the specialist needs of people living at the home. For example, training was provided in cognitive behaviour therapy.

New staff were trained and inducted in accordance with the principles of the care certificate. The care certificate requires new staff to undertake a programme of learning before being observed and assessed as competent by a senior colleague. Staff spoke highly of their induction training and the support offered by the home. All staff that we spoke with confirmed that they had been given regular supervision. We saw that this was recorded in staff records.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The records that we saw showed that the home was operating in accordance with the principles of the MCA. Capacity assessments were decision-specific and were focused on the needs of each individual. None of the people living at the home at the time of the inspection was being deprived of their liberty although staff demonstrated that they understood the MCA and DoLS well.

We sat with people and sampled a meal at lunchtime in the main dining room. People ordered and collected their own food from a serving hatch. None of the people living at the home required direct assistance to eat their meal. The food was prepared from fresh ingredients, well presented and nutritionally balanced. People's preferences, allergies and health needs were recorded and used in the preparation of meals, snacks and drinks. For example, one person asked for a burger which was provided as an alternative to the standard choices on the menu. Alternatives were available to each main meal however the menu was not prominently displayed. The cook demonstrated a good knowledge of the dietary requirements of each person and used this information in the preparation of meals and drinks. The kitchen had recently been awarded a rating of five out of five for food hygiene. The home had also developed two training kitchens. We saw that one person chose to shop for their own food and prepare it with staff support. Another person told us, "I can cook for myself. I enjoy a sirloin steak."

The people that we spoke with had a good understanding of their healthcare needs and were able to

contribute to care planning in this area. For those people who did not understand the provider had identified a named relative or advocate to communicate with. We asked people if they had good access to primary healthcare services. People told us they saw healthcare professionals when needed. Information about visits to primary healthcare services was kept on care records. People also accessed specialist services. All staff spoke of having good links with community mental health teams, crisis services and psychiatrists and there was evidence seen in the care records of regular meetings taking place with the views of the person clearly recorded.

Good

Is the service caring?

Our findings

Throughout the inspection we saw staff engaging with people in a positive and caring manner. Staff spoke to people in a respectful way and took time to ensure that people understood and were comfortable with what was being said. People told us, "Staff always have a lot of time for me" and "nothing is ever too much". One relative commented, "The staff are fond of the residents."

Staff took time to listen to people and responded to comments and requests. One person said, "Since being here I have been able to open up." We saw staff providing appropriate physical contact and re-assurance where required. Staff at all levels demonstrated that they knew the people living at the home and accommodated their needs in the provision of care.

Staff spoke with people before providing care to explain what they were doing and asked their permission. Where people didn't respond staff repeated or re-worded the question to ensure that the person understood. For example, we heard a member of staff discussing the dangers of a person smoking in their bedroom. The staff member was very clear, but re-assuring and took time to ensure that the person understood the risks. We checked the care record for this person and saw that the conversation was in accordance with guidance in their latest risk assessment. We also saw that people declined care at some points during the inspection and that staff respected their views.

People's privacy and dignity were respected throughout the inspection. In one instance we saw that a person had chosen to stay in their pyjamas and dressing gown after breakfast. Staff were able to explain that this helped the person to feel comfortable and manage their anxiety. This approach was reflected in the person's care record. Although the people that we saw during the inspection were independent, staff remained attentive to people's needs regarding personal care. For example one person was gently encouraged to wash their hands and face after eating their lunch. When we spoke with staff they demonstrated that they understood people's right to privacy and the need to maintain dignity in the provision of care. We saw that staff knocked on people's doors and explained why they were there before entering rooms.

Each of the people living at the home that we spoke with said that they were encouraged and supported to be independent. Throughout the inspection we saw people moving around the building independently and engaging in activities of their own choosing. People had access to the local community and went out for walks and to do personal shopping throughout the inspection. Staff supported people to develop the skills that that would need to live independently. For example we heard a conversation with one person regarding budgeting shopping and cooking. The staff member provided support and prompting to ensure that the person had considered all of the relevant factors before making a final decision. The person later collected and signed for their money, shopped for the items and prepared their own meal.

Confidential information was securely stored. Care records and daily notes were respectfully worded and used language which was person-centred. The home was in the process of transitioning from one style of care record to another. We saw that the older care records were more clinical in their language. The

assistant services manager confirmed that the need to evidence a more person-centred approach was one of the reasons that the new records were being introduced.

We spoke with visiting relatives during the inspection. They told us that they were free to visit at any time. One relative said, "Staff are friendly and have the time to talk to me, they are not going through the motions they genuinely care."

The service displayed information promoting independent advocacy services. Each of the people living at the home was able to represent themselves or had a nominated relative or advocate to act on their behalf.

Good

Is the service responsive?

Our findings

Each of the people living at the home that we spoke with told us they received care that was personalised to their needs. We saw that staff delivered care in a different way to each person. For example, some people required regular observation to ensure their safety while others preferred a higher level of independence. One person told us, "Staff always have a lot of time for me." Staff were able to tell us which approach was best suited to which person and why. This information was reflected in care records.

People's preferences and personalities were reflected in the décor and personal items present in their rooms. Important items and photographs were prominently displayed.

We asked people if they had been involved in their care planning and if they were able to make decisions about their care. Each of the people that we spoke with confirmed that they had been involved in their own care planning and felt that they were able to make decisions about their care. We saw clear evidence in records that people had been involved in the review of care.

We observed that care was not provided routinely or according to a strict timetable. Staff were able to respond to people's needs and provided care as it was required. Throughout the inspection we saw staff responding to people's immediate needs as well as completing planned activities.

We asked people living at the home if they had a choice about who provided their care. None of the people that we spoke with expressed concern about their choice of carers. We saw evidence that people's preferences for the gender of care staff was recorded in care records. Each care record contained a section which listed relationships with others (including staff) and how these impacted on individuals, whether positive or negative.

People were supported to follow interests and access activities on an individual basis as part of their care. However, one person told us that they had been unable to go on their preferred activity because their keyworker had not been in work. We spoke with the joint operational manager and were able to confirm that the activity was to be re-started shortly. We also saw evidence that the home had promoted group activities and themed events for example, a 'chippy' night. This was organised as a social activity to encourage some people who were more isolated to share a meal.

Information regarding compliments and complaints was clearly displayed and the provider showed us evidence of addressing complaints in a systematic manner. All of the people that we spoke with said that they knew what to do if they wanted to make a complaint. The staff that we spoke with knew who to contact if they received a complaint. Compliments and complaints had been recorded and analysed.

The home completed satisfaction surveys and asked for comments and suggestions on a regular basis. The results were analysed and shared with people living at the home and their families. The home also promoted other methods for people to share their views. Posters encouraging people to speak-out were displayed throughout the home. From the records we saw the majority of views expressed about the home

were positive.

Good

Is the service well-led?

Our findings

Staff were able to access bi-monthly team meetings where important topics were discussed. We saw evidence that discussions regarding quality and feedback from people living at the home had taken place. The staff that we spoke with were positive about the quality and frequency of communication and felt involved in decisions about the home. We saw evidence of meetings with people living at the home and staff about a recent re-structure and plans for the refurbishment of the home. People's views were recorded in the notes from the meetings.

Some care records were poorly organised and contained out of date information. This meant that it would be difficult for new staff to access the most current, relevant information. The home was working with an external specialist in person-centred planning to improve care records by increasing the use of personalised language and was changing to a new set of templates. The joint operational manager said that the home would take the opportunity to review the contents and structure of care records as part of the process.

The home had a clear vision and values. Each member of staff that we spoke with was able to explain that the home existed to provide a safe place for people to live and to provide a platform for recovery. Staff also said that the home helped people to move to more independent living. The joint operational manager told us, "It's a very open, transparent and chilled service. Relationships between people and staff are brilliant." One relative described it as, "A good environment."

Staff told us they felt confident to question practice although each person said they had not had reason to do so. Staff told us that they felt confident in speaking to senior staff or reporting outside of the home if necessary. They were able to explain what steps they would take if they needed to whistleblow. Information about whistleblowing was displayed in the home and was available through the provider's intranet.

Staff were motivated to provide good quality care and were well supported by the provider. They understood their roles and responsibilities and what was expected of them regarding the provision of care and general conduct. In addition to the information and support available within the home, each member of staff had access to a secure electronic account where they could access information about their employment, training and developments within the organisation.

While the registered manager was not available during the inspection it was clear that the joint operational manager and other senior staff actively engaged with people and their care. We saw that all staff prioritised the needs of people and made themselves available throughout the inspection. People living at the home were clearly very comfortable with approaching staff and managers to ask questions, receive care or just chat.

The provider had systems in place to monitor safety and quality and to drive improvements. We saw evidence of a quality assurance programme which detailed requirements and themes for each month. The registered manager and other senior managers completed a series of audits which included information that was fed-back to the staff team. Areas assessed during these audits included safeguarding and

medication. The records that we saw indicated that all audits had been completed in accordance with the provider's schedule. However, audits had failed to identify that some records, for example care records, were poorly organised which sometimes made it difficult to access the most recent information. We spoke with the joint operational manager and assistant service manager about this and the risk that it may present for new staff. They acknowledged that some records would benefit from cleansing to remove older information.

The home maintained records of notifications to the Care Quality Commission and safeguarding referrals to the local authority. Each record was detailed and recorded outcomes where appropriate. The home had submitted a significantly lower number of notifications than would be expected. We spoke with the joint operational manager about this and looked at relevant records. We were assured that notifications had been submitted as required and that the frequency of significant incidents was genuinely low.