Sunderland City Council

Sunderland City Council - 2 Fenwick Close

Inspection report

2 Fenwick Close, Litchfield Road
Southwick
Sunderland
Tyne and Wear
SR5 2AH

Tel: 01915493875
Website: www.sunderland.gov.uk

Date of inspection visit:
20 June 2016
22 June 2016

Date of publication:
12 July 2016

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 inspection took place on 20 and 22 June 2016. Day one of the inspection was unannounced; this meant the provider did not know we would be visiting. Day two was announced. We last inspected Sunderland City Council - 2 Fenwick Close on 19 June 2014 and found it was meeting all legal requirements we inspected against.

Sunderland City Council - 2 Fenwick Close provides care and support for up to three people who have a learning disability. The home is one of three homes situated in its own small close that is set in its own landscaped grounds. There is one manager responsible for the management of all three homes in Fenwick Close. They have an office base on the close. The close is for the sole use of people living there, their families and staff. The home does not provide nursing care. At the time of the inspection there were two people living at the service.

The manager had been in post since February 2015. At the time of the inspection they were not registered with the Care Quality Commission. The last registered manager cancelled their registration on 18 April 2016.

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 manager was aware of their responsibilities in managing the service and ensuring a quality assurance system was in place to ensure people received high quality care. They said, "I want people to have the best lives they can."

A relative told us communication from the staff and manager was good, and they felt involved in planning their family members care and support.

Care plans and routines were person centred and contained detailed information about the times staff needed to offer support and how this should be managed. Where people were able to support themselves this was identified so staff were able to support people to maintain some independence.

Risks to people had been appropriately assessed and measures were in place to minimise and manage any risks. Risk management plans included emergency contingency plans should they be needed.

Staff knew people well, and had the training, skills, knowledge and experience to support people in an appropriate and safe manner. Staff told us they were well supported by the manager and they attended regular team meetings were they could raise any issues.

People had authorised Deprivation of Liberty Safeguards (DoLS) in place and understood what they meant

for peoples' care. Best interest decisions were recorded within the DoLS authorisation. Some restrictions were in place but they followed the principles of the Mental Capacity Act and were the least restrictive options.

Staff had warm and caring relationships with people and knew how to safeguard them from harm and abuse. Reporting mechanisms were in place but they had not been needed. Complaints policies and procedures were also in place; again these had not been needed.

Staffing levels meant people could be supported appropriately. A relative and staff told us staffing levels were sufficient to meet people's needs. Some staff said they needed more clarity about roles and responsibilities. The manager explained this was due to a recent restructure but work was being done on this.

Safe recruitment practices were in place. People had attended training in recruitment so they could be part of the process of interviewing for new staff.

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.

Medicines were managed safely. People had specific routines they liked staff to follow when supporting them with their medicines.

Risk management plans were in place and included emergency contingency plans.

Staffing levels were such that they met the needs of the people supported.

Is the service effective?

Good

The service was effective.

Staff understood mental capacity and Deprivation of Liberty Safeguards. Best interest decisions were recorded and least restrictive options for supporting people in a safe way were adhered to.

People were supported to access specialist support in relation to their nutritional needs.

Staff said they were well trained and had the skills and knowledge needed to support people.

Is the service caring?

Good

The service was caring.

Staff knew people well and understood their needs.

People were supported in a compassionate and engaging manner.

Relatives said they were involved in their family members care and communication was good.

Is the service responsive?

Good

The service was responsive.

Person centred routines and care plans were in place to ensure people were supported in a way which reflected their needs and preferences.

Activities formed part of people's routines and were based around peoples likes.

Pictorial information was available for people on how to complain. One relative said, "There's been no need (to complain)."

Is the service well-led?

Requires Improvement

The service was well-led.

Staff and relatives said the manager was supportive and committed to the needs of people.

Quality assurance systems were used to identify areas for improvement.

A range of meetings were held to support learning and sharing of best practice.

Sunderland City Council - 2 Fenwick Close

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 20 and 22 June 2016. Day one of the inspection was unannounced. This meant the provider did not know we would be visiting. Day two was announced.

The inspection team was made up on one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We also contacted the local authority commissioning team, and the safeguarding adult's team. We did not receive any information of concern.

During the inspection we spent time with the two people living at the service. We contacted one relative by telephone. We also spoke with the manager, one senior care staff, and three care staff.

We reviewed both people's care records and two staff files including recruitment, supervision and training information. We reviewed medicine records, as well as records relating to the management of the service.

Due to the complex needs of some of the people living at Sunderland City Council - 2 Fenwick Close 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.

Good

Is the service safe?

Our findings

Due to the complex needs of some people we were not able to directly ask them if they felt safe living at the service. We spoke with one person's relative who said, "I know my [family member] is safe by the way they present. I can tell by the way they are around people; it's obvious if they aren't happy or are unsure. I can see they aren't nervous."

Staff understood how to keep people safe. One staff member said, "I've done safeguarding recently, an in house questionnaire. I would go to the senior or management and follow the protocol." They added, "I would monitor any bruising or scratches, was it accidental? Look for anything out of the ordinary, ask people what happened." Staff had access to guidance and there was a log for recording the date of the allegation, the nature of the alert, the immediate action taken, any follow up action and the outcome. There had been no safeguarding concerns however a procedure was in place for reporting, recording and investigating concerns.

We asked staff if they felt there were sufficient staffing levels to meet people's needs. Staff confirmed there were enough staff but some clarity over roles and responsibilities was needed due to a recent restructure. One relative said, "Yes there's enough staff." They explained that the number of staff needed to support people varied according to the familiarity of the environment. They added, "It reassures [family member] to know the staff are there." Staff explained that overnight the staffing levels were reduced. The manager said, "People don't really need support overnight unless there's an emergency. Everything is risk assessed and protocols are in place." There was a protocol for an emergency whereby staff from one of the neighbouring homes would be contacted for support. These staff knew the people and had been appropriately trained to provide support if needed. We did not see any instances where people had needed additional support overnight.

In the event of a night time fire evacuation a procedure was in place. One staff member said, "Both [people] know what to do." Another staff member said, "We do regular questionnaires and tests on fire training. Both [people] understand the alarm, they know how to evacuate. [Person] leaves straight away, [person] is a little more reluctant but they do know what to do."

A fire safety file was in place which included an evacuation plan for each person, a fire risk assessment and a fire log book which had been completed appropriately. There was also evidence of current servicing of the fire alarm system and emergency lighting. Portable appliance testing had been completed and electrical and gas safety certificates were in place.

A business continuity plan was in place, dated February 2016. This included information on the action to take in emergencies such as loss of accommodation, loss of heating and loss of cooking facilities. Emergency information sheets and missing person's sheets were also included in people's care records. These documented vital information staff needed to know in the event of an emergency.

Risk management plans were in place and were detailed and up to date. Where people experienced

difficulties with swallowing, dysphagia risk management plans for choking had been written by the speech and language therapist. The management plans included a description of the difficulties the person experienced, potential triggers and how the risk should be managed.

Risks had been assessed in relation to people needing foot care from the chiropodist and visits from hairdressers. Control measures had been identified and emergency contingency plans were in place. Bathing risk assessments were in place and detailed information in relation to how people's behaviour should be interpreted. For example, that shouting could be interpreted as behavioural rather than the person indicating the water temperature was wrong so it was important for staff to ensure the correct temperature was maintained.

Medicines management was well recorded and included risk assessments. Detailed 'My medicine routines' recorded how people should be supported to take their medicines. Staff understood people's preferences and how to support them. One staff member said, "It's part of their routine. The TV is on and sometimes they will take medicines from the pot, other times we put it in their hand. The second staff member is always ready with a coffee straight away after they take their medicines." They added, "They are compliant more often than not, but sometimes a change of face works." They explained, "[One person] reminds us about their cream and will chase staff to do it."

Medicines were administered using a monitored dosage system (MDS) system. This is a system whereby the pharmacist puts medicines into specific pods dependant on the time of administration. Medicine administration records were pre-printed by the pharmacy and completed by staff when medicines were given to the person. There were no gaps on the MARs. Regular stock checks and audits were completed which showed there were no concerns with medicines.

Accident and incident reports were completed. The manager said, "They are sent to the health and safety team and we get information back." They showed us a spreadsheet which recorded the number and type of incidents each month and said, "It shows a reduction in the number of incidents." The manager went on to say, "The group meets every other month and we look for lessons learnt and triggers."

Recruitment procedures included an application form and interview. Two satisfactory references were required along with a clear disclosure and barring service check (DBS). DBS checks are used to support providers to make safe recruitment decisions about staff who will be working with vulnerable adults. DBS checks were renewed every five years and the manager explained they were introducing an annual disclaimer where staff were required to declare any new convictions.
We saw this procedure had been followed which meant safe recruitment practices were in place.

The manager said, "We need to be careful to choose staff with the right values. Customers [people] have been trained in recruitment. At panel interviews we invite people to be involved. We use videos and customers [people] talking about what they want from staff – knowledge, empathy, which is used to recruit our staff." They added, "We have recruitment evenings and events to stress the importance of the job and the role staff play in people's lives. Customers [people] attend these events."

Good

Is the service effective?

Our findings

We spoke with staff about the training and support they received to enable them to support people appropriately. One staff member said, "Support is good, you can really say what's needed, we are confident to question things." Another staff member said, "Supervisions are done by the senior or [manager]." A third staff member said, "Supervisions and appraisals are always done." We saw people attended regular supervision meetings and had an annual appraisal where their performance was appraised. The manager said, "I do observations, and work alongside colleagues. I need to have a presence and observe communication and engagement. I ask colleagues for their views about staff and value appraisals as it's the only time you get to go through the good stuff and project the good things for the next year. We need to recognise the achievement of staff."

One staff member said, "I moved from a different service and got a full induction here." They added, "I was given time to go through the protocols and the care plans." Another staff member said, "We are well trained." A third staff member said, "I've done, medicines, moving and assisting, but it's not needed here, safeguarding, mental capacity, PMVA, they are all up to date." PMVA is prevention and management of violence and aggression training. The training included how to recognise triggers for behaviour, how to de-escalate situations using distraction, physical and non-physical strategies to manage behaviour and de-briefing techniques.

Another staff member said, "I'm completely up to date with my training. We all do control and restraint and full PMVA training at number two." Another staff member said, "We complete ABC charts for any physical restraint and scatter charts for any behaviour like nipping." They added, "There are full de-briefs for staff after any incident."

Staff were aware of some of the triggers for behaviour, such as the time in between routines and activities. One staff member said, "We use the scatter charts and you can see the trigger times." They added, "We use redirection techniques. There's a rigid routine for staff so no one is left in a vulnerable position." Another staff member said, "We work well together, behaviour may be cyclical but distraction works well, such as looking at photos or soap operas." They added, "We use charts to record behaviours, there's a risk management plan and we always have a debrief to look at why incidents happen. We are always learning about people."

A third staff member said, "We use full PMVA [restraint] sometimes. For example, someone was starting to refuse [a certain aspect of their care] so we looked at whether they had capacity. They didn't so we looked at what was in their best interest for their care which everyone agreed was to [continue with this aspect of their care]." The staff member explained that this aspect of the persons care was now part of their routine which had been care planned, risk assessed and included in the persons Deprivation of Liberty Safeguards (DoLS) authorisation as it involved some aspects of restraint.

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 so that they can 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).

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. The provider had submitted applications for all the people living at the service, all of which had been authorised. Staff understood the need to follow the requirements of the DoLS.

Some restrictions were in place in order to support the management of risk. The restrictions were recorded as being in people's best interest; they were the least restrictive option and involved consultation with all the relevant people. Best interest decisions had been made with the involvement of relevant others, such as family members, healthcare professionals and the staff from the service. Restrictions were recorded within the DoLS authorisation.

We asked staff about capacity and decision making. One staff member said, "People lacking capacity can't make decisions. DoLS gives permission to make best interest decisions for people. We offer support with the decision and involve the family. It all has to be done in people's best interest."

People were supported to have a healthy well balanced diet. Speech and language therapy (SALT) guidelines were in place for one person who had specific requirements around meals and nutrition. One staff member was able to explain people's dietary needs and said, "It's all about knowing [person]." The manager was able to describe a situation where a relative had been involved in the care planning around a person's nutritional need. They explained how they had made a suggestion for how to support the person which had worked really well.

Another staff member had explained how people weren't always able to say if they were feeling unwell, but there were some indicators such as rubbing their belly or using Makaton to sign doctor or dentist. Makaton is a form of sign language used by some people with learning disabilities to support communication. The staff member said, "We are probably over cautious in relation to GP involvement but it's best to be safe."

Records of appointments and discussions with health care professionals were recorded. This included appointments with GPs, dietitians, SALT, dentists and chiropody.

Good

Is the service caring?

Our findings

We asked a relative whether they were happy with the care their family member received. They said the staff are good, they do a really good job."

We asked staff about the people they supported. One staff member said, "[Person] is a pleasure." They added, "[Person] is a great guy." Another staff member said, "I know them really well, I love them to bits." They added, "[Person] is a loveable chap, kind, makes you smile and laugh. They added, "[Person] has a lovely smile. You learn as you get to know people, learn their expressions and what it means."

Another staff member said, "There's a really pleasant atmosphere and it's a really nice place to work, it's like being a family member." They added, "The [people] are lovely, they give you cuddles, they are funny, they have really good sense of humour."

We saw one person was in the front garden area directing staff about where they wanted plants to be put. Staff were responsive to the persons gestures and engaged them in the activity. They chatted in short sentences about what they were doing and used the person's name regularly so they knew they were involved in the conversation.

One person joined us in the manager's office for lunch. They were made very welcome and were clearly comfortable in the environment, sitting where they chose and interacting with the manager.

Particular attention was paid to ensuring the person's glasses were clean and making sure they had anything they needed. For example, they wanted to have a drink but were asked if they wanted it to be cooled down. The manager said they asked this because, "Sometimes they like it cooled, other times they like it hot." The person was encouraged to eat their lunch but when they were not eating it they were asked if they wanted something else, which they did. The staff asked if they wanted to go back home to make something else for lunch.

People freely accessed the office, choosing to spend time with us and the manager. One person offered us their glasses for cleaning and the manager responded immediately by cleaning them and checking the person had their hearing aids in. The person was clearly comfortable and confident in their surroundings, offering appropriate touch and engaging in chatter about activities and plans. We observed warm and respectful relationships. When the person expressed some distress they were reassured and comforted.

People had their own personalised spaces within the house and the communal lounge reflected both people's personalities and interests. One person showed us around their home and gave permission for us to have a look in their room which reflected their likes and interests. The other person did not give permission for us to see their room and this was respected by the staff. The manager said, "Staff respect people's views and people know that. [Person] knows that if he says no it means no and he doesn't need to show any behaviour to reinforce his view as staff listen and respond."

People had access to information on advocacy but did not currently have the involvement of an advocate. Family members were very active in people's care. One staff member said, "There's lots of family involvement, it's part of the routine." One relative said, "I visit as part of the routine, but staff keep in touch. I want to know about [family members] behaviour, their health and the activities they do." They went on to say, "Communication is good. We have good relationships, it feels like we all have the same understanding and they know I'm here in [family members] best interest." They also said, "I have meetings with the staff every six to eight weeks. I say what [family member] likes or if I have any suggestions on what they would like to do. I have lots of involvement around health."

'Customer meetings' were held regularly and people attending were asked about what they would do in the event of a fire and how they would complain. Every meeting also included asking people if there was anything they would like to do or anywhere they wanted to go and whether they were happy living with each other. People's responses were recorded verbatim and any goals were transferred to care plans so people could be supported to achieve their dreams.

Good

Is the service responsive?

Our findings

Staff knew people's likes and preferences such as soap operas, chill out time, gardening, and outings. Staff used this knowledge of people to distract and redirect people if they were distressed or anxious.

Peoples care records were person centred which means they detailed the way care and support should be provided, taking into account the person's specific needs and preferences.

Communication passports detailed how people communicated. These included some speech as well as the use of facial expression and body language. People also used objects of reference to communicate specific things, such as waiting by the door to let staff know they wanted to go out. There was also detail on how people communicated they wanted an activity or outing to end.

Routine was very important for people so they had detailed morning routines, hair washing routines and night time routines. These were specific and included the role each staff member should play in supporting the person. Areas of independence were noted so staff knew people did not need support with these things. Specific phrases staff should use when supporting people were documented. This meant the person and staff would feel reassured as all staff would be supporting them, and responding to them, with a consistent and predictable approach.

As well as specific routines being in place for staff to follow, there were also care plans in relation to social interests and activities, personal relationships, health and personal care and home involvement. These had all been recently written and were evaluated and reviewed on a regular basis.

Where people communicated their needs through their behaviour, which some staff may find challenging, detailed behaviour support plans had been developed. The manager explained the staff team had worked closely with the learning disability team to develop the support plans based on their in-depth knowledge of people. Over time staff had recognised some of the strategies weren't working for people so the manager was liaising with the community learning disability team to arrange a review. The manager explained they were finalising the procedure for a monthly surgery with the learning disability team to support a proactive review of behaviour support plans.

Annual person centred reviews were held and we saw photographs had been taken for people to refer back to. We saw people had been supported to express what they wanted for the future, such as holidays and day trips. The staff responsible for taking the action forward were recorded and actions had deadlines to work towards.

People living at the house enjoyed gardening and had won a gardening competition held by the provider. With their winnings they had purchased a summer house for their garden. There was also a greenhouse in the garden.

One of the rooms in the house was used as a music and pool room so there was a space for people to go

and enjoy activities. People could also spend some quiet time or watch television in the lounge if they chose to do so. We asked the manager about the third bedroom as it was currently being used as an activities room. They said, "A conscious decision has been made for [people] not to live with anyone else. There are no plans for a third person to move in as it would be too oppressive due to space people need."

Staff had supported one person to go on holiday. The person had never had a holiday before and staff were presented with a certificate for the support they offered the person in achieving their goals. One staff member said, "[Person] is going to London to see the palace this year. They had never been on holiday before moving here. We went to a caravan and they were very relaxed. [Person] always wanted to go to London; it's been their ambition so we are going."

During the week of the inspection people had been supported to go to Whitby and to York. One person had also spent time gardening with staff in the hope of winning the next gardening competition.

People had a pictorial complaints policy and service user guides which were kept in their houses. There was a suggestion box in the manager's office. A 'Tell us what you think' policy was available and relatives had shared some feedback with the manager. One relative said, "There hasn't been anything really." They explained a situation when the staff had not acted upon something as soon as they would have liked but they said, "I was reassured and I was told when it had been done so there's been no need to complain."

A family forum was held by the managing director and all relatives from all services were invited. The manager said, "This gives the opportunity for carers [relatives] to meet up. We also invite carers [relatives] to some of the activities and events so they can meet everyone and get support from each other." The last forum had been held in January 2016.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post since February 2015 however they were not yet registered with the Care Quality Commission. The last registered manager cancelled their registration on 18 April 2016. This meant the registered manager condition was not being met. We discussed this with the manager who explained they had submitted an application to be registered. We checked this and found an application had been submitted however it required amendments and we were awaiting a new application.

The manager was accountable and responsible for the management of the three services within Fenwick Close. There were senior support workers in each of the three houses who supported the manager with the day to day responsibilities within the homes. The manager had an active presence in the services and was known to people, their relatives and the staff teams.

They understood their responsibilities as a manager and said, "It's about compliance, documentation, completing notifications, quality assurance, training, consultation. I make sure people are happy and spend time with carers to make sure they are happy with the service." They added, "I want people to have the best life they can."

We asked staff whether they thought the service was well-led. One staff member said, "I'm not interested in leaving, I wouldn't get a more satisfying job." They added, "The company seems in disarray, there's confusion around roles, and it's unclear about the responsibilities within the roles." They went on to say, "There's no animosity across the team, we get on really well. [Director] knows how we feel but they don't seem able to tell us anything. The company is running okay at the minute." Another staff member said, "The company is undergoing change, its developing and thriving."

We spoke with the manager about the company who explained as part of a recent restructure the director wanted an acknowledgement for those staff who were supporting people with the most complex needs. Work on consolidating this was underway. Workforce transformation was discussed within business meetings and team meetings so staff received regular updates and information. The manager said the communication was good from the company, and there were team briefs from the senior management. The plan was to use this as a tool to ensure front line staff had a formal mechanism to feedback to senior management. The manager said, "The idea is to integrate and involve staff more."

Staff told us the manager was supportive. One staff member said, "[The manager] is great, will do anything for you, they are supportive and flexible." Another staff member said, "[Manager] is definitely supportive. They are very supportive of learning and development; I was nominated to do my diploma."

Relatives gave us positive feedback about the manager. One relative said, "I'm very happy with [manager], they are very committed to the clients, I can tell by the way they are, they are happy and [manager] is comfortable with them." They added, "There's no improvements, I can't think of any anyway. They do a really good job. I do get frustrated that the staff are compared to other [staff teams] they don't realise how complex [family member] is. The staff aren't recognised enough for what they do."

Staff said regular staff meetings were held and included business updates, activities and events, rotas, medicines, food hygiene, and the updating of care records and risk assessments. One staff member said, "We have team meetings, not everyone can be there because of days off but everyone is invited. We have access to minutes and have a read and sign sheet." They went on to say, "We always discuss things as a team, the team are good for information sharing. We also have customer meetings which are good."

Organisational health and safety and business meetings included discussions around lessons learnt in relation to safeguarding and accidents from both within and outside the organisation. Additional organisational meetings included a learning and development group, which the manager was part of and CQC and company standards meetings. Meetings were also held with all the managers in the 'hub' area to share best practice and lessons learnt, as well as discussing care records, policies, peer reviews and training.

Monthly senior checklists were completed, and available in the managers records until 15 January 2016. Checklists had been completed since this time and were available in the service. Assessments were made of health and safety, including fire evacuation procedures and equipment, medicines, care records and staff files. We asked the manager why they hadn't been completed since January. They said, "Peer reviews were done in February and March and I did the managers audits in April and May." We saw a manager's monthly monitoring check had been completed in February, April and May with peer assessments completed in March. The May manager's audits had identified that a new fire risk assessment was needed; this had been signed off as completed. There were also audits of medicines, people records and staff rotas. Actions had been identified in red within the audit and we were able to see that any actions had been completed.

The manager explained that peer reviews involved managers from other services completing an audit. They said, "We aim to complete four a year." They added, "I complete an audit afterwards in response to their report to make sure any actions are completed." We saw that this procedure had been followed.