

Lothlorien Community Limited

Laburnum House

Inspection report

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15 September 2016

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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 inspection took place on the 14 and 15 September 2016 and was unannounced. Laburnum House provides accommodation and support for up to six people who may have a learning disability and behaviour which could challenge others. At the time of the inspection five people were living at the service. Laburnum House was last inspected on 6 March 2014 where no concerns had been identified. Each person had a single room and there were two bathrooms, kitchen/dining room, lounge, and a separate lounge called 'The Den'. There was a large garden to the rear of the service with seating which people could access freely.

Although a manager was registered with the Commission they had left the service in 2015. The deputy manager and an interim manager had been managing the service between the time the registered manager left, and June 2016 when a new manager had been appointed. The new manager planned to apply for registration with the Commission. 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.

Some care files contained documentation which was duplicated and unnecessary. However, staff could demonstrate a good knowledge and understanding of people's individual needs, meaning the impact this had on people was minimal. The provider had highlighted this as an area that needed to improve in their internal audits.

There were enough staff with the right skills and knowledge to support people. They had good support and supervision to fulfil their role effectively and felt confident in approaching the manager if they needed extra guidance.

Staff were trained in safeguarding and understood the processes for reporting abuse or suspected abuse. They were aware of the procedures for whistle blowing and felt confident that the management of the service would respond appropriately to any incidents of abuse.

There were safe processes for storing, administering and returning medicines. Medicines were administered by trained staff who were regularly competency checked by the manager and team leader. When errors occurred this was used as an opportunity to learn and additional safety checks were introduced.

Incidents were recorded and audited to identify patterns and the manager used this as an opportunity to learn and improve outcomes for people

Appropriate checks were made to keep people safe. Safety checks had been made regularly on equipment and the environment.

The service was good at responding to people who needed help to manage their health needs. People were supported to access outside health professionals.

The manager had a clear understanding of the principles of the Mental Capacity Act 2005 (MCA). People were offered advocacy services and the service had taken the appropriate steps to meet the requirements of the legislation.

People were supported to take part in activities which were suitable for their individual needs and had the opportunity to discuss activities they wished to undertake in the future. People discussed their aspirations with their key workers and action was taken to achieve them. People were supported to maintain relationships with their relatives and other important people.

Staff demonstrated caring attitudes towards people. People felt confident and comfortable in their home and staff were easily approachable. Interactions between people and staff were positive and encouraged engagement.

People and their representatives were encouraged to express their views and provide feedback so the service could continuously improve.

People were helped to complain and staff supported people who were unable to use the easy read complaints policy by understanding what their body language meant if they were unhappy.

The manager understood the key challenges of the service and had started to make changes to improve the service people received. The manager had the right skills, experience and knowledge to lead the rest of the staff team to provide support in a way which improved people's lives. Staff said they felt well supported by the manager and able to talk to them at any time for support and guidance.

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.

There were enough staff to support people and meet their individual needs.

Accidents and incidents were recorded and audited to identify patterns.

People received their medicines safely.

Individual risk assessments were in place to reduce risks to people and help them understand the repercussions of unwise decisions.

Is the service effective?

Good ●

The service was effective.

Staff had appropriate training to support people with their individual needs. Staff received regular supervision to support their role.

The provider was meeting the requirements of The Mental Capacity Act 2005.

People's health needs were responded to promptly and people were supported to access professional healthcare when they required this.

People were supported to make their own choices around their food and drink. People were supported to manage their diet with input from outside health professionals.

Is the service caring?

Good ●

The service was caring.

People were treated with respect and dignity.

Staff spoke to people in a kind, patient and engaging way. There was a good rapport between people and staff.

People felt comfortable in the presence of staff and were treated as equals.

People were supported to maintain contact with relatives and friends.

Is the service responsive?

Good ●

The service was responsive.

Care plans were detailed, informative and person centred.

People were encouraged to follow their own paths and participate in the activities they liked. People's aspirations were recorded and steps were taken to help the person achieve them.

There was a complaints procedure available for people should they be unhappy with any aspect of their care or treatment.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

Some documentation was duplicated and unnecessary.

Although a manager was registered with the Commission they had not been in post for a considerable amount of time.

People's feedback was sought so improvements to the service could be made.

Staff demonstrated positive attitudes to their work and it was evident the service was trying to improve the service people received.

Staff felt they could go to the manager for guidance and support.

Laburnum House

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 the 14 and 15 September 2016 and was unannounced. The inspection was conducted by one inspector. Before our inspection we reviewed information we held about the service, including previous inspection reports and notifications. A notification is information about important events, which the service is required to tell us about by law. We reviewed the Provider Information Return (PIR) and used this information when planning and undertaking the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

During the inspection we spoke with five people, two relatives, seven staff, the manager, and the regional manager. Before and after the inspection we received feedback from two healthcare professionals. Some people were not able to express their views clearly due to their limited communication, others could. We observed interactions between staff and people. We looked at a variety of documents including four people's support plans, risk assessments, activity plans, daily records of care and support, three staff recruitment files, training records, medicine administration records, and quality assurance information. The provider was asked to send us some information after the inspection which they did in a timely manner.

Is the service safe?

Our findings

A relative said, "I'm reassured my relative is safe, I'm happy with their care and have no concerns".

Staffing was sufficient and flexible to meet people's needs, four staff were available over a 12 hour period during the day, at night there was one sleep in staff and one wake night staff. Three people were allocated one to one support during the day and two people shared one staff member between them. The manager covered any shortfalls if there were not enough staff to cover shifts. People were responded to quickly when they asked for assistance and staff had enough time to engage with people in an unhurried and meaningful way. There was an on call system covered by the manager and regional managers should staff require guidance or support at any time.

Recruitment processes were in place to protect people: Employment gaps had been explored, references and photographic identification obtained and Disclosure and Barring Services (DBS) checks made. These checks identified if prospective staff had a criminal record or were barred from working with adults. Other checks made prior to new staff beginning work included references, health and appropriate identification checks to ensure staff were suitable and of good character.

People had their own individual risk assessments according to their needs. Risk assessments had been completed to support people to remain safe. These included information about; the risk description, risk levels, and controls. Staff understood that it was the person's right to accept certain levels of risk and would support the person to understand the consequences of their actions. For example one person had issues around their diet and food management so was on a restricted intake of daily calories. Staff had worked with the person to help them understand the repercussions of not maintaining their agreed calorie intake. They were prescribed a medicine which had to be taken half an hour before their breakfast. To help them manage this time restriction on their food they had been issued with a timer that they would set themselves to count down when the required time had passed.

People had individual personal emergency evacuation plans (PEEPs) that staff could follow to ensure people were supported to leave the service in the most appropriate way in the event of a fire. Fire evacuation drills were conducted so staff understood how people's PEEPs would be put into practice. Appropriate checks were made to keep people safe. Safety checks had been made regularly on equipment and the environment. This included electrical, fire doors, emergency lighting, fire escapes, fire alarms, and water checks.

Some people could display behaviours, which were physically and verbally challenging. People had behavioural guidelines in their care plans to help staff manage incidents. Accidents and incidents were recorded and audited to identify patterns and the manager used this as an opportunity to learn and improve outcomes for people. Incident forms were used to record triggers, behaviours observed, consequence analysis and a recovery phase (what support people were given). Information was then inputted into the providers online system so further analysis could be conducted and to ensure good oversight of incident management.

Staff were aware of their responsibilities in relation to keeping people safe. They knew how to whistle blow and report any concerns to their manager and also to external agencies such as the local safeguarding team or the Commission. Staff were able to describe how to raise safeguarding concerns and who they could report concerns to outside of the organisation.

There were safe processes for storing, administering and returning medicines. People had individual assessments around how they liked their medicines to be administered and staff that administered medicines were trained to do so. The team leader was responsible for ordering and returning stocks of medicine, when they were unavailable the manager was responsible. The manager and team leader competency checked any staff that dispensed medicines to ensure good practice continued. Daily and monthly audits were conducted by the team leader and manager and when errors had been made further safety check tools were implemented to reduce the risk of repeat mistakes occurring.

There had been a recent error when the new stock of medicine had been delivered. A person's prescription had been changed but this had not been updated on the new cycle of medicine. The person had continued to receive their old prescription for two days before it was noticed the dose was incorrect. The manager sought advice from the person's GP and implemented an extra checklist to be used when new stocks of medicines were received into the service to double check they corresponded to the most current prescription. Staff that had not picked up this error sooner had been re-trained in medicine administration. There had been no further errors since this incident. Regular audits monitored errors, temperature checks to ensure safe storage of medicines had been completed and occasional medicine (PRN) protocols were up to date. A homely remedies list had been obtained and agreed by the GP should a person need any medicine for minor ailments such as colds or minor pain.

Is the service effective?

Our findings

A staff member said, "I get supervisions, I had one a few days ago. The staff have a good relationship with the new manager".

Regular supervision was offered to staff every six weeks and conducted by the manager. Although no staff had been recently employed, the manager explained the induction process that newly employed staff followed. New staff spent five days shadowing other staff as part of their induction when beginning employment with the service and were issued with an induction plan to complete. New staff would not lone work until their competence was confirmed by the manager. The Care Certificate would be issued to supplement the provider's own induction processes. The Care Certificate was introduced in April 2015 and are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life.

Staff had appropriate training and experience to support people with their individual needs and demonstrated a clear understanding of the people who lived there. All staff completed mandatory training in the form of face to face or e-learning sessions. Mandatory training included; fire awareness, medicines, first aid, basic life support, infection control, health and safety and safeguarding people. Additional training was offered to staff in specialised areas such as epilepsy, Prader-Willi syndrome (Prader-Willi syndrome (PWS) is a rare genetic condition that causes a wide range of problems. These may include a constant desire to eat food driven by a permanent feeling of hunger, learning disabilities and behavior problems), and Autism awareness. Staff were able to describe how they supported people with their individual needs including behaviour which could challenge others, and managing a person's epilepsy.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 with the manager. They demonstrated a clear understanding of the process that must be followed if people were deemed to lack capacity to make their own decisions. 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 are called the Deprivation of Liberty Safeguards (DoLS).

Five people were subject to a DoLS to deprive them of their liberty and one person was being re-assessed as the manager felt their capacity had changed due to a recent health diagnosis. The provider was working within the principles of the Act. We saw recorded documentation of how the service had responded to meet the requirements of this law and the needs of the people living there.

One person had a specialised dietary requirement, support plans had been made to manage the person's behaviour around food so meal times could be as least stressful for the person as possible. A staff member said, "We measure a person's food to work out their calorie intake. They are agreeable and understand this.

We break up food times throughout the day to make it easier for the person". The person had input from the dietician so staff understood what the calorie intake should be. Menus detailing the daily meal options were displayed in the kitchen, each weekend people had a meeting to discuss the following week's menu. If people wished to have an alternative meal option this was catered for. One person told us they loved to have picnics and had made sandwiches for the picnic they were going to have in the afternoon. During our visit people moved freely around the kitchen helping themselves to drinks and choosing what they wanted to have for their breakfast.

People were supported well to monitor their health care requirements and received appropriate treatment from outside health professionals. One person's epilepsy resulted in them having seizures; protocols were in place should the use of rescue medicine be necessary. Staff demonstrated a good understanding of the action they should take if the person had a seizure. During the night assistive technology in the form of a sensor matt and audio monitor were used to check if this person was having any seizure activity. The equipment alerted the wake staff in a less intrusive way and respected the privacy of the person. Capacity assessments had been made and the use of assistive equipment was included on the persons DoLS authorisation.

People were supported to attend health appointments, including appointments with their psychologist, doctor, dentist, optician, neurologist and annual health checks at their doctor's surgery. Appointments were documented and followed up and staff communicated with the rest of the staff team any information which may need to be shared to support the person following appointments attended. Each person was assigned a key worker who would produce a key worker report to monitor health needs and follow up appointments which may be missed.

Is the service caring?

Our findings

A relative said, "I trust the staff and I trust the new manager they are fantastic, I have no major concerns. One staff bought (person) up on the train to visit us and that has not happened before. The staff member has great ability".

The service was well furnished and welcoming; there were many pictures around the service of people enjoying various days out and activities. One person spent time with us showing us the pictures and explaining what they had been doing, they told us they had enjoyed a trip to Brighton where they had eaten fish and chips. People's bedrooms were decorated in a personal way and they had many objects such as stuffed toys, photographs, pictures, puzzles, and games to make their rooms feel homely and comfortable. Staff knocked and asked for permission before entering people's bedrooms.

Throughout our visit people came and went as they pleased and had several areas where they were able to spend time, such as the garden, the lounge, their own room or The Den, which had some sensory equipment and a CD player. One person frequently used The Den to play their favourite music whilst staff supported them. The manager had an open door policy and spent time with one person in the office having a meeting which was at the persons request.

People were always spoken to in a dignified and respectful manner; people's choices were listened to and respected. It was apparent that people felt confident and comfortable in their home and that the staff were easily approachable. Staff sat with people in the lounge and kitchen chatting in an unhurried, relaxed and sociable way. One person was watching their favourite programme on the television which included songs. The person held a staff member's arm whilst they sang together.

Throughout our visit we observed many interactions between people and staff which were positive and encouraged engagement. People were relaxed in each other's company and had positive interactions. Two people were spending time talking to one another over their breakfast, although staff were present during this exchange they did not interfere with the conversation people were having together. There was a good rapport and humour between people and staff. One person wrapped a staff member up in a blanket and said, "Don't you go to sleep!" the person and staff laughed together.

People were encouraged to express their views and make their own decisions. For example, one person had a tent in the garden which they would go to when they wanted quiet space away from other people. Staff encouraged the person to decide for themselves when they wished to use their tent. Although the person was allocated continuous staff support, staff respected that the person wanted their own space and observed them from a distance to respect their privacy. If people needed help with decisions which were complex they were supported to access independent advocacy services.

There was a sense of inclusion within the service and people were treated as equals. People were allocated their own tasks within the service to promote independence and responsibility. On the kitchen wall was an information board with photographs called 'Who's house day is it?' People took it in turns to be in charge of

the daily cleaning and housework. One person said "It's my turn on Friday", and pointed to their name and picture. Another person said, "It's my house day today, I strip my bed and Hoover, I like doing it". This information helped people who found routines reassuring.

Is the service responsive?

Our findings

A relative said, "There's been a complete turnaround, I feel really assured since the new manager has been put in place. Before people were not going out as much now my relative has a full time table of activities they like".

Staff had a good understanding of people's individual needs and preferences. For example, one person could become anxious around certain events. Staff used a communication tool called, 'Social Story Folder' to help the person manage their anxieties. The folder contained pictures explaining what would happen before, during and after the event. This had been a successful tool for the person to use and anxieties had been minimised. The person's care plan supported the use of this tool and staff were able to describe how they put the use of this tool into practice.

People's care files were written in an easy read format which included pictures to help people understand its content. Information included life histories, risk assessments, behavioural guidelines, personal profiles, a one page overview of their basic needs and preferences, and aims and objectives. Care plans contained more detail in specific areas including communication dictionaries and support plans for specific areas of the person's everyday life. People's religious preferences had been highlighted within the care plan and people were supported to practice their religion if they wished. People had health action plans with specific information about their health needs and appointments they had attended. This meant staff had clear guidance to follow to support people with their individual needs in a personalised way. Documents gave a good level of detailed guidance to inform staff of how to deliver person specific care.

The manager had introduced an activity folder for each person. The folders contained photographs of recent activities and outings people had attended and information about the person's goals and aspirations. People were encouraged to take part in adding information to their activity folder to make it a more meaningful experience. Each person was allocated a key worker and co-keyworker who were responsible for conducting weekly key worker sessions. The purpose of the sessions was to allow people to have the opportunity to feedback what was working well for them, how things could improve and what action was required to achieve this. A person said, "Key workers look after us". The person then went on to explain which staff was allocated to which person. Recent key worker meetings had highlighted that one person wished to purchase new curtains for their bedroom, another person wanted to go on holiday and visit an attraction and another person wished to see a musical show in London. All of these aspirations had been achieved.

People chose to participate in a variety of recreational activities, a minibus was available for people to use and a bus stop and train station was close by. During the inspection some people went for a picnic, and others went for a walk and pub visit. Other activities that people could do included attending the day centre, lunch out, swimming, cinema, and going to the disco at the day centre. One person had been on a boating holiday the week before to the Norfolk broads, and two people had recently been to the New Forest for their holiday. One person said they had been out to get their hair cut the previous day and were looking forward to showing it off to their relatives. Another person had been to a pop concert and a tribute singing act had

been booked to attend the service to perform. People were supported to maintain contact with relatives and friends, some people frequently had visits home.

The service had recently organised a barbeque for a person's birthday and several relatives had attended. The person said, "It was my birthday, I had a burger and presents. I got a new watch, a hat, DVDs and tee-shirts". One relative had sent the service a thank you card after the barbeque complimenting them on the event and the care their relative was receiving.

The service responded to complaints appropriately and had robust systems in place; an easy read format was available for people who may need it. When concerns or complaints were made these were recorded and follow up action taken and recorded. Some people found it difficult to understand how to complain following the formal process. They relied on staff to recognise if they were unhappy about the service they were receiving by understanding their body language and other means of communicating. There were no open complaints at the time of the inspection.

Is the service well-led?

Our findings

A relative said, "The new manager is a person of integrity. Their commitment is undoubted, they go out of their way and the staff seem happy". A staff member said, "The staff morale has changed, we didn't know for a while who the manager would be, it felt very unsettled. Since we have got the new manager its really nice, laid back, I feel able to go to them with any problems".

The manager was in the process of updated peoples care plans to reduce the quantity of duplicated information and make information easier for staff to locate quickly. The provider's internal inspection had identified this was an area which required improvement. Since this internal audit the manager had started to make improvements to the care files. The risk to people not receiving the appropriate support was minimal as staff demonstrated they understood and knew them well and care files contained the relevant information to support people with their needs although some files were vast. This is an area which requires improvement.

Although a manager was registered with the Commission they had not been in post for a considerable amount of time. The manager had taken up their post in June 2016 and staff and relatives were positive about this appointment. A staff member said, "We're so happy now the new manager is here. The house is calmer and (person) is much calmer. We work well as a team. I came in on my day off for the barbeque; I wouldn't have done that before". The manager understood the challenges they faced and had achieved a great deal in a short amount of time. For example, they had improved medicine practice to be safer, incident management was more robust and staff had received supervisions to support them in their roles. The manager encouraged staff to provide feedback so the service could continue to improve in a team focused manner.

The manager had identified areas they wished to improve and had taken proactive steps to meet the identified areas of improvement. For example, they had recognised that additional behavioural management training would be beneficial for staff to have to deal with a person's behaviour if it became more difficult to manage in the future. They had requested the additional training through the provider and were awaiting a date for this to be delivered.

The manager conducted their own 'out of hours' spot checks to identify areas which required improvement. They also conducted reviews of any safeguarding's and serious incidents, daily medicine checks, monthly infection control audits, monthly health and safety checks, and audits to ensure equipment and premises were in good work order and safe for people to use. During an audit they had conducted in June 2016 they had identified that hand hygiene procedures should be discussed with staff and alcohol hand rub should be purchased. Both identified points had been achieved.

There was good communication between staff to ensure people's daily needs were met. A 'Staff checklist and Handover' was completed by staff to ensure basic information was communicated. This included a handover of medicines administered, if there had been any incidents, which staff was allocated to which person, petty cash responsibilities, and where people were if they had left the service to do activities or

attend appointments.

The provider strived to continually improve the service to improve the lives of the people living there. An internal benchmarking inspection had been conducted in June 2016 by the provider which had identified several areas that required improvement. The inspection found there were not enough staff in post to cover the needs of the service and there was a reliance on staff to work long hours and overtime to meet the needs of people. The manager said this had been a particularly difficult time as the service was supporting the transfer of a person to another service within the providers group. Staffing deployment had since improved and staff no longer worked excessive hours or consecutive days. One staff member was in the process of becoming a permanent member of the team rather than a bank worker which would further help.

The internal inspection had also identified that incident management was poor and systems and processes had not been followed according to company policy. The manager had worked hard to investigate incidents which had taken place before they had taken up their post and incident management was now robust and transparent. It had been noted on the recent fire risk assessment audit that the fire doors were in need of an upgrade to comply with safety standards. The provider had arranged for this to take place on 26 September 2016. The manager had made a contingency plan for when the fire doors were going to be replaced and had made arrangements for people to go out and do activities so this would cause them as little stress and disruption as possible.

People and their representatives were encouraged to express their views and provide feedback so the service could continuously improve. Questionnaires had been issued to relatives and advocates in March 2016 and people had 'Your Voice' meetings to discuss what they wanted to change or improve in the service. Feedback identified that relatives thought more stable managements and staffing would be beneficial. This had improved since the questionnaires had been completed.