Relativeto Ltd

Longfield House

Inspection report

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Date of inspection visit: 8 October 2014
Date of publication: 09/01/2015

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

Overall summary

We inspected Longfield House on 8 October 2014 and the visit was unannounced. Our last inspection took place in July 2013 and at that time we found the home was meeting the regulations we looked at.

Longfield House is a specialist residential care home for adults with learning disabilities and complex needs located in Clayton village. The service consists of Longfield House a five bedded home and Longfield Coach House which has four self-contained apartments. There are communal areas within the complex for people to enjoy activities and social events.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Not everyone who lived at the service was able to communicate verbally therefore we observed how staff interacted with people over short periods of time throughout the day to ensure we caused only minimal disruption to their daily life. Four people who were able told us they enjoyed living at the service and staff were friendly and supportive.

Everyone who lived at the service was supported on a one to one or two to one staff ratio whilst in the home during the day and two people were supported on a three to one staff ratio when they accessed community based activities. This was because their complex needs meant they could exhibit behaviour that challenged which might put either themselves or others at risk of harm.

The organisation's staff recruitment and selection procedures were robust which helped to ensure people were cared for by staff suitable to work in the caring profession. In addition all the staff we spoke with were aware of signs and symptoms which may indicate people were possibly being abused and the action they needed to take.

The staff had access to a range of training courses relevant to their roles and responsibilities and were supported to carry out their roles effectively though a planned programme of training and supervision.

People's care plans and risk assessments were person centred and the staff we spoke with were able to tell us how individuals preferred their care and support to be delivered. Care plans and risk assessments were reviewed on a regular basis to make sure they provided accurate and up to date information and were fit for purpose.

Staff received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and were able to demonstrate a good understanding of when Best Interest Decisions need to be made to safeguard people.

People were encouraged to participate in a range of appropriate social, educational and leisure activities both within the service and the wider community and staff actively encouraged them to maintain and develop their daily living skills.

There was an effective quality assurance monitoring system in place which quickly identified any shortfalls in the service and there were systems in place for staff to learn from any accident, incidents or complaints received.

Summary of findings

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. The staff recruitment and selection procedure was robust and newly appointed staff were not allowed to work until all relevant checks had been completed and references received.

Medication policies and procedures were in place and prescribed medicines were being stored, administered and disposed of safely. However, we found the guidance on administering covert medicines to one person was not being followed. This was rectified by the manager on the day of the inspection.

The staff we spoke with knew how to recognise and respond to allegation of possible abuse correctly and were aware of the organisation's whistleblowing policy.

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Is the service effective?

Good

The service was effective. Staff training was up to date and staff had regular supervision meetings with the manager which helped them carry out their roles effectively and plan for their future career development.

People who were able told us the way their care, treatment and support was delivered was effective and they received appropriate health care support. We saw documentary evidence which demonstrated that people who lived at the home were referred to relevant healthcare professionals in a timely manner and staff always followed their advice and guidance.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. This legislation is used to protect people who might not be able to make informed decisions on their own.

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Summary of findings

Is the service caring?

Good

The service was caring. People who were able said the staff were friendly and supported them to maintain and improve their daily living skills. This was confirmed by our observations, which showed staff had good understanding of people's needs and assisted them to meet their goals and objectives.

Records showed wherever possible people were involved in any decisions which related to their care. Arrangements were in place to provide advocacy services for people who needed someone to speak up on their behalf.

Is the service responsive?

Good

The service was responsive to people's needs. People's needs were continually assessed and care and support was planned and delivered in line with their care plan. Care plans and risk assessments were person centred and contained good information about how people's care and support should be delivered.

People who were able told us they knew how to make a complaint if they were unhappy and were confident if they made a complaint it would be investigated by the manager. There was evidence that learning from incidents/investigations took place and appropriate changes were implemented.

Is the service well-led?

The service was well-led. The manager was clear about the future development of the service and was proactive in ensuring wherever possible both people who lived at the service and staff were involved in improving service delivery.

People who were able told us the manager and senior management team were approachable and listened to what they had to say.

There was a quality assurance monitoring system in place that was designed to continually monitor and identify shortfalls in the service and any non-compliance with current regulations.

Longfield 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 checked 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.

The inspection took place on the 8 October 2014 and was unannounced. The inspection team consisted of one inspector and a specialist advisor who specialised in mental health and learning disabilities. We used a number of different methods to help us understand the experiences of people who used the service. We spoke with four people who used the service, nine members of staff, the registered manager and the clinical service manager.

We also spoke with an external training provider, two social workers who specialised in working with people with learning disabilities and a community nurse (learning disabilities) to obtain their views and opinions of the service.

We spent eight hours observing care and support being delivered. We looked at four people's care records and other records which related to the management of the service such as training records and policies and procedures.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Good

Is the service safe?

Our findings

Everyone who used the service was supported on a one to one or two to one staff ratio whilst in the home during the day and two people were supported on a three to one staff ratio when they accessed community based activities. This was because their complex needs meant they exhibited behaviour which challenged which might put either themselves or others at risk of harm. The rota showed staffing levels were always maintained in line with people's assessed needs and funding arrangements.

Records showed there was a good skill mix within the staff team and there was always experienced and skilled staff on duty throughout the day and night to ensure less experienced staff received the supervision and support they required to carry out their roles safely. People who were able told us they felt safe living at the service and the staff helped them to lead a full and active life. One person said, "I know who my key workers are and they always listen to me if I have a problem."

The provider had a policy in place for safeguarding people from abuse. This policy provided guidance for staff on how to detect different types of abuse and how to report abuse. There was also a whistle blowing policy in place for staff to report matters of concern.In addition, the manager told us they operated an open door policy and people who used the service, their relatives and staff were aware that they could contact them at any time if they had concerns.The staff we spoke with told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact. They told us they knew how to contact the local authority Adult Protection Unit and the Care Quality Commission (CQC) if they had any concerns. They also told us they were aware of the whistle blowing policy and felt able to raise any concerns with the manager knowing that they would be taken seriously. These safety measures meant the likelihood of abuse occurring or going unnoticed was reduced.

Safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. This included ensuring a Disclosure and Barring Service (DBS) check and at least two written references were obtained before staff started work. We spoke with two recently employed members of staff who told us the recruitment process was thorough and they had not been allowed to start work before all the relevant checks had been completed.

Staff disciplinary procedures were in place and the manager gave examples of how the disciplinary process had been followed where poor working practice had been identified. This helped to ensure standards were maintained and people were kept safe.

We looked at the provider's medicines policy. The policy demonstrated the provider had taken steps to ensure that they complied with current legislation and best practice in the administration of medicines. Staff who administered medication had received training and supervision records confirmed the manager monitored their on going competency.

We checked the medication cupboard. We saw it was kept in an orderly manner. Most medication was administered via a monitored dosage system supplied directly from a pharmacy. This meant that the medicines for each person for each time of day had been dispensed by a pharmacist into individual trays in separate compartments. Individual named boxes were seen inside the medication cupboard. They contained medication which had not been dispensed in blister pack form.

We saw that all lotions and creams were separately and appropriately stored and were dispensed to named people.

When 'as and when required' (PRN) medication had been prescribed we saw staff had recorded whether the medication had been given or not. Also the dosage which had been administered had been recorded. This showed us people received PRN medication correctly and in a timely manner.

We were informed that one person received their medicines covertly. We found that the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and imposed conditions in the authorisation were not being met. We saw that a condition of the approval for covert medicines required three attempts to be made to administer the medicines by normal means before resorting to disguising the medicines. In practice this was not happening with covert medicine administration being the primary method of administration. We asked the manager if there was any other supplementary documentation to support the covert medicine

Good

Is the service safe?

administration we had witnessed. We were informed the medicines were not being administered correctly. During the inspection the manager made arrangements for re-assessment of the person who received medicines covertly and assured us that until then medicines would be administered within the terms of the current approval. We were confident this was an oversight by senior staff and overall the requirements of the DoLS authorisation for the covert administration of medication were being adhered to.

Risk management to protect individual people and maintain a safe environment was a key feature of care planning. Risk assessments had been completed to ensure safety within the home such as kitchen access and the ability to prepare hot drinks. Community based risk assessments were also in place for such things as road safety and the participation in social and leisure activities. This showed people were encouraged to maintain their independence.

Good

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We were told that seven people using the service were subject to authorised deprivation of liberty and a further two applications had recently been made. Our scrutiny of people's care records demonstrated that all relevant documentation was securely and clearly filed.

Staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. Staff demonstrated understanding about the Mental Capacity Act and Deprivation of Liberty Safeguards. They were able to give examples of instances when Best Interest Decisions had been made with the involvement of relevant professionals. Care plans evidenced information regarding people's capacity to make decisions. This ensured that people were protected against the risk of excessive and unlawful control or restraint.

We spoke with nine members of staff about the use of restraint. They were able to describe de-escalation techniques to minimise the use of restraint. They also demonstrated their understanding that restraint should only be used in a way which respected dignity and protected human rights. They described to us the value of providing a stimulating environment and effective communication to prevent behaviour that may be of risk to individuals. This meant that staff had a good understanding of the people who lived at the home and how they could deliver care respectfully and within the law.

We saw that each person had an individual physical intervention risk assessment. This assessment identified each person's past history of inappropriate behaviours. It listed the known signs and symptoms of agitation which could escalate into inappropriate behaviour along with previously successful de-escalation techniques. The document denoted the specific physical intervention (restraint) techniques that could be used. We saw that on every occasion restraint was used the event was documented and any learning points acted upon. The staff we spoke with told us only staff trained in restraint techniques could be involved in the process.

We asked staff what they did to make sure people were in agreement with any care and treatment they provided on a day to day basis. The staff told us they always asked people's consent before providing any care or treatment and continued to talk to people while delivering care so people understood what was happening. Throughout the visit we saw staff treated people with respect by addressing them by their preferred name and always asked people their preferences and consent when they offered support. This demonstrated to us that before people received any care or treatment they were asked for their consent and staff acted in accordance with their wishes.

We saw that people had the ability to influence the food served at the home. For example, people were involved in menu planning and wherever possible went with their support worker to the local shop or supermarket to purchase food. In addition, three people cooked their own meals in their own flats supervised by a member of staff. We saw that each person had a food record book which recorded all food eaten. We saw that special dietary needs were being met; for instance a person of the Islamic faith had Halal food provided. We found that people's dietary needs were being met and staff encouraged people to eat a varied and balanced diet.

The manager told us all staff completed a comprehensive induction programme which took into account recognised standards within the care sector and was relevant to their workplace and their roles. We were also told following induction training new members of staff always shadowed a more experienced member of staff until they felt confident and competent to carry out their roles effectively and unsupervised. This was confirmed by the staff we spoke with.

We looked at a sample of staff training records and found that staff had access to a programme of training. Mandatory training was provided on a number of topics such as safeguarding vulnerable adults, manual handling, first aid and fire safety. Additional training was provided on specialist topics such as pressure area care and dementia care. Some of the staff had achieved the NVQ (National Vocational Qualification) level 2 award and others had progressed to NVQ level 3. We spoke with the NVQ assessor employed by an external agency and they told us the manager was proactive in making sure staff had the skills they required to carry out their roles effectively.

The manager told us individual staff training and personal development needs were identified during their formal one to one supervision meetings which were held on a two

Good

Is the service effective?

monthly basis. Supervision meetings are important as they support staff to carry out their roles effectively, plan for their future professional and personal development and give them the opportunity to discuss areas of concern. The provider did not carry out formal yearly appraisals for all the staff, however during a discussion with the manager and the clinical services manager it was agreed that appraisal would be commenced at the earliest opportunity.

The manager told us staff worked closely with community based services in specific areas of people's care which included both their physical and mental health. We saw the input of other healthcare professionals involved in people's care and treatment was recorded in their care plans. We saw evidence of hospital appointments, medication reviews with psychiatrists and visits by and to other health care professionals such as a community psychiatric nurse, a chiropodist and a dentist. We saw that were appropriate people had been encouraged to access breast screening clinics. One person attended the local mental health services three-weekly to receive depot antipsychotic medication. We also noted that one person had been referred to a dietician due to significant weight gain. We saw that advice given had resulted in a marked reduction in their weight which was evidenced on their weekly weight charts. This showed when necessary the manager had ensured other professionals were involved in the care and treatment of people who lived at the service.

Following the inspection we spoke with two social workers who specialised in working with adults with learning disabilities and had placed people at the home. Both said they had no concerns about the standard of care and support provided by the service. We also spoke a community nurse (learning disabilities) who told us they had no concerns about the care and support provided at the service and staff always followed their advice and guidance.

Good

Is the service caring?

Our findings

Some people living at the service had difficulty communicating verbally but our observations indicated people were happy with the care and support they received. One person told us, "I really enjoy going out with my support worker, we have a laugh and have a good time". Another person said, "My goal is to be allowed to go out to the shops by myself but I really don't mind going out and about with my support worker."

We observed staff supporting people in a positive way. Some people living at the home had Autistic Spectrum Disorders (ASD). We saw staff interacted with people with ASD in a structured and therapeutic approach. Staff were helping people to develop social skills and manage stress. Staff communicated in a way which helped them understand what others may be trying to communicate to them. We saw the service used schedules and timetables to give the necessary structure and visual cues to people with ASD.

The staff we spoke with were able to tell us how individuals preferred their care and support to be delivered. They also explained how they maintained people's dignity, privacy and independence. They told us about the importance of knocking on doors before entering people's private accommodation and making sure curtains were closed when supporting people with personal care. This demonstrated the staff had a clear knowledge of the importance of dignity and respect when supporting people and people were provided with the opportunity to make decisions about their daily life.

Some people however had a learning disability with co-morbid mental disorders, including mood disorders, personality disorders and abnormally aggressive or seriously irresponsible behaviours. We saw that these people were under constant close supervision by one or two staff. Whilst we understood the need to protect others from harm and to be close enough to de-escalate a potential problem we found the supervision being provided to be oppressive and gave a custodial rather than a therapeutic impression of care. We discussed our observations with the manager and recommended that a means of less restrictive and oppressive support should be explored to ensure a more therapeutic environment is provided. We did however acknowledge that some people's level of observation and close control had reduced over time with the benefits of greater freedom that brought, and overall we considered the requirements of DoLS authorisations in place were being adhered to.

We saw that people had been able to make choices about the decoration and furnishings in their rooms and some people had the greater benefit of a flat with the associated benefit of being able to prepare their own meals.

Health and care services are legally required to make 'reasonable adjustments' for people with learning disabilities under the Equality Act (2010) to ensure equal and fair treatment and promote independence. We found that information such as breast cancer screening had been made available to relevant people in a format they could understand. Staff had been specifically trained and health checks were carried out and health problems treated.

In addition, the manager told us people's healthcare needs were discussed with them during their monthly meetings with their key worker and everyone who lived at the home was registered with a local doctor. This showed us the service involved people in discussions about their healthcare needs.

We were told that two people had been appointed with Independent Mental Capacity Advocates (IMCA) as defined in the Mental Capacity Act 2005 (MCA). Whilst neither person spoke to us about the appointments it was clear that the appointment was relevant as they had no-one who could be appropriately consulted when making a decision and they did not have the capacity to make that decision alone. We saw that the IMCA had been involved in the care planning and review process and was the key person in the circle of support. This showed people received appropriate care, treatment and support.

We saw that all care plans and documents relating to individual people were securely stored thereby providing a good degree of confidentiality.

Good

Is the service responsive?

Our findings

The staff we spoke with told us the daily routines of the service were flexible and based around people's individual needs. Care plans recorded what each person could do independently and identified areas where the person required support. When people moved into the service detailed assessments took place which ensured people's independence was maintained. We also saw evidence of pre-admission assessments by psychologists to ensure those people with Autistic Spectrum Disorders (ASD) were placed in a suitable therapeutic environment.

We looked at three care plans. They were person-centred and were written in the first person to document people's wishes in relation to how their care was provided. The care plans evidenced how people liked to spend their time and how they liked to be supported. The plan also showed what people told staff about what provoked their anxieties and inappropriate behaviours. Where appropriate easy read documentation had been used to enable people to understand their care plans. We saw that on all occasions the care plan had been endorsed by the person themselves, a relative or an advocate (IMCA).

We saw that one person's care strategy had been developed through a multi-disciplinary team (MDT) approach and a best interest meeting. The strategy was to modify behaviour and enable participation in an activities programme through a rewards based system whereby access to activities had to be earned. The outcome of this approach as recorded in the care plan showed demonstrable benefits to the person and an improvement in relations with staff.

The staff we spoke with told us they had input in to the care planning process through the key worker system and used the care plans as working documents. The key worker system meant that all people living at the home had two named staff who took a specific interest in their care, treatment and support. The staff we spoke with demonstrated a good knowledge of people's needs and how individuals preferred their care and support to be delivered.

We spoke with four people who told us of their social and leisure activities in the local and wider communities. They were clearly happy with these activities and had aspirations for the future. Their individual care plans recorded these events and the resulting therapeutic benefits. This showed that people did not live in isolation but were actively encouraged to participate in a range of appropriate social, educational and leisure activities.

We looked at the complaints policy which was available to people who lived at the service and staff. The policy detailed how a complaint would be investigated and responded to. We spoke with nine members of staff who were able to tell us how they would support people to make a complaint. However, as no complaints had been received from people who lived at the service since the last inspection we were not able to check the effectiveness of the policy.

The people we were able to communicate with told us they had no complaints about the service but knew who they should complain to. We saw the complaints procedure was on display within the home in an easy read pictorial format and the manager told us it could be provided in other formats or languages if required.

Each person's records included a daily record of care given. The record showed personal care; activities participated in, independent living tasks such as cleaning their room, observed mood and behaviour, appointments with other health care providers and incidents. The record was not only signed by the key worker but recorded all staff participating in that persons care.

We saw that care plans were regularly reviewed by staff and that an annual review took place which included near relatives or advocates and appropriate healthcare professionals. This showed us the provider had taken appropriate steps to involve all relevant people in the care planning process.

Good

Is the service well-led?

Our findings

We saw there was a quality assurance monitoring system in place that was focused on providing positive outcomes for people who used the service. The manager told us to ensure compliance with current regulations the service received support from other staff and departments within the organisation. This included human resource staff, the clinical service manager and the training unit.

Records showed decisions about people's care and treatment were made by the appropriate staff at the appropriate level. There was a clear staffing structure in place with clear lines of communication and accountability within the staff team. We observed the manager interacting with the deputy manager and the deputy interacting with the care staff. A common line of communication involved junior staff asking for guidance and timely instruction or guidance being given in response. The staff we met were well trained and competent to make most of the routine care decisions. They said they knew when and how to report any issues or concerns and they were confident management would provide any necessary advice or support if required.

We saw evidence of a rolling programme of meaningful audit to ensure a reflective and quality approach to care. Audits carried out by the manager included medicines, care plans and the internal environment and fabric of the building. The outcomes of these audits were translated into action to ensure problems were addressed speedily. For instance, we saw that any maintenance issues within the service were identified quickly and recorded in the maintenance register for action by a suitable contractor.

Audits of care planning were also conducted by the provider's clinical services manager on a monthly basis. Infection control and prevention audits took place bi-monthly and were carried out by an external accredited person. This showed the provider was taking appropriate action to ensure the service was managed in people's best interest.

We saw a senior member of the organisations management team met with all the managers within the organisation on a monthly basis to discuss matters of common interest. This included learning points from incidents, training needs and performance. This ensured that the provider had a strategy for maintaining quality and conformance across all services.

Within the service the manager met with the deputy and team leaders and the team leaders met with all support staff on a monthly basis. Our scrutiny of minutes indicated that key care matters such as safeguarding, infection control and risk management were a common feature of topics for discussion.

The staff we spoke with told us they were well supported by the manager and senior staff team and were encouraged to air their views and opinions about the service so that improvements could be made if necessary. We saw the minutes of the resident meeting which recorded current and proposed menus and suggestions for activities. This showed us the provider had put appropriate systems in place to obtain the feedback of both people who lived at the home and staff.