North East Autism Society

Meldan

Inspection report

16a Leechmere Road
Sunderland
Tyne And Wear
SR2 9NB

Tel: 01915653485

Date of inspection visit:
04 December 2018
05 December 2018
07 December 2018
14 December 2018
18 December 2018

Date of publication:
19 February 2019

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Meldan is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service was first registered in January 2018 and this is the first fully comprehensive inspection of the service.

Meldan is a purpose built residential care home located within Sunderland, Tyne and Wear, and provides personal care and support for a maximum of four people with learning disabilities and autistic spectrum disorders. The service has four large bedrooms, a communal lounge, conservatory, dining area, bathrooms, laundry area and a kitchen which have all been designed to support and encourage the independence of the people living there. At the time of the inspection there were three people living at the service.

There was a registered manager in post who had been registered with the Care Quality Commission (CQC) since January 2018. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was aware of their responsibilities and had clear vision for the service in partnership with the provider's organisation vision. The registered manager had submitted notifications to the Commission appropriately.

The registered manager worked with staff to promote the independence of people living at the service to help to enable them to achieve their aspirations for life. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

During the inspection we observed people carrying out activities with staff and attending sessions in the local community. We saw records of activities undertaken by people and they were supported to carry out their own choices for activities. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The service actively encouraged regular feedback from people and relatives about the service and the care provided.

There was a quality and assurance process in place to monitor the quality and safety of the care provided to people. There was a robust governance framework in place which documented regular auditing of the service by the registered manager and provider. Care plans for people reflected their individual needs and personal risks were assessed and mitigated. There were regular reviews of people's care needs and these reviews included involvement from other health care professionals.

People were treated with dignity and respect by staff. We observed caring, kind and warm interactions

between staff and people. People and staff knew each other well and staff understood how to effectively support each person. Relatives were happy with the care provided by staff to people and were very complementary about the staff.

We found there were policies and procedures in place to help keep people safe. Staff were safely recruited and they were provided with all the necessary induction and training required for their role. Staffing levels at the service matched the assessed needs for people living at the service. Staff received training in delivering end of life care and accessed regular training sessions in all mandatory training modules. Staff received regular supervisions and appraisals in line with the provider's supervision policy.

The service had a comprehensive complaints and compliments policy in place. Any complaints received were logged, responded to within the stated time frames and analysed. Action plans were created and lessons learned were documented. The service promoted advocacy and there was accessible information available detailing what support people could access to help make choices about their individual lives. There was information available about safeguarding, complaints and advocacy displayed in communal areas and available in easy read formats for people.

There were regular checks of the premises, equipment and utilities which were documented to ensure the safety for people living at the service, visitors and staff. There were infection control policies in place and staff adhered to these. Medicines were safely managed and there were medication policies and procedures in place. There was a business continuity plan in place for use in emergency situations.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received care from staff who were trained and aware of safeguarding procedures.

Risks which people faced were assessed and reviewed regularly. There were suitable staffing levels.

Medicines were administered safely and in line with safe medicines management procedures.

Is the service effective?

Good

The service was effective.

People received care that was delivered in line with the Mental Capacity Act 2005 (MCA).

Staff providing care to people had received appropriate training and received on-going support to carry out their roles.

Consent was sought before staff provided care to people.

Is the service caring?

Good

The service was caring.

The service worked in partnership with people to promote their independence. Staff upheld people's privacy and dignity.

People were treated with kindness and respect by staff.

People and their relatives were involved in planning their care.

Is the service responsive?

Good

The service was responsive.

People enjoyed a wide range of social activities. People were supported to maintain their independence and choice with activities.

People received personalised care which met their needs and was regularly reviewed.

There was a robust complaints procedure in place. The registered manager investigated all complaints and used this to continuously learn and improve the service.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post who understood their role and responsibilities. Relatives and staff were very positive about the registered manager, their skills and care provided.

The provider and registered manager had a clear vision, strategy and plan to promote the independence of people living at the service.

There was a robust quality and assurance framework in place to monitor the quality of the service provided and identify any areas for improvement.

Meldan

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 site visit took place on 04 and 05 December 2018 and was announced. We gave the service 24 hours' notice of the inspection visit because it is small and we needed to be sure people and staff would be in.

Inspection site visit activity started on 04 December 2018 and ended on 18 December 2018. It included speaking to staff and relatives via telephone interviews. We visited the office location on 04 and 05 December 2018 to see the people living at the service, registered manager and office staff; and to review care records and policies and procedures.

The inspection was carried out by one adult social care inspector and one adult social care inspection manager. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information that we held about the service. This included any statutory notifications received. Statutory notifications are specific pieces of information about events that happen within the service, which the provider is required to send to us by law.

Prior to our inspection we sought feedback from the local authority contracts monitoring and safeguarding adults' teams, and reviewed the information they provided. We also contacted Healthwatch, who are the independent consumer champion for people who use health and social care services to obtain their feedback. We used the feedback gathered from these parties to inform our inspection and judgements.

During the inspection, we spoke with one person living at the service, three relatives, four members of staff including the registered manager. We reviewed the care records for two people, the medication records for three people and the recruitment records for three members of staff. We reviewed documentation,

inspected the safety of the premises and carried out observations in the communal areas.

Good

Is the service safe?

Our findings

Relatives of people living at Meldan told us that the service was safe. One relative said, "Yeah it's safe." Another relative commented, "I always feel it's safe." We discussed the safety of the service with staff and they commented that people were at the heart of the service and their safety and wellbeing was everyone's main priority.

There were safeguarding policies and procedures in place to keep people safe. Safeguarding information was available in easy read format for people, relatives, visitors and staff. This included how to raise a concern to the local authority or Care Quality Commission (CQC). Staff had received training in safeguarding vulnerable adults and this was also discussed in supervisions and team meetings. Staff were able to explain their role in keeping people safe. One staff member told us, "I've completed all of my safeguarding training," and followed this by explaining what they would do if they saw anything of concern.

The registered manager appropriately escalated all safeguarding concerns to the local authority and notified the CQC of these. Accidents and incidents were investigated, all outcomes recorded and lesson learned shared with people, staff and relatives. The registered manager analysed all accidents and incidents frequently for any trends. Lessons learned were also shared at a wider provider management meeting, to help improve not only the service but other services the provider owned. Minutes of the management meetings documented the sharing of lessons learned and best practice.

Risks to people were identified and managed well so that people were safe. People's care records reflected people's current needs and included personalised risk assessments to help keep people safe. We found one risk assessment for the use of a harness required that required further development. The registered manager took immediate action with this and completed a new risk assessment for the person, including an updated best interest and mental capacity assessment.

Staff recruitment was safe. All staff had a current Disclosure and Barring Service (DBS) check in place. The DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role. Other pre-employment checks had been carried out such as gathering references from previous employers.

We reviewed the needs of people living at the service and compared this to the staffing rota. There was enough staff to support people safely and the registered manager regularly reviewed staffing numbers if people's needs or requirements changed.

We looked at the arrangements for the management of medicines. Medicines were securely stored in a locked treatment room. Medicine stocks were recorded when medicines were received into the service. This is necessary so accurate records of medicines were available and staff can monitor when further medication would need to be ordered. The medicines administration records (MARs) contained recent photographs of people to reduce the risk of medicines being given to the wrong person. The records we checked clearly stated if the person had any allergies. This reduced the chance of someone receiving a medicine that they

are allergic to.

People's medicine support needs were accurately recorded in their care records and the MARs showed staff recorded when people received their medicines and entries had been initialled by staff to show they had been administered. Protocols were in place to administer 'as required' medicines. The protocols assisted staff by providing clear guidance on when 'as required' medicines should be administered and provided clear evidence of how often people require additional medicines such as pain relief medicines. There were regular audits of people's medication and staff followed medicines guidelines by the National Institute for Health and Care Excellence (NICE).

We carried out a tour of the premises to make sure they were safe for people living at the service. We reviewed records for the testing of equipment, water, electrical, gas and other premises requirements to keep people safe. The service had current certificates to show it was fully compliant with all health and safety requirements. The kitchen was clean and followed standard food hygiene procedures. There were risk assessments in place for the control of substances hazardous to health (COSHH). There was a fire risk assessment in place at the service and this also included people's personal emergency evacuation plans (PEEP). A PEEP is an individual escape plan for a person who may not be able to reach an area of safety unaided or in a safe amount of time in an emergency. We saw evidence of infection control procedures, audits, rotas and cleaning throughout the inspection. The main office area, communal lounge, dining areas, conservatory, living room and kitchen were well presented and very clean.

There was an infection control policy in place and we saw staff following this at all times. When required staff used personal protective equipment (PPE), for example disposable gloves, to deliver care.

Good

Is the service effective?

Our findings

People in receipt of care from Meldan had their support assessed and delivered in line with current national best practice standards and guidance, such as the Mental Capacity Act 2005 (MCA), National Institute for Clinical Excellence (NICE) guidance, Building the Right Support and the Medicines Act 1968.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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. For people who did not always have capacity, mental capacity assessments and best interest decisions had been completed for their care and treatment, for example for use of positive behaviours support techniques and life changing choices about serious medical treatment or where to live. Records of best interest decisions showed involvement from people's relatives, GPs and staff.

We found some decisions were not specific, for example relating to the use of a harness whilst travelling. The MCA and Code of Practice states that a person's capacity must be assessed specifically in terms of their capacity to make a particular decision. This meant people's rights to make particular decisions may not have been always upheld and their freedom to make decisions may not have been maximised. The registered manager told us they would review these and ensure the records detailed the specific decisions. By the second date of inspection the registered manager had reviewed all of the MCA assessments and was working with the GP, relatives and staff to get these reviewed.

People received care from skilled staff who had completed training that the provider deemed as mandatory for their roles, such as safeguarding vulnerable adults, infection control, first aid, epilepsy awareness, medicine administration and moving and handling. All new care staff who did not have previous qualifications or experience in health and social care, received a detailed induction in line with the 'Care Certificate'. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by staff to provide safe, effective and compassionate care. Staff told us that they received regular training and that the registered manager always discussed training and development during their supervision sessions. There was a training matrix in place at the service so that the registered manager could easily identify any refresher training requirements or knowledge gaps.

The registered manager scheduled in regular supervisions with staff and annual appraisals. Minutes from

supervision records showed that there were discussions around safeguarding, training and equality and diversity. There was a supervision contract in place between staff and management that they received these every two months, which was in-line with the provider's supervision and appraisal policy.

People's care records showed details of appointments with, and visits by, health and social care professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. For example, GPs, psychiatrists, specialist nurses, dentists and social workers. Care plans reflected the advice and guidance provided by external health and social care professionals. This demonstrated that staff worked with various external agencies and services to seek professional advice and ensure the individual needs of the people were being met.

Daily communication notes were kept for each person. These contained a summary of the care and support delivered and any changes to people's preferences or needs observed by staff. This helped ensure staff had the latest information on how people wanted and needed to be supported. Handover records showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty at the beginning and end of each shift. We did note that one person's care plan did not fully document the support the person required. The registered manager agreed with this as the service was providing more support than stated in the care file. The registered manager said that they would update the plan to reflect the amount and type of support provided.

People received support with nutrition and hydration, systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. We saw regular recording of people's weights and regular reviews of people's nutritional needs. If risks were identified the registered manager told us that people would be referred to the GP or dietician or the speech and language team (SALT). People's preferences for food and drink were recorded and we observed one member of staff supporting a person to make their lunch. The staff member was aware of the persons preferences and encouraged the person to eat their meal.

The service was appropriately adapted, nicely decorated and had pictorial signage throughout. Pictorial signage helps people to visualise certain rooms and items, if they are no longer able to understand the written word. People had personalised bedrooms with decoration and items they had selected themselves.

Good

Is the service caring?

Our findings

Relatives of people living at Meldan told us that staff were caring and kind. We observed many positive interactions between staff and people during our inspection. We observed one member of staff carrying out a catching and throwing activity with one person. The person was smiling and enjoying this activity. During the second day of inspection we also observed one member of staff supporting one person to decorate a Christmas tree. The person was happy and was being encouraged by the staff member to choose where to place the decorations. The person was very proud of their decorated Christmas tree and showed this to the inspection team.

We also observed one person being encouraged by staff eating their lunch. The staff member explained to the person what was for lunch and it was food he liked. The person was smiling at the staff member and began eating their lunch.

One relative we spoke to told us, "He's well cared for and it's really good for him. They are brilliant with him and with me." Another relative commented, "He's happy and calls it home now," and "The give brilliant care. I can't fault the staff. They want what is best for the them. They are always going out of their way so the needs are met with the best standards."

The registered manager and provider had a clear vision and strategy regarding the care for the people living at the service, this was to promote the independence and wellbeing of everyone using the service. Staff encouraged this and we saw many interactions where people were encouraged to be independent. One person was in the process of being assessed to transition to their own property. Staff were working with the person to develop their cooking skills. This included food shopping and preparing their own meals with guides. The person was successfully achieving this and we saw documentation to support this.

Staff encouraged independence and did this in a respectful way. People's privacy and dignity was respected by staff. For example, during the inspection we observed staff knocking on doors asking for permission to enter before walking into people's bedrooms. The registered manager ensured staff encouraged people's confidence, engaged partnerships between families and the staff team, and maximised independence, choice and control where possible. People were encouraged to be independent and people told us they chose what they wanted to do each day, where they wanted to go and made their own choices. Equality and diversity policies were in place to ensure that people were treated with dignity and respect regardless of the sex, race, age, disability or religious belief.

All staff were working together to create a respectful, trusting and caring environment which made a difference to people's lives. Staff told us, "We're always pushing for the [people living at the service]'s best interests and promoting independence." One relative told us that they could see a visible difference in people and that their views were always listened to. They told us, "Staff take an interest in him."

People's care files included information about people's own personal preferences including how they liked to be supported, their interests, relationships, their social circles and to communicate with them. Staff had

known people for a long time and were aware of their personal histories and journeys. We saw involvement from people and their relatives on the creation of people's care plans. These included best interest decisions and mental capacity assessments. These were clearly documented and had signatures from all involved. We saw regular documented updates from people about how they felt about their care. People, relatives and other health professionals regularly attended meetings at the service to review people's needs.

There was information, advice and guidance available to relatives and people at the service which was of benefit to people and their families such as local safeguarding contact information, leaflets on learning disability support groups, advocacy services and advice on relevant topics of interest. At the time of our inspection no one was accessing an advocacy service.

Good

Is the service responsive?

Our findings

People in receipt of care from the service received person-centred care. Person-centred care planning is a way of helping someone to plan their care and support, focusing on what is important to them. Following an initial assessment, care plans were developed for people's daily needs such as physical wellbeing, diet, mobility and personal hygiene. These gave specific information about how people's needs were to be met and gave staff instructions about the frequency of interventions. Care plans were reviewed and updated at least once a month to ensure they contained relevant information. Each care plan we viewed was person centred and they contained detailed instructions for carrying out people's care. The service ensured there was a holistic approach to meeting people's needs. Care plans included sections on social, emotional, cultural and religious needs as well as their physical needs.

The service worked with people to support their independence and regularly reviewed people's needs to support their choices and independence. One staff member told us, "We regularly review care plans and talk to relatives." Another member of staff said, "We make sure relatives are involved. Family visit and have regular contact with [person] and the input into care and what he needs." One relative told us, "I'm involved in care planning and kept update with medicines and behaviours. I'm always told of any incidents and they explain fully." Another relative commented, "I'm involved in decisions, attended regular meetings with staff, social workers and the mental health team at Meldan." This demonstrated that relatives were involved in regular reviews at the service and this ensured that people's choices and decisions were included via their relatives.

People had individualised goals to work towards these recorded within their care records. One person's file included independent living skills to help them to start the transition process to have their own property. Each of these goals were followed up with detailed actions for the person to follow. For example, if the person chose to make spaghetti and meatballs, there was a pictorial ingredients list for shopping and a visual step by step process to make the meal.

People were supported to express themselves and staff took time to understand people as individuals by monitoring the ways people displayed their emotions. Staff could recognise them and offer intervention before the person became more anxious or distressed. Staff offered support to resolve any problems by offering the person time. This provided guidance to staff so they managed situations in a consistent and positive way, which protected people's dignity and rights.

Communication care plans were in place and were appropriate for people. We saw specific information for staff to follow in relation to how they engaged with people. One person, who was unable to verbally communicate, staff were instructed that the person would nod or shake their head to indicate agreement and staff were to interpret their anger by the tone of their vocal prompts or body language. This approach meant staff provided responsive care, recognising that people living with communication needs could still be engaged in decision making and interaction.

One person was following a special diet which was reflective of their religious beliefs. Staff worked with them

and their relatives to create bespoke menus with ingredients they liked. Staff told us what arrangements were in place to allow the person to actively follow their religion in the service. This included playing audio versions of their holy book and prayers. The registered manager told us that staff had worked with the person's family to make sure the service was providing everything possible to allow the person to actively be part of their religious community.

During our inspection we observed people leaving the service to take part in learning and social activities. One person was attending a local education centre during both days of inspection and we saw this documented in their care file. Another person had returned from a weekend stay with their relative and we observed care staff supporting the person returning to the service. Staff involved relatives with any changes to people's care needs. One person was currently receiving a review for their medication due to their behavioural changes. Staff were able to demonstrate their knowledge of the person and highlighted how they had requested a review by the GP due to the changes in the way the person presented. This demonstrated that staff were responsive to people's needs and escalated appropriately to other health professionals.

There was a comprehensive complaints procedure in place at the service. This was available to people and their relatives. We reviewed the complaints log for the service and the actions taken. The registered manager addressed all complaints within the designated timescales and took action when required. Lessons learned were acted upon and shared with staff during meetings and supervisions. The registered manager and provider regularly audited the complaints log and identified any themes. Compliments received about the service were also shared with staff and used as examples of good quality care. One relative told us, "I've got no concerns within the service but did I did highlight issues to registered manager and they looked straight into them." Another relative said, "I'm aware of the complaints process."

At the time of our inspection no one living at the service was receiving end of life care. Staff had received training in the delivery of end of life care. People's end of life choices and wishes had been documented but these plans were not being followed currently.

Good

Is the service well-led?

Our findings

There was a registered manager in post who had been registered with the Care Quality Commission (CQC) since January 2018. This was in line with the requirements of the provider's registration of this service with the CQC. The registered manager was aware of their responsibilities and had submitted notifications as and when required. The registered manager was present during the inspection and assisted us by liaising with people, their relatives and staff on our behalf.

Relatives were very complementary about the registered manager and the support they had provided to them and people at the service. One relative told us, "The Registered manager is excellent with him and knows him very well. She deals with his needs and was above and beyond other staff. She has the knowledge and skills. She was absolutely amazing with him." Another relative commented, "Spot on manager, really good and has his best interests at heart. Really good with him and me."

Staff we spoke to were also very positive about the registered manager. One member of staff said, "She's very good and very supportive." Another member of staff commented, "Amazing manager. She's brilliant, so supportive and there when you need her. She always provides best practice guidance." The registered manager knew people, relatives and staff very well and was able to use this knowledge to provide personalised support to people. The registered manager told us about each staff members strengths and how they worked to supported people and the service. During our inspection we observed staff asking the registered manager guidance questions. One staff member told us after asking the registered manager a question, "She's very good as a manager. I can go to her with anything and she's supportive."

The registered manager had a clear vision for the service which incorporated the values described in the provider's statement of purpose. The registered manager told us, "At the centre of everything is how do we meet the individual needs of people and overcome barriers to full fill that." The registered manager was very passionate about the care provided to people using the service and they worked with other professionals to ensure that people were able to be as independent as possible. They had many plans to take the service forward and one main focus for the service was to encourage the transition of people within society to meet their own aspirations.

There were regular staff meetings at the service and we reviewed the minutes from these. The registered manager had discussed lessons learned from a recent complaint received, safeguarding updates, best practice guidance and people updates. Staff received regular supervisions and appraisals from the registered manager. These were monitored on a matrix alongside a training matrix. The registered manager discussed training requirements with staff and was currently working on a new training programme in partnership with Cardiff University around autism and neuro diversity training. We reviewed the minutes from resident meetings and conversations included how people were feeling, anything that could be improved and anything extra that they would like. Relatives were also invited to attend these meetings with people.

People, relatives and staff were asked to provide feedback to the provider about the service. Due to the

positive relationships between all parties, regular feedback was received and documented. Improvements ideas from feedback was used to improve the service and wider provider network. Quality audits were carried out by the registered manager and by the provider's wider management team. These were all recorded electronically and provided real-time action plans which could be analysed to see where the service was performing well and it highlighted areas for development. The registered manager carried out daily, weekly and monthly audits of the service and we saw evidence of these. The provider also carried out a quality assurance audit of the service on a monthly basis. These all allowed for the key areas of the service to be monitored and if any faults or errors were identified they could be acted upon.

The service had an open, transparent and honest relationship with partnership agencies such as the local authority and the Clinical Commissioning Group (CCG) and we saw evidence in people's care files of joint working with external professionals to support people.