Care Quality Commission

Sanctuary Home Care Limited

Tony Long House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on the 10th and 11th of February 2015 and was unannounced.

The service provides personal care and support to six people with needs arising from either physical disabilities or a combination of learning and physical disabilities. Limited personal care support is also provided on a domiciliary care basis to four people living independently in the adjacent flats.

The service is required to have a registered manager and one was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People in the service were actively involved in making decisions about their care and were asked for their consent before being supported. Relationships between staff and people were relaxed and positive.

Summary of findings

People chose how they wanted to spend their time. They had a wide range of opportunities to take part in activities and events and could access the community when they wished.

Prospective staff were subject to appropriate checks of their suitability and received the training and support they needed to carry out their role and to keep people safe.

The service responded flexibly to people's individual wishes and changing needs and sought support from health and wellbeing specialists when necessary. People's dignity and privacy were respected and supported by staff.

If concerns or issues were raised they were addressed and people felt the manager and staff were approachable and listened to their point of view. People's views had also been sought through surveys and resident's meetings.

The format of care plans was being revised to one which was more focused on the individual and better reflected their wishes and choices. The manager and provider carried out a series of audits to monitor the operation of the home and action was taken to address any issues identified.

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 because appropriate action was taken where any concerns were raised.

Staff received training and understood how to keep people safe from harm an injury. Staff skills and knowledge were checked in key areas of work. Risk assessments took place and actions were taken to address identified risks.

Pre-employment checks were carried out before staff were employed.

Is the service effective?

Good

The service was effective because staff communicated effectively with people and each other. People were able to make decisions about their care and lifestyle.

Staff received appropriate training and support to enable them to meet people's needs.

There were enough staff to respond flexibly to people's needs and wishes and enable them to access their preferred activities.

People's dietary and health needs were met effectively.

Is the service caring?

Good

The service was caring because staff engaged positively with people and encouraged them to make choices about their own care and how they wished to spend their time.

People's dignity and privacy were respected by staff.

People were given sufficient time to process information, make decisions and do things for themselves where they wished to.

Is the service responsive?

Good

The service was responsive because support was provided flexibly in response to people's needs, wishes and choices.

People were involved in planning and reviewing their care. Care plans were being made more centred on people's wishes.

People's views were sought through surveys, residents meetings and complaints and any issues were acted upon.

Is the service well-led?

Good

The service was well led because the manager and provider monitored its performance in key areas and took action to remedy any shortfalls.

People could approach the manager or raise any issues or concerns with the provider and were confident that they would be addressed.

The advice of external healthcare specialists was sought where necessary.

Tony Long 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 10 and 11 February 2015 and was unannounced.

The inspection was carried out by one inspector. Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

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. We looked at the information provided in the PIR and used this to help us plan the inspection. We contacted the local authority who fund all six of the beds in the service, to obtain their views.

During the inspection we spoke with the registered manager of the service and two of the staff. We examined the care records of four people supported by the provider within Tony Long House and four people who received support in their own homes from the service. We read other records relating to the operation of the service. These included risk assessments, training records, staff supervision and appraisal records and management monitoring systems. We also spoke with two of the people in the service and the relatives of two others and observed the care provided. After the inspection we spoke on the telephone to one of the people supported in their own home.

Good

Is the service safe?

Our findings

Relatives and people felt that they were safe when supported in, or by staff from Tony Long House. One person told us: "I always feel safe here". A relative told us: "I have never seen anything to concern me". One person supported in their own home told us: "I feel confident and safe".

Appropriate action was taken to safeguard people when any concerns had been raised. All staff had attended training on safeguarding vulnerable adults apart from the two most recent recruits who were booked to do so in March 2014. The training was provided by the local authority which helped ensure that staff were familiar with the local system as well as the general principles.

People were safeguarded when being supported with their moving and handling needs because staff had received appropriate training and had their competency assessed annually. People in the service had volunteered to take part in staff moving and handling training using the equipment provided for them. The registered manager told us that all identified risks were assessed and suitable plans put in place to address or minimise the risk.

Where people were supported with moving and handling equipment a risk assessment identified their needs, how they should be met and any necessary training. For example one person's moving and handling risk assessment identified the need for staff to be trained on the use of the ceiling track hoist, which had then been provided. Another person's risk assessment identified the need for two staff to assist with their transfers to and from bed. Risk assessments had been reviewed within the last 12 months.

Four people used bed-rails to reduce the risk of falls from bed at night. In each case a risk assessment had been done on their suitability for the individual and appropriate consent had been sought for their use. One person's file included reference to how staff had explained the risks to the person so they could make an informed decision about using bed-rails.

People supported in their own homes had a risk assessment completed to identify any risks associated with their home or its environment, to safeguard people and staff. The resulting risk management plan detailed any actions to address or minimise identified hazards.

The registered manager told us that the local authority were very good when repairs where needed to equipment they supplied. For example to a broken shower chair which had been collected, repaired and returned the next day. The provider carried out regular checks on safety-related equipment, health and safety of the environment and fire safety systems. This ensured that any such concerns were identified and rectified quickly.

The pre-employment checks carried out helped to minimise the risk that people might be employed who were unsuitable to care for vulnerable adults. The recruitment files for the two most recent recruits showed that an appropriate system was in place for pre-employment checks and the required records were available to confirm these had taken place. The staff files included copies of a signed application form, a full employment history, references, a health declaration, confirmation of identity and a check on any previous criminal record.

The staff compliment for the home was registered manager, deputy manager and 18 support workers, supported by maintenance and domestic staff. The support provided to people in their own homes was by a separate team of three support workers managed by the registered manager. Staff retention was good with low turnover. Vacancies were advertised and recruited to promptly to avoid staff shortages. There were two part-time support worker vacancies at the time of this inspection which had been advertised and the shortlisting process was about to take place. The registered manager also had access to an in-house group of 'bank' part-time staff who tended to work at least one shift per week in the service to maintain their knowledge of the people living there. No staff from external agencies were used which helped to maintain consistency and continuity of care.

Staffing was sufficient to meet people's needs and wishes. The staffing levels provided were four staff throughout the daytime, including the manager and deputy plus a domestic support worker. From 6pm there were two staff plus a domestic support worker. Night staffing was one staff member awake and one sleeping in on call if required. Staff could access support out of office hours from the registered manager or deputy via the duty on-call system or could contact the provider's on-call number. Details of the on-call manager were on the staff rota.

Good

Is the service safe?

People told us that staff helped them with their medicines appropriately. One person said: “They always give me my tablets”. All of the people in the service had been assessed as requiring support with their medicines. This was addressed within a medicines risk assessment and recorded in their care plan. In order to personalise this support the medicines for the current week were stored in a locked cabinet in each person’s bedroom to which staff held the key. Remaining medicines stock for the month was kept centrally in a locked medicines cabinet.

Staff had received training on medicines management and had their competency in this area assessed. However, nine staff had not had their competency reviewed within the last 12 months. Staff had signed to confirm they had read and understood the medicines procedure.

The registered manager told us there had been no medicines administration errors in the previous 12 months and said there had been two instances of medicines not having been signed for. In each case staff were required to re-do the medicines computer-based training and had their competency reassessed so people were kept safe.

Staff described appropriate ways to respond to any refusals to take medicines by giving people time and then re-offering them, perhaps by a different member of staff. On-going refusals were recorded and discussed with the GP. The service had an appropriate medicines management and recording system. Unused medicines were returned to the pharmacist for disposal. Records were kept of regular checks of the temperature within people’s medicines cupboards to ensure they did not exceed suitable levels. The registered manager had introduced an in-house medicines audit tool in January which was to be completed monthly to ensure people were kept safe from risks associated with medicines.

Good

Is the service effective?

Our findings

Relatives and people were complimentary about the effectiveness of the service. One person told us the staff always asked what they wanted and said: "they always ask if everything is ok". One person was more critical of the service, giving some positive feedback and saying only that: "Sometimes the food is nice". They didn't expand further on what it was they hadn't liked.

One person explained how the staff helped them communicate their wishes, saying: "Staff help me write down what I want". One relative told us a person was not a big eater but was: "Given what [the person] wants" and added that their: "Health needs were met". One of the people supported in their own flat told us that: "staff were trained and skilled" and added: "They involve you in decisions" and provide: "support with my meals and cook my choice of meal".

Where staff supported people to eat their meal they offered options such as seasoning to the person and sat with the person they were supporting for the duration of the support. They assisted one person at a time and allowed them time to eat at their preferred pace. Staff interacted positively with the people supported throughout the process.

All of the people in the service were able to make their own decisions about what they wanted to eat on a daily basis, so there were no set weekly menus. People chose daily what they wished to eat. They either prepared meals themselves or were encouraged and supported by staff where necessary, according to their care plan and personal wishes.

Records were kept of what people had eaten to monitor diet. Some people shopped for their own meal ingredients, others could choose from the range of options available in the service. Staff sought people's wishes from them with regard to the foods they enjoyed so these could be kept available. Some people had chosen to have their own small fridge in their bedroom to keep favourite items in.

Staff supported people to make healthy eating choices. A risk assessment had identified that one person was at risk of weight gain due to medication. An appointment had been made with a dietician with the person to help them make healthy choices for themselves. People were weighed monthly unless there was a need to do this more often. The home used specialist wheelchair scales to minimise the impact of this process. Where people were unwell, records were kept of food and fluids intake. One person had a risk assessment in place around the risk of choking on food. Advice had been sought from the GP and Speech and Language Therapy team.

There was a record of the induction process for staff and of the induction training for the use of specific aids and equipment to ensure that staff knew how to use them safely. Induction was based on nationally recognised standards.

Records showed and staff confirmed that they were provided with a range of core training from various sources, including the local authority, external specialist trainers and computer-based courses. Training updates were provided on a planned cycle. If a concern was identified, staff had to undertake specific training updates, for example on medicines management, before continuing to deliver that aspect of care. Staff also confirmed that they completed competency assessments in areas such as medicines management and moving and handling to ensure they understood the correct ways of working.

All of the staff had attained a nationally recognised care qualification apart from the two most recent recruits. The provider put people forward to work towards this qualification once they had completed their initial six months probationary period.

People's needs were met promptly because staff communicated well, both informally and in handover meetings between shifts. Written records of handovers helped ensure that information was passed effectively between shifts to maximise continuity of care. Staff confirmed that team communication was good and support was available from senior staff.

Staff attended regular supervision with either the registered manager or deputy to discuss their progress and any training or other needs. The manager held team meetings around every two months. Keyworker meetings also took place to discuss people's individual needs. The manager observed care practice and spoke with people informally and fed back any issues to staff. The manager attended handover meetings between shifts and worked some weekends as part of monitoring the service.

Good

Is the service effective?

Staff had performance appraisals after six months and annually thereafter to discuss their on-going professional development. We saw examples of recent appraisals having been completed during the three months before the inspection.

Of the people supported within the service one was able to come and go from the service freely without staff support. Three others were dropped off and picked up from events when they went out but did not require staff support whilst there. Two people were supported by staff when outside the service.

The manager said the staffing provided meant that people could be supported to attend their regular planned outside activities as well as any they wished to attend on the spur of the moment, so there was no limitation on people's liberty. For this reason, no Deprivation of Liberty Safeguards (DoLS) applications had needed to be made. DoLS applications are part of the Mental Capacity Act 2005. They are a way the provider obtains authorisation for any limitation on a person's liberty deemed to be in their best interests such as if they would not be enabled to leave the building when they wanted. The Mental Capacity Act 2005 safeguards people who may not have the ability to make some or all decisions about their care and wellbeing for themselves.

All of the people had capacity to make day-to-day decisions about their lives and to consent to their care. Written records of various consents were present on people's care files. One person had arranged their own advocate for support. Everyone had been given the contact numbers for an advocacy service, their GP, dentist, care manager and the local authority safeguarding team. All but one had their own mobile phones.

During our observations of care people were supported to consent to their day-to-day care and to make decisions where they were able. One person had been provided with a voice generation touch-screen device with symbols to support them to communicate their wishes and needs. The equipment had been obtained by the provider and funded by the local authority.

People retained control over their own finances apart from one person whose funds were managed on their behalf by the local authority and provided monthly.

Some people could at times require support to manage their behaviour. Where this was the case individual management plans were in place. Most staff had attended previous training on managing challenging behaviour based on nationally approved course teaching defusing techniques. No physical interventions were used. A training DVD was also available to staff as a refresher about the techniques. New training details had recently arrived for the latest on-line update to this training which some people had already completed. Staff confirmed this approach and told us they kept records of particular behaviours where necessary to monitor them and the effectiveness of their intervention.

One person made their own GP and dental appointments and the others were offered support with this. People had few specialist healthcare needs. One person was at risk of seizures. Their care plan identified their wish to remain at home and an ambulance would be called if required. One person was at risk of pressure sores and received support from the district nursing service and the tissue viability nurse.

Good

Is the service caring?

Our findings

Relatives and people were mostly happy with the care and support they received. One relative told us that staff were: "Friendly and relaxed" and were: "Good people, they make me feel welcome". The relative described how the person was taken out by staff when they wanted. Another relative told us staff were: "Very good, patient and kind".

One person had mixed feelings about the staff. They gave some very positive feedback but also said that some staff could hurry them at times. Another person told us they were very happy with the staff and said they were: "always asked about their care needs". They described the staff as: "Gentle and patient". One person said they had discussed an upcoming medical procedure with staff. They described how they had been given the information to decide about the type of anaesthetic they wanted.

One of the people supported in their own flat told us the permanent staff were: "kind and caring and very good" and added that they: "Definitely look after privacy and dignity". However, the person told us that this wasn't always the case if their support wasn't provided by one of the regular staff, who were familiar with them.

Staff engaged with each person in a friendly and positive way. We saw that they provided for people's dignity and privacy and discussed their care with people to obtain their consent and encourage choice. For example when one person had spilled something on their clothes staff supported them to their room to change their clothes, having agreed this with the person.

The care records were written in positive and respectful language. They provided details about the care given and the involvement of people in decision-making. References were made to people's choices and to their requests having been met. Care plans also identified how people preferred staff to refer to them and this was respected by staff.

People's needs in relation to physical and learning disability were met effectively by the staff who gave people time to explain their needs and supported them to take the time they needed to accomplish things for themselves. People had specialised seating and wheelchairs where necessary to support their posture and provide independent mobility where possible.

The care plans provided staff with information about people's needs and also their preferences about how their support was provided. Where people managed aspects of their own care either partially or entirely, this was described in the care plans. The records of care also indicated examples where people had managed their own care so it was clear where staff had or had not had a role.

In support of their dignity and privacy people were given the option of taking their medicines in private in their bedroom rather than in the lounge or dining room. Staff described other ways in which they respected people's dignity. They only provided support behind closed doors and explained what they needed to do and sought the person's agreement, before providing care. Staff told us they always encouraged people to do what they could for themselves to support their independence.

One care plan described how staff were to support a person who required transfer by hoist when showering. Two staff were to support the person with the hoist transfer as per their risk assessment. Then to maximise their dignity one staff member only, was to remain to support them with showering.

People could have visitors at any time they wished. The manager told us and people confirmed that visitors came during the daytimes, evenings and at weekends. During the inspection a number of people were visited by family.

The view of the contracts team of the local authority who purchase the places was that: "Staff have been observed to be supportive and positive in their approach, treating those in their care with respect and making every effort to maintain dignity at all times".

Good

Is the service responsive?

Our findings

People were happy that the service met their individual needs. One person told us the staff were "All helpful, if you want anything you can buzz [the call system] or go and see them". People told us about the range of activities and things they went out to do in the community. One attended regular local football matches others went out together or individually with staff support whenever they wanted. One person said: they planned to do some gardening in the summer, and added: "The staff will help me". People told us that staff checked their well-being with them. One told us: "If I'm not well I tell staff and they will get a doctor". People also confirmed that they chose what they wished to eat, saying: "We choose the meals we want". The contracts officer for the local authority who support people in the service, told us: "The provider has proved to be responsive, demonstrating effective partnership working and has been willing to look for innovative solutions".

The view of the local authority contracts team who funded the care was that "People who reside at Tony Long House consistently benefit from a high level of person-centred care and support, having every opportunity to be involved in their own planning and reviews".

The office copies of the care files for the people supported in their own flats did not always contain the most up to date copy of care plans or risk assessments. However, the current copies were present in the files held in people's flats so staff would have access to the current information.

From discussion with the manager the service seemed to be primarily focused on the support provided to people in Tony Long House. People supported in their own flats had care plans identifying the personal care support they received. However, the additional support provided was not always as clearly defined. The level of support for three of these people, who were largely independent, was minimal but could be on an ad hoc basis rather than being limited to planned care visits. For example they might also be supported with making appointments or phone calls or with reading and dealing with documents and letters. At times people appeared to have expected support that was outside the remit of the service. This could potentially lead to misunderstandings about who was responsible for some aspects of support. One person living in their own flat told us the staff response was usually good but sometimes they could be busy.

The service was in the process of converting its care plans into a new, more individualised format. We looked at examples of both versions and could see the improvements within the new format. People were involved in discussions about their care needs. They either read their resulting care plan or it was read to them to seek their views and obtain their consent. Care plans contained references to people's wishes, preferences and choices. They addressed the person's individual needs including where they might sometimes need support to manage their behaviour.

People were enabled to choose their own keyworker who took the lead on overseeing their individual needs, their care planning and reviews. The manager also assigned a co-keyworker to support the keyworker role and provide continuity during periods when the keyworker was absent. It was evident from staff interactions that they were familiar with the needs and preferences of the people they supported. In this way they had identified changes in people's wellbeing promptly and sought medical assistance or other advice in a timely way.

Changes in people's care needs were discussed with them and, where appropriate, their family. In one case a person's medication had been reviewed and changed in consultation with them and the appropriate health specialist. In another case staff had worked effectively with one person to moderate an aspect of their own behaviour. One relative, who was not formally involved in a person's reviews, felt they were kept appropriately informed about their wellbeing. They also felt able to express their opinions and felt these would be heard.

One person had been provided with a night-time hoist sling, to support their need for minimal disturbance during the night. Where someone had difficulties with their medicines staff had arranged these in a different form or at different times following consultation with the GP to better meet individual requirements.

People had been offered alternative types of accommodation within the home where this had been appropriate and had chosen their preferred facilities.

Most people had been supported to identify their end-of-life wishes through discussion or using accessible written formats. The manager planned to further adapt the written format so the remaining people had the opportunity to do this.

Good

Is the service responsive?

People told us and record showed that they enjoyed a good range of activities and regular access to the community. A relative told us people's: "social life was good". People regularly attended activities, day services and clubs in the community as well as local shops. Support was provided for visits to peoples' family and for things like swimming, football and pub visits. People's feedback and wishes about activities were responded to by the staff. On person told us they used to attend a club but didn't like it so they don't go now. People would be supported to attend places of worship if desired. One person told us staff: "Would take us to church if we wanted".

People had been supported to go away on holidays or outings according to individual wishes. Staff support was discussed and agreed with people as was whether other people from the service went with them. Two people had been successfully supported to have a holiday without staff support apart from transporting them and helping them settle in.

The complaints procedure was posted in various parts of the service and was available in an easy-read format. One person told us they were very happy with the service and said: "No complaints from me". Another relative told us they would go to the registered manager if they had any concerns and was confident they would be addressed. They added: "I only have to say something and it's sorted out". One person living in the flats told us they had asked for a rota so they knew which staff would be providing their care support but they were still waiting for one. A relative told us they had had no complaints and added that: "If we did, it would be dealt with".

The complaints log had two issues recorded in the previous 12 months which had been resolved appropriately.

In the course of examining records we identified one further informal complaint which should have been included within the complaints log. This matter had already been followed up and addressed. Immediately following the inspection the manager confirmed this had now been included in the complaints records.

The manager explained that one person without capacity made a lot of day-to-day complaints which related to their lack of sufficient insight into their support needs. For example the person told us they wanted to go out shopping alone which not have been safe. It had been agreed within the team that these issues would only be documented as complaints where an actual or potential impact could be identified or where the person's body language indicated the matter was actually a complaint. There was no evidence this approach had been agreed with the person acting on their behalf.

People told us they attended resident's meetings and any issues raised there were discussed and usually resolved at the time between people. People told the staff about things such as their preferred meals and any disliked foods individually. However, mealtimes or food had also been discussed sometimes during resident's meetings. People had been made aware of the provider's policy on safeguarding them from abuse and encouraged to report any concerns.

The manager told us the last full survey of people's views about their care had been completed by the provider two years ago. However, an in-house survey had been sent out in December 2014 and some responses had already been received. We saw some of the returned surveys on people's files. The feedback to date was positive with no major issues raised. The matters that were raised had been dealt with appropriately. For example, feedback about particular staff not knocking before going into bedrooms was addressed with them via supervision.

Good

Is the service well-led?

Our findings

People and relatives felt the service was well run and a safe place to live. They told us the staff and management were approachable and listened to their views. One relative said the registered manager was "Open, and we get on well". One person told us: "The manager listens".

The registered manager said and staff confirmed that she operated an open-door policy and staff could raise issues freely. She gave examples of staff raising concerns about people's well-being or safety and the action that was taken. Staff could contact the registered manager, the deputy manager or the area manager if they needed support out of office hours and could also raise any concerns with the provider's human resources department if they wished. The registered manager took part in handover meetings between shifts to remain up-to-date about day-to-day issues. A staff member told us: "You can talk to [the manager] anytime, things get sorted out". They added: "It's a good team, no blame culture".

The development of the service was driven through training, team meetings and external advice and support. When support was required to help people manage some behaviours the service sought appropriate external advice and training. Team meetings were minuted and the records showed that four of these had taken place in the previous 12 months. The provider supplied staff with an employee handbook detailing the expectations about their conduct and professionalism.

The registered manager maintained an overview of the effective operation of the service through a range of audit and monitoring tools. These included maintaining records across the team for such things as staff training. The manager set up a system to maintain an overview of staff supervision, following discussions during the inspection. Key events and incidents were monitored and audits of recruitment records, medicines management and infection control were completed. Monthly medicines audits identified any medicines errors and the action taken to address them. The quarterly infection control audits for the previous 12 months had identified no issues of concern. We saw copies of monthly recruitment records audits which each sampled two staff files and showed the file examined contained the required records.

An area manager or the registered manager from another of the provider's services carried out monthly compliance monitoring visits to the service. Copies of the previous year's reports were supplied which raised no issues of concern. The registered manager also completed regular audits of the service and the support service provided to people in their own flats.

The provider carried out an annual quality assurance audit of the service, which had recently taken place in January 2015. These visits resulted in an action plan to identify and monitor any necessary improvements. The local authority that supported the placements of people in the service carried out quality assurance visits which also resulted in a report to the manager. The latest local authority monitoring report from August 2014 raised a small number of action recommendations which were addressed. The pharmacist also completed medicines management audits. The most recent pharmacist report dated December 2013 identified no required actions and made one recommendation. The provider and registered manager produced an annual service improvement plan which identified any areas for improvement identified through the various audits.