All In Mind Care Services Limited

Castle View House

Inspection report

9 Castle View Road
Rochester
Kent
ME2 3PP

Tel: 01634721107

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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

Summary of findings

Overall summary

This inspection took place on 18 December 2018. The inspection was unannounced.

Castle View House is a 'care home'. People in care home services receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Staff provided residential care for up to eight people living with a mental illness. There were seven people living at the service when we inspected.

A registered manager was employed at the service and they were present during the inspection. The registered manager was also the provider of the service. 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.

Staff assessed and treated people as individuals so that they understood how they planned people's care to maintain their safety, health and wellbeing and choices. Risks were assessed within the service, both to individual people and for the wider risk from the environment people lived in.

Actions to minimise risks were recorded. Incidents and accidents were recorded and checked by the registered manager to see what steps could be taken to prevent these happening again. Staff understood the steps they should take to minimise risks when they were identified. The provider's health and safety policies and management plans were implemented by staff to protect people from harm.

Staff were encouraged and supported to raise any concerns they may have. Incidents and accidents were recorded and checked by the provider to see what steps could be taken to prevent these happening again. Staff were trained about the safe management of people with behaviours that may harm themselves or others.

We observed safe care. Staff had received training about mental health and protecting people from abuse. The management and staff showed a good understanding of what their roles and responsibilities were in preventing abuse.

The registered manager and other senior staff held professional mental health qualifications and were registered to practice with the Nursing and Midwifery Council (NMC). They worked alongside their staff to deliver care. Therefore, the management had an in depth knowledge of how the service was running and got to know people and staff very well.

The registered manager involved people in planning their care by assessing their needs in partnership with the person and the community mental health team. Staff practice was based on recognised Mental Health

person centred approaches. We observed and people described a service that was welcoming and friendly. Staff provided friendly compassionate care and support.

People were encouraged to get involved in regular reviews of their care and how their care was planned and delivered. All of the people had the support of a community psychiatric nurse (CPN) and an in house key worker. People were given maximum control over their lives based on positive risk taking practice. People could involve relatives or others who were important to them when they chose the care they wanted.

Care plans were kept updated to assist staff to meet people's needs. Care plans recorded people's life story, recorded who the important relatives and friends were in people's lives and explained what lifestyle choices people had made. Care planning told staff what people could do independently, what skills people wanted to develop and what staff needed to help people to do.

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People and staff felt that the service was well led. They told us that staff and the registered manager were experienced, understood people's needs, were approachable and listened to their views. The registered manager continued to develop business plans to improve the service.

People were asked if they were happy with the care they received. The provider offered an inclusive service. They had policies about Equality, Diversity and Human Rights. People, their relatives and health care professionals had the opportunity to share their views about the service either face-to-face, or by using formal feedback forms.

Safe recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service. The provider recruited staff with relevant experience and the right attitude to work with people who had mental health illness.

New staff and existing staff were given an induction and on-going training which included information specific to the people's needs in the service. Staff were deployed in a planned way, with the correct training, skills and experience to meet people's needs.

Staff received supervision and attended meetings that assisted them in maintaining their skills and knowledge of social care and people's needs.

Staff understood the challenges people faced and supported people to maintain their health by ensuring people had enough to eat and drink. Pictures of healthy food were displayed for people and dietary support had been provided through healthy eating plans put in place by dieticians. Staff supported people to maintain a balanced diet and monitor their nutritional health.

There were policies and procedures in place for the safe administration of medicines. Staff followed these policies and had been trained to administer medicines safely.

People had access to GPs and their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell. Good quality records were kept to assist people to monitor and maintain their health.

The quality outcomes promoted in the providers policies and procedures were monitored by the management in the service. Audits undertaken were based on cause and effect learning analysis, to improve quality. All staff understood their roles in meeting the expected quality levels and staff were empowered to challenge poor practice.

Management systems were in use to minimise the risks from the spread of infection, staff received training about controlling infection and carried personal protective equipment like disposable gloves and apron's.

The registered manager had demonstrated a desire to improve the quality of the service for people by listening to feedback, asking people their views and improving how the service was delivered.

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 experienced a service that made them feel safe.

Individualised and general risks were assessed to minimise potential harm.

Staff knew what they should do to identify and raise safeguarding concerns. Management understood how to report safeguarding concerns and notified the appropriate agencies.

The provider used safe recruitment procedures and general and individual risks were assessed. Medicines were managed safely.

Incidents and accidents were recorded and monitored to reduce risk.

Infection control and equipment risks were managed safely.

Is the service effective?

Good

The service was effective.

People's needs were assessed.

People accessed routine and urgent medical attention or referrals to health care specialists when needed.

People were cared for by staff who knew their needs well.

Staff encouraged people to eat and drink to maintain their health and wellbeing.

Staff met with their managers to discuss their work performance and each member of staff had attained the skills they required to carry out their role.

The Mental Capacity Act 2005 was understood by the management and staff received training about this.

Is the service caring?

Good

The service was caring.

Staff used a range of communication methods to help people engage with their care.

People had forged good relationships with staff so that they were comfortable and felt well treated.

People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Staff provided care to people as individuals. People were provided with the care they needed, based on a care plan about them.

People could take part in activities and socialise according to their lifestyle choices.

Information about people was updated often and with their involvement so that staff only provided care that was up to date.

People were encouraged to raise any issues they were unhappy about.

Is the service well-led?

Good

The service was well led.

The provider operated systems and policies that focused on the quality of service delivery.

The aims and values of the organisation were shared by staff.

People were asked about the quality of the service they experienced.

The registered manager operated systems and policies that were focused on managing risks and the quality of service delivery.

The staff worked with other organisations to manage people's

care.

Castle View 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 18 December 2018 and was unannounced. The inspection team consisted of one inspector and an expert by experience. The expert by experience was a person who has personal experience of using similar services or caring for people with mental illness.

We used information we held about the service and the provider to assist us to plan the inspection. This included notifications the provider had sent to us about significant events at the service. We also 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.

During our inspection we spoke with four people about what it was like to live at the service. We spoke with three staff members which included the registered manager, the director of care and one support worker. We asked for feedback about the service from five external organisations involved in contracting and monitoring the service.

We looked at risk and quality audit records, policies and procedures, complaint and incident and accident monitoring systems. We looked at three people's care files, three staff recruitment files, the staff training programme and medicine records.

The service had been registered with us since 28 February 2018. This was the first inspection carried out on the service to check that it was safe, effective, caring, responsive and well led.

Good

Is the service safe?

Our findings

One person told us, "I feel safe, I don't feel threatened. If I didn't feel safe I would speak to a member of staff." Another person said, "I feel safe because of good staffing. If I didn't feel safe I would try and calm down and maybe speak to a member of staff." Another person said, "You get at least three members of staff during the day and at least two at night. There are enough staff numbers to get things done from day to day."

The risks and vulnerabilities people faced living with mental illness fluctuated and this was taken into account by the registered manager. Assessments were carried out in liaison with people's community psychiatric nurse (CPN). As the risks to people from their mental health increased, the staff interventions increased as well to ensure people's mental health remained as stable as possible. People were protected from harm through assessments and open and transparent risks management processes. People had been assessed to see if they were at any emotional or physical risk during periods of mental illness. People were safeguarded by staff who were trained to protect them from harm. Staff had access to the provider's policy about safeguarding people and this policy was up to date with current practice.

Staff understood how they reported concerns in line with the safeguarding policy if they suspected or saw abuse taking place. Staff gave examples of what would concern them and need reporting, for example, bruising or changes in people's behaviours. Staff had read and understood the provider's whistleblowing policy. A member of staff said, "Safeguarding is covered as part of our induction and training." The providers policies included protections for people's finances. No safeguarding concerns had been raised about this service since it was registered. The registered manager understood how they should report and investigate any safeguarding concerns under the 'Multi-agency safeguarding vulnerable adults: Adult protection policy, protocols and guidance for Kent and Medway.' (This document contained guidance for staff and managers on how to protect and act on any allegations of abuse).

There were systems in place to monitor and collate incident and accident data to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. Risks were reduced by consensus and with respect to people's independence. Accident records included information that management were investigating and reviewing the accident reports and monitoring for any potential concerns.

The registered manager assessed risks to the environment people lived in to protect them and staff from potential hazards. The premises were kept well maintained and maintenance issues were logged and records kept showed that repairs were completed in a timely way. For example, some fire doors and flooring had recently been updated. Responding to maintenance issues protected people from environmental risks.

Staff with the right skills supported people in the right numbers to be able to deliver care safely. People were encouraged to be independent with their life skills and staff were not required by people all of the time. We could see that the way staff were deployed matched people's needs in their care plans. The staff duty rotas demonstrated how staff were allocated on each shift. We reviewed the rotas, these showed that the required number of staff were consistently deployed. The registered manager and director of care made themselves

available to cover shifts and were on the staff rota. This showed that arrangements were in place to ensure enough staff were made available at short notice. We saw that there were enough staff to supervise people and keep them safe, both at home and in the community.

People were protected from the risk of receiving care from unsuitable staff. New staff had been through an interview and selection process. The registered manager followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Applicants for jobs had completed applications and been interviewed for roles within the service. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications. Staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

People were protected from the risks associated with the management of medicines. Medicines were managed in liaison with people's community psychiatric nurse (CPN). One person said, "Staff give us meds and cook for us, painkillers and extra meds would be given to us if necessary." Staff followed the provider's policy on the administration of medicines which had been reviewed and was up to date. There were systems in place so that medicines were ordered in good time and available as prescribed. Staff who assisted people to administer medicines received competency checks and yearly training updates. Staff understood how to keep people safe when administering medicines. There was a policy about the safe management of 'As and When Required Medicines' (PRN), for example paracetamol. PRN assessments for each person were in place.

The system of medicines administration records (MAR) allowed for the checking of medicines, which showed that the medicine had been administered at the right times and signed for by the person when they had taken their medicine. We sampled the MAR records and these had been completed correctly. This meant that people's health and wellbeing was being maintained through the appropriate use of prescribed medicines.

The registered manager had policies about protecting people from the risk of service failure due to foreseeable emergencies so that their care could continue. There was an out of hours on call system, which enabled serious incidents affecting peoples care to be dealt with at any time. People who faced additional risks if they needed to evacuate had a personal emergency evacuation plan written to meet their needs. Records showed fire safety equipment, gas appliances and electrical items were regularly checked and serviced. Assessing and reducing risks to people from foreseeable emergencies protected people from potential harm.

People were protected from potential cross infection. Water systems were managed to minimise the risks from legionella. The premises looked clean and staff received infection control training. Staff told us they always had access to personal protective equipment [PPE] when appropriate, such as disposable gloves and aprons. Cleaning followed a schedule that was checked and audited by the registered manager. Following cleaning and infection control minimised the cross infection risks.

Good

Is the service effective?

Our findings

One person said, "Staff are good at their jobs. If they say they'll do something they'll do it." Another person commented, "Staff are professional and well-trained." Another person said, "They (staff) are attentive to my mental health needs."

People's health and wellbeing was maintained and reviewed in partnership with external health services. Referrals had been made as necessary to community healthcare teams, for example to GP's, and mental health teams. There were records of contacts and advice given by health care professionals. One person said, "We have physical health checks every few weeks." People accessed a range of health and wellbeing services. For example, dental care.

People were to be supported to have enough to eat and drink to maintain their health. People routinely chose what they wanted to eat and drink. Staff were aware of people's individual dietary needs and their likes and dislikes. Where staff were helping people to maintain their health and wellbeing through assisting them to prepare meals, we found that people were happy with the food staff cooked for them. One person said, "Staff cook and prepare food for me. I like baking cakes." Where people's wellbeing was at risk from not eating and drinking healthily a plan was in place to monitor and respond to the risk. For example, with staff support people kept their own food diaries if they were at risks of gaining to much weight or not eating enough.

People benefited from staff who had appropriate training and skills to meet their needs. New staff completed an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. They confirmed to us that they had started with an induction. Staff then started to work through the training to Care Certificate standards which was recorded in their staff files. The Care Certificate includes assessments of course work and observations to check staff met the necessary standards to work safely unsupervised.

Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. The staff on shift told us they had received training to carry out their roles. Records showed staff had undertaken training in all areas considered essential for meeting the needs of people in a care environment effectively. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people.

Staff received additional specialised training for example in the management of mental health. Mental health training was planned for staff. Training records confirmed that staff had attended training courses or were booked onto training after these had been identified as part of staff training and development. Staff receiving specialised mental health training meant that they understood the challenges people faced living with mental illness and how their needs could best be met.

The registered manager checked how staff were performing through an established programme of daily staff handover meetings and formal supervision. These are one to one meetings and an annual appraisal of

staff's work performance. This was to provide opportunities for staff to discuss their performance, development and training needs, which the registered manager was monitoring. Staff confirmed to us that they had opportunities to meet with the registered manager to discuss their work and performance through supervision meetings.

The Mental Capacity Act 2005 (MCA 2005) 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 people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager had a good understanding of the Mental Capacity Act (MCA) 2005. They told us that no one was subject to a current DoLS authorisation. There was an up to date policy in place covering mental capacity. Staff had received training in relation to protecting people's rights.

People with changing capacity to make day-to-day decisions about their care were still offered choice and provided with information to help them decide what they wanted to do.

Good

Is the service caring?

Our findings

People described their care positively. People told us that staff were kind, friendly and respectful. One person said, "They (staff) talk to us nicely and they treat us well." Another person said, "They're (staff) caring. They do what they can." Another person said, "I wash myself and bath myself. They'll (staff) knock on the door before entering (my room)."

The care people received was person centred and met their most up to date needs. People's likes and dislikes had been recorded in their care plans. Staff encouraged people to be as independent as possible. All of the people who provided feedback told us they were involved in planning their care. We observed good communication between staff and people living at Castle View House. We observed staff to be friendly and caring.

People living with mental illness often suffer discrimination. The provider had a range of policies setting out their approach to dignity, equality, diversity and human rights (EDHR). These were accessible to staff and EDHR choices were included in people's initial assessments. Staff received training about the culture of the organisation in promoting dignity and human rights. Staff knowledge of EDHR was discussed at recorded supervisions meetings with the registered manager. Staff we spoke with demonstrated to us how they delivered care respectfully. This meant that care was open and inclusive. At the assessment stage people were encouraged to discuss their sexuality or lifestyle preferences as well as their rights, consent and capacity. Capturing information about people was an evolving process.

Staff we spoke with were friendly and happy to provide care. Staff were tested on their attitude to care when they applied to work at the service. All of the staff we spoke with displayed a caring attitude. We found that people were supported by caring staff that were sensitive in manner and approach to their needs. Staff described how they delivered friendly compassionate care. They told us how they made sure that people were comfortable and relaxed in their presence. Staff described how they made sure people had all they needed. Each person had a named key worker. This was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their dreams and aspirations.

Information about people was kept securely in the office and the access was restricted to senior staff. Staff understood their responsibility to maintain people's confidentiality.

Good

Is the service responsive?

Our findings

One person said, "We are informed of the care provided. If [one's] needs change from day to day they will adapt." Another person said, "They (staff) support me with my relationships, especially with my family and friends." Another person said, "They'll always keep me updated and informed of any care needs and plans." People consistently told us they knew how to make complaints if they were not happy.

Peoples care needs, preferences and choices continued to be discussed and agreed with people and recoded in a care plan about them for staff to follow. People could choose to share information about their beliefs and sexuality. Care plans were individualised and gave details about each person's needs and how they liked to be cared for. One person said, "Staff are aware of my family and personal details." Sections included family, interest, health and wellbeing and independence. Care plans contained information on a range of aspects of people's needs including mobility, emotional wellbeing and specific physical and mental health support.

The staff we spoke with were aware of what was important to people and were knowledgeable about their preferences, hobbies and interests. They had been able to gain information on these from the 'Person centred care plans', which had been developed through talking with people and their relatives. This information enabled staff to provide care in a way that was appropriate to the person.

The support people received was based on promoting mental health recovery and becoming more independent. For example, if people became unwell and anxious, staff would adapt their approach in line with guidance from a community psychiatric nurse (CPN). People's care and wellbeing was discussed and communicated within the team and recorded at shift handover meetings. Records detailed the information shared between staff about risks within the service.

Mental health support care plans detailed early interventions based on people's individual needs. This enabled staff to intervene early if they saw people's mental health deteriorating based on known patterns of behaviour. Staff understood the recorded behavioural triggers for each person. If people's needs could no longer be met at the service, the registered manager worked with the local care management team to enable people to move to more appropriate services. The registered manager sought advice from health and social care professionals when people's needs changed.

People told us their needs were reviewed and kept up to date and this was confirmed in people's records and by staff. People told us that they had a care plan folder with information in it about their care. Records showed that people had been asked their views about their care. People told us they had been involved in the care planning process and in the reviews of those plans. Reviews of the care plan could be completed at any time if the person's needs changed. Where changes were identified, people's plans were updated promptly and information about this was shared with all staff. We could see that care plan reviews had taken place as planned and that these had been recorded.

Records of multi-disciplinary team input had been documented in care plans. These gave guidance to staff

in response to changes in people's health or treatment plans. Information was displayed for people to access about health services and advocacy support. This meant that there was continuity in the way people's health and wellbeing were managed.

To promote wellbeing and reduce isolation activities to be planned and coordinated. People followed their own routines and had minimal staff support in the community. However, staff encouraged and motivated people to remain engaged with their local community. For example, people could request support for activities including participating in leisure activities, going to the pub for lunch and personal shopping. Staff were allocated to people's activities based on their skills and experience. This meant staff could understand and meet this person's individual needs. Staff helped people to stay in touch with their family and friends.

Staff told us they read people's daily reports for any changes that had been recorded and the registered manager reviewed people's care notes to ensure that people's needs were being met. When we spoke with staff they showed that they knew people well and what was important to them. This was evidenced by the knowledge and understanding they displayed about people's needs, preferences and wishes. The staff were able to tell us how they provided people with care that was flexible and met their needs. For example, they told us how they assisted people with physical care needs, emotional needs and their nutritional needs.

People we spoke with felt at ease to raise concerns with care workers or any member of the management team. People had one to one meetings with staff. At these meetings people were encouraged to talk about any concerns or complaints they had about the service. Staff built up trust with the people and met with them to discuss their aspirations.

The provider had a comprehensive complaints and compliments policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The complaints procedure was openly displayed in the service. One person said, "I have been here for [XX] years and have never made a complaint." The policy included information about other organisations that could be approached if someone wished to raise a concern with an external arbitrator, such as the local government ombudsman. There had been no complaints received by this service. The service staff had also received compliments in the last year. All people spoken with said they were happy to raise any concerns. The meetings and communication in the service reduced the risk of situations requiring people to make complaints.

No end of life care was provided at this service. However, staff worked closely with people and their community psychiatric nurse (CPN) to capture and discuss people's wishes for any end of life care planning.

Good

Is the service well-led?

Our findings

People knew who the management team were and were confident to approach them with any problems or concerns. One person said, "Overall, I'm happy with everything. I wouldn't change a thing." Another person said, "The service is good. I'm not sure how it could be improved." Another person spoke to us about the registered manager and staff. They commented, "They do a good job."

There was a registered manager in post. 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. We observed the registered manager was well known by people and the staff. They knew people's names and assisted with care when needed.

The service was well led by managers who maintained their skills and understanding in mental health issues. The registered manager and director of care held current nursing registration to practice as mental health nurses. They were both based at the service. They continued their professional learning and development and had recently been reaccredited by the Nursing and Midwifery Council.

There were systems in place to review the quality of all aspects of the service. This included infection control, medication, safety of the premises, staff records, training and care planning. Appropriate and timely action had been taken to protect people from harm and ensure that they received any necessary support or treatment. There were auditing systems in place to identify any shortfalls or areas for development, and action was taken to deal with these for example, refresher training for staff. Records showed that auditing process were kept up to date. These checks were carried out to make sure that people were consistently safe.

Improvements to the quality of the service were driven by the registered managers responses to risks and consistent audits. For example, the work required to fire safety in the service had been completed. There was also new flooring and decoration in the communal areas of the service.

A range of people including people using the service, relatives, staff and external healthcare professionals were asked to give their views about the service. The provider's quality assurance system included an analysis of people's responses to measure their performance.

Staff met regularly with the registered manager. Staff meetings gave staff the opportunity to discuss people's care and issues they may want to discuss about the quality of the service. Staff continued to receive appropriate supervision and told us that the registered manager was supportive and that they were listened to.

Policies and procedures governing the standards of care in the service were kept up to date, taking into account new legislation. For example, medicines policies followed guidance issued by the National Institute for Health and Care Excellence. The registered manager referred to external published guidance when

managing risk. For example, safety alerts from the Health and Safety Executive. The service worked with others including community mental health teams.

The culture of the service was open and inclusive. Staff we spoke with consistently demonstrated the provider's values to help people regain their confidence and continue to live independently and manage their mental health. The aims of the service at Castle View House was to offer a wide range of information on activities and events that will help tenants to build confidence, self-esteem and knowledge. From feedback we received from people these aims were being delivered for people.

Management was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. Management understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This ensured that people could raise issues about their safety and the right actions would be taken.