Mrs Taslimah Salamut

Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 10 and 14 March 2016 and was announced. The provider was given 48 hours notice as it is a small care home and people are often out during the day. We needed to be sure someone would be in during our inspection. The service was last inspected in November 2013 when it was found to be meeting the requirements inspected.

Residential Care home is a care home proving care to up to six people with learning disabilities. At the time of our inspection five people were living in the home. The service provider is a registered individual. This means there is no requirement to have a registered manager as the provider is considered a registered person. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

Staff knew people well and described in detail how to support people and manage risks. However, risk assessments were not robust and did not describe measures used to reduce the risk of harm. Care plan documentation was not person-centred. We have made a recommendation about person-centred care plans.

The service completed quality assurance questionnaires and audits. However, the audits used were not robust and did not identify areas for improvement. We have made a recommendation about quality assurance processes.

The service recorded incidents and accidents but did not complete analysis to see if lessons could be learnt. We have made a recommendation about incident recording and analysis.

People told us they felt safe, and staff were knowledgeable about safeguarding adults from harm.

There were sufficient numbers of staff to provide people with the support they needed. Staff received the support and training they required to carry out their roles and responsibilities.

People were supported to take medicines, and this was managed in a safe way. People were supported to access healthcare services and follow medical advice.

People had consented to their care. The service was working in line with legislation and guidance regarding capacity and consent. People were involved in making decisions about their care and had regular meetings to review their care and support.

Care plans contained details of people's dietary preferences and needs. People were supported to maintain a culturally appropriate diet that met their nutrition and hydration needs.

People and staff had developed positive, caring relationships with each other. People's individual identities,

cultural and spiritual backgrounds were supported. People were supported to have private time when they wanted and staff maintained people's dignity during care.

The home had a robust complaints policy and complaints were resolved in line with it.

The home had a positive culture that recognised people's individuality and preferences. People and staff spoke highly of the registered provider and the manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments lacked detail and did not include measures to reduce the risk of abuse.

Staff had a good understanding of how to protect people from harm.

There were enough staff to keep people safe and meet their needs.

People's medicines were managed so they received them safely.

Is the service effective?

Good

The service was effective.

Staff received training and support which ensured they had the knowledge and skills required to perform their roles.

Consent to care was sought in line with legislation and guidance.

People were supported to eat and drink enough and maintain a balanced diet.

People were supported to maintain their health and access healthcare services.

Is the service caring?

Good

The service was caring.

Staff had the time and the skills to develop positive, caring relationships with people using the service.

People were involved in making decisions about their care.

People's privacy and dignity were respected and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Incidents and accidents were not analysed to ensure that lessons were learnt.

Care plans were not always person centred and lacked detail in terms of the support required.

Staff knew people well and were able to describe the support they provided in detail.

The complaints policy was robust and complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance audit was not effective at identifying areas for improvement.

The culture of the service was positive and person centred.

People and staff spoke highly of the manager and the registered provider.

Residential Care Home

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 14 March 2016 and was announced. The provider was given 36 hours' notice because the location was a small care home for adults who are often out during the day and we needed to be sure that someone would be in.

Before the inspection we reviewed the information we already held about the service including statutory notifications. 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 it does well and improvements they plan to make.

The inspection was completed by one inspector. During the inspection we observe how the staff interacted with people who used the service. We spoke with five people who used the service, the manager, deputy manager and two support workers. We spoke to the registered provider by telephone after the inspection. We looked at four people's care files including support plans, risk assessments, reviews, monthly updates, health records and medicines records. We looked at three staff files, including recruitment records, training, supervision and appraisal. We also viewed the staff duty rotas, a range of audits and feedback, various meeting minutes, maintenance logs, incident and accident log, policies and procedures for the home, and other documents relevant to the management of the service.

Requires Improvement

Is the service safe?

Our findings

The registered provider completed individual risk assessments for people living in the home. People's care files contained a range of risk assessments relating to different areas of support, including mobility, accessing the community, aggressive behaviour, medicines and personal care. However, risk assessments did not fully describe the actions in place to reduce risk and were vague in their instructions for staff. For example, measures to reduce the risk of aggressive behaviour were described as "Educate and encourage [person] to understand the consequences of [behaviour]." A risk assessment relating to one person's mobility stated, "Requires one staff when using [their] frame." This did not tell staff how to support the people to understand consequences or use their mobility aid. Another person had received medical input regarding weight loss. Although the records of their appointments were clear, there was no risk assessment regarding the activities that had caused the weight loss. There were no assessments of how to manage the risk and reduce the risk in the future. The management of risk was discussed with staff. Staff described in detail what they did to mitigate risks and to reduce the risk of harm. However, this detail was not captured in the documentation.

The service supported people to manage their finances. A designated member of staff supported people to withdraw money and kept it safe within the service. There were clear records of all financial transactions. However, there were no checks in place to ensure that the designated member of staff was appropriately supporting people to manage their finances. This member of staff was the only person who had access to people's money and there were no systems in place, such as a second member of staff checking transactions, to prevent them from misusing people's money. This meant there were not appropriate measures in place to reduce the risk of financial abuse. This was brought to the attention of the manager and registered provider who advised they would update the risk assessments to ensure they were more detailed and robust.

The above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us they felt safe in the home. One person said, "It's safe here." The registered provider had a robust policy regarding safeguarding adults from abuse. Staff were knowledgeable about the different types of abuse people living in the home might be vulnerable to and correctly described the action they should take if they had concerns that someone was being abused. The provider told us they would report any concerns to the local authority to investigate which is the correct procedure. The home had had one safeguarding concern since the last inspection which had been appropriately responded to. The registered provider had not notified CQC of this safeguarding as required. This was brought to their attention and the appropriate notification has been submitted.

Staffing levels at the service were determined by the needs of the people living in the home and varied according to the activities planned for the day. For example, if a person had an appointment or activity scheduled the registered provider or manager worked to ensure safe staffing levels. Staff absences were covered by colleagues, or by a small pool of bank staff. This meant people were not supported by staff they did not know. Records showed that the registered provider carried out appropriate checks on staff before

they commenced employment, including identity and criminal records checks to ensure they were safe to work in a care setting.

People had support plans in place regarding medicines. The home had a folder which included the details of what medicines people were taking, what they were for and any potential side effects. The home used printed medication administration records (MAR) supplied by their local pharmacy. Daily checks on MAR charts were completed at handover and the manager completed further weekly checks. The records viewed were complete and showed people were supported to take their medicines as prescribed. Staff received training in administering medicines and were able to describe the process clearly including how they would respond to discovering any errors. The manager updated the recording system for counting medications during the inspection to ensure it was clearly recorded how much medication was in the service.

The service had a system of health and safety checks, including fridge and freezer temperature checks, water temperature checks and routine maintenance checks which were completed regularly. During our inspection a representative of the local authority's food safety team also inspected the service and found they were meeting the standards for food hygiene.

Good

Is the service effective?

Our findings

Staff attended a range of in-house and external training events which they described as "Useful" and "Very helpful." Staff training included safeguarding, food hygiene, first aid, moving and handling, medicines, infection control, the Mental Capacity Act (2005), risk assessment, equality and diversity, challenging behaviour, care planning and recording, fire safety, dementia and learning disabilities. All permanent staff had completed their level 2 NVQ in Health and Social Care and most were working towards completing their level 3 qualification. Records of staff meetings showed these were used to explore learning from training and to discuss if there was a need for specialist training.

New staff completed a comprehensive induction programme which included two weeks of shadowing more experienced staff as well as time to read people's care plans and policies required to work for the service. Staff told us they found this useful as it gave them time to build up their confidence before working with people. More experienced staff were involved in training new staff.

Staff told us, and records confirmed, the manager conducted regular supervisions with staff. These were used to discuss individual performance and training needs. They were also used to talk about people's needs and whether or not changes were required to support. Staff told us they found supervisions useful. One member of staff said, "They're nice. We get told when we've done well as well as when we need to work on things." This meant staff were supported to develop the skills and knowledge they required to carry out their roles and responsibilities.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. No one living in the home was subject to a DoLS authorisation. The home had submitted applications but the local authority had conducted assessments which established that all the people living in the home had the capacity to consent to their care. People's care files contained documents that they had signed to indicate their consent to their care. Staff talked about, and we observed, people being offered choices and being encouraged to make their own decisions as far as possible.

People told us they liked the food and we observed that people were involved in preparing meals where they were able. Care plans contained details of people's dietary preferences. For example, one person was very clear they did not like "Oven food" and was supported to eat culturally specific food. Where people were required to follow specific diets for health preferences staff had a good understanding of what was required and described this in detail.

People living in the home lived with a variety of long term health conditions including epilepsy and diabetes. The home supported people to attend appointments and used specific forms to record health appointments and medical advice. Any new information was also recorded in handover notes. This ensured that people were supported to have access to healthcare services and follow medical advice.

Good

Is the service caring?

Our findings

People told us they liked the staff. One person said, "[Staff member] helps me." Interactions between staff and people living in the home were observed to be positive, encouraging and friendly. Staff facilitated communication between the inspector and people living in the home, both in terms of specific language needs and clarity of speech. People appeared relaxed and comfortable in staff company. Staff knew the people they supported well and spoke about them with affection. The registered provider said, "It's like a family here, we look after each other."

One person living in the home had specific language needs and communicated in a mixture of English and their mother tongue. The service ensured there was always a staff member on duty who spoke the same language. Two people living in the home practiced a religious faith and were supported to attend their places of worship regularly. People were encouraged to be independent in practising their faith and had been supported to develop relationships with people who shared their faith who supported them at religious events.

The staff team was small and stable. The newest member of the team joined a year prior to the inspection. Staff described how they had time to get to know the people they were supporting. A new person had recently moved into the home and staff said they had had time to speak with them to build up their communication and support.

People were supported to maintain their dignity. Staff told us how they ensured people were supported with personal care in rooms with the doors closed. This was particularly important for one person who had previously been supported in an environment where their dignity had not been maintained. This person did not always recognise the importance of their own dignity but staff encouraged them to maintain their privacy.

People were supported to express their views about their care and the service. An advocate from a local advocacy service regularly visited the home. Records showed people were involved in reviewing and updating their care plans.

Requires Improvement

Is the service responsive?

Our findings

Two people living in the home were keen to show the inspector the art work they had created during in-house arts and crafts activities. They demonstrated pride in their art and were pleased with the finished products. People were supported and encouraged to be involved in the daily activities of the home. Staff knew people well and described how people were supported to be involved in the routines of the house. For example, staff described and observation confirmed, that one person liked to prepare lunch and set the table for their housemates. People were supported to attend a range of in-house and community activities including places of worship, college, work, visiting museums and galleries and shopping.

Care plans and risk assessments were reviewed and amended at least every three months. People had meetings with their key workers each month where they completed goal monitoring sheets. This meant the service was ensuring that people were continuing to make progress towards the goals identified in their care plans. Records showed these monthly meetings were used to evaluate people's support and make changes when required. For example, one person had reduced the number of days they worked.

People completed monthly questionnaires to provide feedback to improve the service. One questionnaire focussed on the person and how they were finding the support. The other questionnaire focussed on the service and asked about the food, activities and staff skills. The feedback was positive in both questionnaires. The home had a robust complaints policy which included details of the timescale for response and investigation process. Records showed that complaints were responded to in line with the policy.

The home used an incident and accident book to record incidents that occurred in the home. Records showed that the service took appropriate action in response to incidents involving people living in the home. However, the format of the records did not allow for further analysis of the cause or trigger for incidents. There was no audit of incidents which meant the opportunity to learn from them was not being utilised.

We recommend the service seeks and follows best practice guidance in incident recording and analysis.

Care plans contained details of people's key relationships and interests as well as what areas they needed support with. The detail of what tasks people could complete and what level of support was required for them to do so was lacking from written documentation. Although staff were able to describe the support in detail, this had not been captured in care plans, which were generic in terms of the descriptions of support required. For example, regarding activities such as cooking and cleaning two people had support described as "Full support required with cooking, hoovering, ironing." One person's plan stated, "Support [person] in areas where he is unable to undertake fully." Another person's file contained a person centred plan which included good detail about their past and important relationships. However, the section called "How to best support me" started each sentence with "I cannot." This meant the focus was on what the person could not do, rather than where they could have been involved in the task. This was brought to the attention of the manager who sought further guidance on good practice in person centred planning. This meant that care

plans did not contain enough detail to facilitate staff providing personalised care.

We recommend the service seeks and follows best practice guidance in terms of personalised care plans.

Requires Improvement

Is the service well-led?

Our findings

Staff spoke highly of both the registered provider and the manager. One staff member said, "She [registered provider] is a good leader, we work towards delivering the best care. She is always making sure staff are well trained." The registered provider was unable to attend the service during the inspection, however, the manager was able to provide all the information required and the provider's absence did not have an impact on the running of the service.

The registered provider told us they promoted a family atmosphere at the home, and this was confirmed by staff. One staff member said, "It's like a family, it feels like it's well run." All the staff spoke about the people they supported with kindness and an attention to detail that supported the family atmosphere of the home.

The service held regular staff meetings which staff told us they found useful. Records showed these had been used to discuss safeguarding, medicines, people's changing needs and the wider social care environment. Staff told us these meetings were, "Very useful, about staff improvements and expectations." The manager worked closely with staff and supervision records showed that any inconsistencies in care delivered were quickly addressed. Staff told us they could raise any concerns easily with the manager and they were confident she would respond appropriately.

The home used a self-evaluation audit tool to monitor the quality of the service. This had been completed in February 2016. The audit involved an assessment of various aspects of the service including individual needs and choices, lifestyle, personal and healthcare support, concerns, compliments, the environment, staffing and conduct. The service had scored itself highly on this audit and had not identified the issues our inspection uncovered regarding risk assessment, financial support and support plans. It was noted that the template for the audit was created in 2007 and as such referred to previous models of inspection. This was discussed with the manager who advised a new approach to quality assurance would be developed with the registered provider.

We recommend the service seeks and follows best practice guidance around quality assurance systems for care homes.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not robust and did not contain appropriate control measures to reduce the risk of harm.