MacIntyre Care

Ceely Road

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

Summary of findings

Overall summary

This unannounced inspection took place on 5 and 6 March 2017. Ceely Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ceely Road provides care for up to six adults with learning disabilities in one adapted building. At the time of the inspection six people lived in the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Ceely Road has a registered manager in place. 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.

Improvements had been made in the area of infection control since our previous inspection in November 2015. An infection control audit along with other audits such as health and safety were in place to monitor the quality of the service provided.

At the time of the inspection, the number of staff available to support people was not always sufficient. Following our inspection we were told this had been remedied and staffing levels would be increased to meet the demands of the service.

Trained staff administered medicines to people. Most medicine records were up-to-date and accurate. Where records were not accurate these were amended before the end of our inspection.

Staff recruitment was carried out safely; this was to prevent unsuitable people from working with the people at Ceely Road. Staff were trained and received support to ensure they had the skills and knowledge to carry

out their roles. They were encouraged to feedback ideas to assist with the improvement of the service, through supervision, meetings and general discussion.

Staff were trained to identify signs of abuse and how to report concerns. Where people required additional support with maintaining their health, professionals such as psychologists and GPs were consulted.

Where people were not able to make decisions for themselves, their mental capacity was assessed and the best interest process was followed. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People and their relatives spoke positively about the caring nature of staff. We observed how staff supported people with their care in a dignified and sensitive way. People's communication needs were identified and staff had the skills and knowledge to work in an inclusive way with each person.

People's relatives told us where appropriate they were kept up to date with changes to people's needs and their day to day lifestyle choices. Relatives told us there was an honest and open culture in the service.

People were supported to remain as independent as possible; involvement in the community was encouraged. Activities were available to people to protect them from the risk of social isolation.

Care plans and risk assessments were in place to ensure staff knew how to support people appropriately and safely.

People, relatives and staff spoke positively about the registered manager and the staff. Staff understood the aim of the service and worked together to accomplish providing good quality and effective care.

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's safety and well-being had been considered and steps had been taken to ensure that any risk of harm had been assessed.

Medicines were stored and administered in a safe way.

The provider had systems in place to ensure checks were carried out prior to candidate's being offered employment. This minimised the risk of unsuitable candidates working with people.

Is the service effective?

Good

The service was effective.

People's health was monitored and when necessary external professionals were contacted to provide support to people on maintaining good health.

Staff received training in how to care for people in a caring and respectful way.

Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how this applied to people's care.

Is the service caring?

Good

The service was caring.

People were supported by staff who demonstrated a caring nature and who were knowledgeable about people's needs and the care required.

Staff knew how to protect people's dignity and privacy and demonstrated this throughout our visit.

People were able to communicate with staff in a way that was meaningful to them. Systems were in place to encourage

effective communication with people.

Is the service responsive?

Good

The service was responsive.

Relatives of people that used the service told us they could speak to the staff at any time. Staff were honest and open with them about the welfare of the people living in the service.

People participated in activities both in the service and in the wider community. This encouraged inclusion and protected people from social isolation.

Staff raised complaints on behalf of people when suitable to do so. Relatives told us they knew how to raise complaints. The registered manager knew how to manage complaints.

Is the service well-led?

Good

The service was well-led.

There were clear visions and values for the service. There was a shared philosophy of person-centred care, which enhanced the service to people.

The registered manager and the senior staff encouraged an honest and open approach. This reassured staff to feed back any ideas or comments they had about how the service could be improved.

The service worked closely with other organisations to improve the lives of the people using the service.

Ceely Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on the 5 and 6 March 2018. The inspection was carried out by an adult social care inspector.

Prior to the inspection we reviewed the information we held about the service, this included notifications we had received from the provider. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about. We reviewed the information provided to us in the 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.

During the inspection we spoke with four staff members including the registered manager and the deputy manager. During our visit we were not able to speak with the people who were present in the service due to communication barriers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Following the inspection we spoke with three relatives of people living in the service and one health care professional.

We reviewed documents associated with four people's care and their medicines. We examined records associated with the employment of two staff. We read records related to health and safety, incidents and accidents and audits connected to the running of the service.

Good

Our findings

During our previous inspection in November 2015 we made a recommendation about the staffing levels in the service. This was because people were left unsupported for periods of time without any meaningful interaction from staff whilst staff carried out domestic chores. At that time we were told by the registered manager they would look into rectifying the situation. During this inspection we found the situation had not changed.

Two staff were on duty in the service each morning. Each day from Monday to Friday one staff member escorted people to the day service. One staff member remained in the service with people who were not attending the service. We observed the people who remained at the service were left to listen to music or wander around the house. This was because the one remaining staff member was involved in domestic duties including cooking and cleaning. The same situation occurred in the afternoon when one staff member had to leave to collect people from the day service. People were not always able to participate in domestic or cooking activities. They received minimal supervision from staff, until the second staff member returned approximately an hour and a half later.

One staff member told us, "I think I speak for everyone, I feel like I have a cleaning job if I am honest. We do try our best, but if there are activities to do we are all rushed." We discussed this with the registered manager, who told us this had been raised with the provider prior to our visit and discussions had taken place regarding budgets and staffing levels. Following our inspection we were informed that the service would be employing extra staff to carry out 15 hours of cleaning each month. This would enable staff to work directly with people as well as maintaining a safe environment. Daily cleaning could be carried out without people being left alone and at risk.

During our previous inspection in November 2015 we made a recommendation regarding infection control. This was because the registered manager did not have an infection control audit in place. During this inspection we found this had improved and an audit had been put into practise. We found areas of the bathroom needed a more thorough clean and this had been carried out by the second day of the inspection. However, this had not been identified on the audit. The registered manager acknowledged this oversight and assured us they would make more thorough visual checks in the future.

People's relatives told us they felt the service was safe. This was because they believed staff were skilled and knowledgeable about people's needs and how to support them.

Trained staff administered medicines to people. Medicines were stored securely in a locked cupboard. Records of the medicines administered were up-to-date and accurate. Protocols were in place for "as required" medicines, for example pain relief. The document used to evidence the administration of medicines is called a medication administration record (MAR) chart. When each medicine is administered staff sign the MAR chart to register this had been completed. However, we found a problem with the transcribing of medicines from the prescription to the MAR chart. Insufficient information had been recorded on the chart to ensure safe administration. For example the record did not indicate which ear a person required drops in. This was amended by staff before the end of our inspection.

Staff had received training in how to protect people from abuse. They were clear about how to identify indicators of abuse, and what action they would take if they had concerns. The process for reporting concerns to the local authority was clearly visible on the wall in the office. When any safeguarding concerns had been raised these had been dealt with appropriately by the registered manager.

Systems were in place to minimise the risk of employing unsuitable staff to work in the service. Applicants completed application forms, reference checks were undertaken with previous employers. Disclosure and Barring Service (DBS) checks had been obtained. The DBS helps employers make safer recruitment decisions through the disclosure of criminal records. Identity checks and health questionnaires were carried out. These ensured candidates were fit and safe to work with people.

Documents showed risks to people's health and welfare had been assessed and risk assessments had been completed. Risk assessments had been carried out in relation to the care provided. For example the risks associated with choking whilst consuming food and drinks. We found care plans described the care to be provided clearly. Where people displayed behaviour that was challenging when they were anxious or upset this was clearly documented along with guidance for staff. Through our observations of staff supporting people, it was clear they knew people well, and knew how to positively interact with people to keep them and others safe.

Incidents or accidents were recorded and reviewed, to identify trends to ensure any risks of a reoccurrence were minimised. Information was shared with the provider's health and safety manager and area manager for monitoring purposes.

Environmental risks had also been considered. For example gas and electric supplies had been checked as safe to use. Fire risk assessments, including personal emergency evacuation plans, drills and equipment checks were in place. Legionella checks and asbestos checks had been undertaken. This protected people from the risk of harm from unsafe utilities and equipment.

Good

Our findings

People's relatives told us they felt staff were trained and competent to meet the needs of the people living in the service. Staff told us they felt they had received sufficient training to carry out their role. The registered manager informed us when new staff were appointed they received an induction and attended training in the areas deemed mandatory by the provider. These were in areas such as fire training, safeguarding, and first aid amongst others. Staff also completed the care certificate. The care certificate is part of induction training and covers the minimum set of standards that social care workers adhere to in their daily working life. Records showed staff training was up-to-date. Where staff required additional training because of their role, this was provided.

Staff were further supported throughout their employment by receiving supervision and appraisals from senior staff. Staff told us they found this useful. One staff member told us, "It is really useful yes. It gives you an opportunity to speak about any problems and get it off your chest. We also get reminders about training or anything in the service we need to get up to date with."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people had restrictions in place to ensure their safety and wellbeing, applications had been made and authorised by the local authority's supervisory body.

Staff understood how MCA and DoLS applied to people and their care. Records showed mental capacity assessments and best interest processes had been completed. Relatives told us they were involved in the planning of care and were able to make suggested changes to care plans if these were in the best interest of their family member.

People were supported with their hydration and nutritional needs. Where people required support with eating or drinking this was provided by staff. We observed how people were supported with their lunch. Food was prepared in line with people's care plans. For example, where people required food to be pureed this was done. Where people had difficulties with food and drink, specialist advice was sought and the advice was being followed. Where appropriate care plans highlighted the risks of choking for people and how the risk of this could be minimised.

People were assisted to access the healthcare support they needed when they required it. A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. For example this included psychologists, GP and dentists. Where specific guidance was given to staff by external professionals, this was documented and acted upon. This ensured people were supported to maintain or improve their physical and mental health.

Good

Our findings

People's relatives described the attitude of the staff as "Very good, caring and kind", "Extremely good, extremely kind and attentive" and "Genuinely caring, very very good and very consistent."

The service ensured that people had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place by the NHS from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

The PIR stated "We have an up to date communication profile so that staff can have a way of understanding how people communicate information and how they receive it." Records confirmed this was the case. The provider trained staff in the 10 key facilitation skills used to aid communication with the people they support. These skills included touch, observation, and reflection amongst others. These enabled staff to consider what form of communication they used and how people responded. This gave them the opportunity to improve communication with people, by reviewing techniques that worked well with people.

Other aids used to enhance communication included objects of reference. This is where objects were used to help people make choices or to indicate what activity was about to happen. For example a cup may indicate the offer of a drink, or request for a drink. Other pictorial support was available to show people which staff members were on duty. Symbols and words on signage around the service indicated the room each door led into, for example the laundry. Some people used Makaton sign language; we saw staff communicating with people in this way. The provision of person centred accessible information enabled people to maintain and develop independence skills and dignity through care.

Staff knew how to protect people's dignity and privacy. One staff member told us how maintaining independence enhanced people's dignity. They said, "If you can't express yourself because you are non-verbal, that is quite sad." They felt being able to communicate was important to people's sense of self-worth. Both staff explained how they protected people's dignity and privacy whilst providing personal care.

From our observations we saw staff interacted with people in a positive and sensitive way. Interactions were meaningful and respectful. When people's care needs were apparent, staff responded quickly and discreetly supported people with personal care. Although some people required close support by staff, their movements were not restricted unless there was a risk to themselves or others. We observed laughter and fun within the service, with staff and people joking together.

People were supported to maintain relationships that were important to them. Relatives told us they were able to visit whenever they wished. Most relatives had to travel, so to ensure their trip was beneficial they would telephone the service beforehand. One relative explained to us how staff supported the person to visit them at service, which involved travelling by train into London. Without this support both parties would have difficulty in maintaining their relationship.

Good

Our findings

Relatives told us how they were kept up to date with any changes to people's needs and the care provided. One relative told us, "I have very good contact with the carers [staff]. There are some [staff] who have been there a very long time. If anything is wrong they let me know straight away." Relatives were united in the view that their involvement with the service was beneficial to appropriate care being provided to their family member.

All the relatives we spoke with told us they felt part of the care planning process and their opinions were listened to by staff working in the service. Relatives were invited to participate in annual reviews meetings. These were held to review the care being provided and to share ideas and information which could enhance the service provided to people. One relative told us they found the reviews useful. They said, "The reviews are very good, they are informal but informative. In years past it was quite daunting going into a room full of professionals. They [staff at Ceely Road] try to make it friendly. You are able to contribute and given the opportunity to bring up any concerns. They ask your opinion and they listen to you. It is very good."

One relative told us how they had wished for their family member to visit their extended family in Ireland. This involved a great deal of planning by staff as the person had never flown on an aeroplane before. We were told the person enjoyed the trip. They visited their family member in Ireland including their great grandmother. This was a new experience for the person. This demonstrated how the person-centred support they received enabled them to participate in new social experiences.

Care plans were clear and directed staff how to support people. Where appropriate each person had a behaviour support plan. This directed staff on how to understand the cause of behaviours, and how to avoid causing upset or anxiety to the person. It also provided information on how to deal with situations as they arose. These individually addressed each person's needs. Risk management plans were in place to minimise the risk of harm to people, for example, when people were involved in activities such as swimming.

Care plans reflected people's preferences and daily routines. They also covered health appointments, and areas such as opticians and dental care. We were told by the registered manager the staff in the service had received training in oral care and hygiene. For one person this led to staff identifying a dental problem which had led to changes in the person's behaviour. They were able to refer the person for dental treatment which quickly resolved the difficulty. This demonstrated how effective training and record keeping enabled staff to provide appropriate care.

People's diverse needs were considered by the service. One person attended church every other Sunday. People were encouraged to participate in community experiences regardless of their abilities. For example we were told people went swimming, horse-riding, shopping and dining out.

People's relatives knew how to make a complaint. None had felt the need to do so in the last year. Where concerns were raised these were dealt with through discussions or meetings between the staff and the person's relative. Staff advocated on behalf of people living in the service. We saw two complaints had been made by staff on people's behalf. One was to an external service and a response was given. For the internal complaint, action was taken to prevent a reoccurrence.

At the time of the inspection, no one was receiving end of life care. People did not have end of life care plans in place. We discussed with the registered manager why this was the case. They told us it was because death and dying were very difficult concepts for people to understand. They had implemented bereavement care plans, which detailed what actions should be taken once the person had died, for example funeral arrangements. The registered manager told us they planned to explore other methods of completing end of life care plans for people which would include information they already knew about the person. This would probably include a best interest process and involve family members or those who knew the person well.

Good

Our findings

Relatives of people living in the service and staff spoke positively about the registered manager. Their comments included, "She is very approachable", "[Registered manager] is an extremely good head of house….I can talk to her about anything. She is extremely good" and "[Registered manager helps my confidence. She is always accessible; we can ring her anytime even when she is not on shift."

At the time of the inspection the registered manager was managing two services. The other service was in the process of closure. This had taken up a lot of their time. A deputy manager was in situ in Ceely Road and along with the registered manager was available to ensure the day-to-day running of the service was effective.

Relatives commented on the length of time some staff had worked in the service. This had enabled people and their relatives to build up a strong relationship with staff, who over time had got to know people's needs well. From our observations and through the documentation we examined, we could see people were treated fairly and equally regardless of their ability or needs.

Relatives made positive comments about the quality of the service included, "They [staff] all seem to know their [people's] needs well. I am happy with everything"; "I think it is a very good house. If there is ever a mistake they apologise and are very sorry, they are very open" and "It is a very well run place."

Another relative spoke to us about the culture of the service. They told us, "Staff are very good and are very reassuring. They are 'on the ball' and always come back to me if I leave a message for them to ring me. I never feel they are covering anything up." Staff told us there was not a 'blame culture' in the service but one of learning. One staff member told us that some time ago they had made a medicines error. No harm came from the error, but they had learnt from their oversight and would never make the same mistake again.

Staff and relatives felt supported by the registered manager. Everyone told us how accessible they were. Staff were clear about the aim of the service and the role they played in achieving this. They told us their aim was, "To promote independence, and give people choices so they could live an ordinary life" and "For every individual we support here to have the best life."

A number of audits had taken place at the service. These included infection control audits, accidents and incidents and health and safety audits. Staff were able to offer feedback to the registered manager on how the service could be improved through dialogue during supervision, appraisals, and staff meetings and on a

day-to-day basis.

Questionnaires were also produced for people to complete to enable them to give their opinions on how they would like to see improvements to the care provided. However, due to the fact that people were unable to complete these questionnaires, they were handed over to relatives to complete on people's behalf.

We spoke with the registered manager about this. They felt the questionnaires should be sent to relatives to obtain their views on the service, and for a different approach to be devised to obtain people's views and reactions. They told us they were looking into a number of different possibilities to ensure feedback from people was captured, but not necessarily through a questionnaire. These systems of checking and receiving information about the service helped drive forward improvements to the service.

The registered manager understood their responsibilities in relation to their position. The provider has a legal duty to inform us about changes or events that occur at the service. They do this by sending us notifications. We had received notifications from the provider regarding changes and events at the service. Records related to the people living in the service and confidential information was stored securely in locked cupboards within the locked office.

Documents within the service highlighted the involvement of other key organisations, including the local authority and multidisciplinary teams, including the learning disability team. We spoke with one senior health professional who wrote to the registered manager praising the staff for the joint work that had been undertaken between the staff at Ceely Road and the learning disability team. The aim for one person was to reduce the use of medicines to treat a mental health condition. The feedback included the following statement," I believe that without the outstanding support [named person] received from the staff, this reduction and discontinuation would not have been so successful and I would like to congratulate all of the staff involved." This demonstrated how effective teamwork with outside agencies had enhanced the quality of life for the people who used the service.