Newcastle-upon-Tyne City Council

# Connie Lewcock Resource Centre

## Inspection report

West Denton Road
West Denton
Newcastle Upon Tyne
Tyne and Wear
NE15 7LQ

Tel: 01912643439
Website: www.newcastle.gov.uk

Date of inspection visit:
26 April 2016
27 April 2016

Date of publication:
26 July 2016

## 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? | Requires Improvement |

# Summary of findings

## Overall summary

The inspection took place on 26 and 27 April 2016 and was unannounced. This means the provider did not know we were coming. We last inspected Connie Lewcock Resource Centre in June 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Connie Lewcock Resource Centre is a 23 bed care service that provides short stay care for older people who require community rehabilitation or emergency care in crisis situations. At the time of our inspection there were 20 people staying at the centre.

The service did not have a registered manager and we have followed this up with the provider. 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.

We found that people's care and support was delivered safely in a clean and comfortable environment. Risks to personal safety had been assessed and action was taken to protect people from avoidable harm. Staff were trained in recognising and preventing abuse and there had been no safeguarding concerns raised about the service.

A thorough recruitment process was followed to make sure only suitable staff were employed. There were enough skilled and experienced staff to provide people with safe and consistent care. Staff were given appropriate training and support to equip them to meet people's needs effectively.

People were well supported in maintaining or improving their health and welfare. Arrangements were made for people to access a full range of health care services and for prescribed medicines to be given safely. Nutritional needs were monitored and dietetic advice was obtained when necessary. A varied and balanced diet was offered and people told us they enjoyed the food.

The service worked within the principles of mental capacity law and sought people's consent to care and treatment. People were consulted about and involved in making decisions about the care they received.

Staff treated people respectfully and were kind and caring in their approach. People were afforded privacy, cared for in a dignified way, and supported to be as independent as possible. Systems were in place which encouraged people to express their views about their care and the service in general.

People had personalised care plans which addressed how their needs would be met. Care was kept under weekly review and was aimed at supporting people to return to their own homes. A programme of social and therapeutic activities was made available to help people stay active and meet their social needs.

The management team provided leadership within the service and were committed to providing an open and inclusive culture. Any comments, suggestions or complaints were taken seriously and acted on. Methods had been established to routinely monitor the quality of the service and make sure any identified improvements were implemented.

## 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.

Appropriate measures were taken to safeguard people from harm and abuse.

Any risks to people's safety and welfare were identified and managed.

Sufficient staff were employed to ensure people using the service received continuity of care.

Robust arrangements were in place for administering people's prescribed medicines.

### Is the service effective?

Good

The service was effective.

People were cared for by staff who were trained and supported in meeting their needs.

People consented to their care and had their rights under the Mental Capacity Act 2005 upheld.

The service enabled people to access a full range of community and specialist healthcare services to support their rehabilitation.

People enjoyed a good, varied diet that met their nutritional needs.

### Is the service caring?

Good

The service was caring.

Staff were caring and compassionate towards people using the service.

People were given the necessary support and information they needed to make choices and decisions about their care.

People's privacy, dignity and independence were promoted.

## Is the service responsive?

Good

The service was responsive.

People were given personalised care that was responsive to their needs.

A programme of activities was offered that provided people with opportunities for social stimulation.

Any concerns raised about the service were promptly responded to and acted on.

## Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had failed to notify the Care Quality Commission of the service's management arrangements. An established manager was in post; however they had not been proposed to be registered in respect of the service.

The service had an experienced management team who provided leadership and ensured that good standards were maintained.

There was active monitoring of the quality of the service, including people's experiences of the care they received.

# Connie Lewcock Resource Centre

**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 was 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.

The inspection took place on 26 and 27 April 2016 and was unannounced. The inspection team consisted of an adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

During the inspection we talked with 12 people staying at the centre and four relatives. We observed how staff interacted with and supported people, including during a mealtime. We spoke with the manager, two team leaders, and eight care and ancillary staff and professionals from the community rehabilitation team. We looked at four people's care records, medicine records, and a range of other records related to the staff and the management of the service. On 5 July 2016 we carried out a visit to the provider's offices to examine staff recruitment information.

Good

# Is the service safe?

## Our findings

People using the service told us they felt safe staying at the centre. One person commented, "I've been treated very well." Relatives told us their family members were well looked after and safely supported. One relative said, "My mother is very safe here."

People had access to information about their rights to be protected from abuse. Local authority safeguarding leaflets were displayed in the reception area and provided in the information packs which were made available in each bedroom. The guide to the service was being revised and we were told this would also include details about safeguarding for people to refer to.

New staff were introduced to the provider's safeguarding and whistleblowing (exposing poor practice) procedures during induction. All staff received safeguarding training every three years on a rolling programme to keep their knowledge updated. There had been no safeguarding concerns raised in the period since the last inspection. Some people admitted to the centre were already subject to the safeguarding procedure. The manager told us that in these instances they clarified the current position of protection plans to make sure they were adhered to during people's stays.

Following the inspection we received confirmation the provider had developed a 'duty of candour' policy and that this was being disseminated to staff. The duty of candour requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

People were provided with a lockable facility or could choose to have money and valuables held for safekeeping. Any financial transactions undertaken were appropriately recorded, witness signed and, where applicable, receipts were obtained. Weekly audits of cash and balances were conducted to ensure people's money was being handled safely.

There had been a recent staffing restructure at the service and a recruitment drive had resulted in eight new staff being appointed to date. The manager told us the local authority's thorough recruitment process had been followed and our review of staff records confirmed this. All necessary pre-employment checks had been carried out to validate the suitability of applicants. These had included completion of application forms, interviews, seeking proof of identity and references, including one from the last employer, and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with vulnerable groups.

The manager told us rosters had been changed to promote an improved skills mix. They said information about the dependency levels of people using the service was being collated with the intention of regular reviews of the staffing levels. At present, the staffing was generally based on full occupancy as the numbers of people using the service fluctuated. Across the day a minimum of five care staff were rostered, including 'health and social care co-ordinators' who led shifts, and there were two care staff on duty each night. The manager and two team leaders worked mainly in a supernumerary capacity in addition to these levels. The

staff team worked in conjunction with an on-site community rehabilitation team of health and social care professionals and there were separate ancillary staff for housekeeping, laundry and catering.

During our visits we observed there were enough staff to safely meet people's needs and that staff worked at a steady pace. One person we talked with said, "There seems to be plenty of staff, but I do think the night staff are a bit pressed." Cover for staff vacancies and absence was provided by existing staff for continuity and by staff from other local authority care services who were familiar with the centre. An on-call system was operated between the provider's three resource centres outside of office hours. This system enabled staff to get advice and support when needed and, if necessary, to escalate any emergencies to the senior management.

Risks to people's safety and welfare were identified and managed. Care records demonstrated that on admission, people's needs and any risks associated with providing their care were assessed. Detailed measures had been put in place to reduce risks to individuals, with input from the community rehabilitation professionals, where applicable. There was clear guidance recorded for staff on managing risks such as moving and handling, mobility, falls and nutrition. Each person also had care plans focused on safe admission and the aim of facilitating their safe discharge from the centre. This included, where applicable, home visits, preparing the home environment, and arranging other care services.

The centre was clean, comfortable and appropriately equipped to support safe care. Adjustable beds, assisted bathing facilities and moving and handling equipment were provided. Some people brought their own aids and the physiotherapists and occupational therapist assessed and acquired any further aids needed for individual use.

The maintenance of the building and systems for reporting repairs were well organised. A range of checks and audits were also carried out to make sure people were being cared for in a safe and hygienic environment. Accidents and incidents, including any 'near misses', were reported and followed up, including regular analysis to identify any trends or safety issues. Fire safety procedures were routinely reinforced with people and each person had a plan devised for their safe evacuation from the centre in emergency circumstances. An 'incident and continuity management plan' was also in place in the event of disruption to the service.

Robust arrangements were made for the management of medicines. Staff often reconciled medicines, contacting pharmacies and GP's, to obtain sufficient supplies and get the correct information about people's current prescribed medicines. Medicines were administered by two staff at all times from blister packs and original boxes and bottles with the dispensing instructions. All care staff were trained in the safe handling of medicines and had an assessment to check they were competent on an annual basis.

People's independence in managing their own medicines was encouraged wherever possible and the risks were assessed. Medicines routines were built into care plans, for example specifying where a person was able to self-manage their medicines with verbal prompts from staff. People agreed to staff administering their medicines and no medicines were authorised to be given covertly (disguised in food or drink).

Medicine administration records (MARs) were recorded with specific directions and had a photograph of the person for identification purposes. Separate records were kept for medicines given outside of the usual drugs round times. The MARs we examined were accurately completed and included the use of codes and comments to explain any reasons why medicines had not been administered. Staff audited the MARs five times a day which meant any discrepancies were readily identified and corrective action could be taken.

Good

# Is the service effective?

## Our findings

The people we talked with felt their needs were met effectively at the centre. Their comments included, "It's been good for me; I'll soon be well enough to go back home", "I've every confidence in the staff", and, "I have been really well cared for here."

The service had specified criteria for admission, the referrals process and planned outcomes including preventing people from being inappropriately admitted to hospital or residential care. Information was regularly gathered about the numbers of people who used the service and measuring the success of helping people to return to live in their own homes.

The new staff employed at the centre were undergoing an in-house induction that included shadowing and being mentored by the health and social care co-ordinators. They were then going on to complete the Care Certificate, a standardised approach to training for new staff working in health and social care. Regular reviews were planned to take place with each of the new staff during the probationary period to determine their knowledge, skills and competency.

All staff were given opportunities to undertake face-to-face and e-learning training. An overview of mandatory training was kept which showed all of the staff team had completed courses in safe working practices. This included moving and handling, fire safety, first aid, infection control, food hygiene and personal safety. A variety of training topics including mental capacity law were provided through the Learning Management System (LMS), a programme of e-learning. A designated area was being set up in the centre to enable staff to access this training in the workplace. There were plans for the community rehabilitation team to provide training sessions to new staff about their different roles and co-ordinated working. Some further training, specific to the needs of people using the service, such as safe use of oxygen and PEG feeding (a specialist feeding technique), was arranged to be delivered by health care professionals.

Staff were supported in their roles through individual supervision and an annual 'my conversation' appraisal. The manager acknowledged that the frequency of supervisions had lapsed. This was being rectified by the introduction of a delegated system, with each health and social care co-ordinator supervising a group of care staff. The schedule for planning supervisions had also been updated and was being monitored.

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 found the service worked within the principles of the MCA. Information about what to expect from using the service was provided and most people were able to give informed consent to their care. Mental health needs were assessed and if there were any doubts about a person's capacity, a mental capacity assessment was carried out. We saw that people had signed their consent to sharing personal information and to agree a summary of their care plan. A professional from the community rehabilitation team told us, "We work to strong values of doing everything with people's consent." None of the people who had stayed at the centre to date had required DoLS to be put in place.

Nutritional needs were assessed and care planned, and people's weights were monitored. The dietitian based at the centre provided further assessment and support. For instance, we observed they had regularly reviewed and evaluated the care of a person who required a soft texture diet. We noted that food intake charts for people who were nutritionally at risk were not always fully completed. Action was taken during the inspection to remind staff about keeping accurate records, including details of snacks between meals. Good hydration was encouraged and we observed people were given regular hot and cold drinks and that refills were offered.

People's dietary preferences were recorded on admission and passed onto the catering staff. The cook confirmed this and told us they often also discussed individual requirements directly with the person. They were able to cater for special diets and worked to a seasonal three week menu, which offered a balanced diet with choices at all meals. People were asked to choose from the menu each day and alternatives could be provided. The people we talked with were very complimentary about the meals. They told us, "The food is excellent", "I've put on a little weight since I came here, the food is so good", "It's like being in a hotel the food is excellent", and, "The food is absolutely fabulous, and there is plenty of choice."

The service had good arrangements for supporting people to access health care services. Medical history information was gathered, followed by a health assessment that identified where referrals to other professionals were needed. The manager told us staff were vigilant in checking people's well-being and gave an example of how this had led to a person being diagnosed with a particular medical condition. People could be temporarily registered with a local GP practice, have input from the district nursing service, and there were systems for fast access to services such as podiatry. The centre had forged links with a specialist falls team and a local hospital unit that specialised in the care and treatment of older people. Weekly goal planning meetings were held with health and social work professionals to monitor people's progress during their stays.

Physiotherapy, occupational therapy and dietetic input was provided from the rehabilitation team. Therapy was also built into daily routines, including exercise sessions and a 'breakfast club' that supported people in maintaining or improving their independent skills in making food and drinks. The lead physiotherapist told us there were plans to further evaluate the benefits of the exercise sessions and said, "We're already seeing evidence of a reduction in dependency and increased mobility." They also described how satisfying it was for the physiotherapy service to be able to follow up on people's progress once they were discharged from the centre.

Good

# Is the service caring?

## Our findings

People using the service told us the staff were caring in their approach and supported them to be independent. Their comments included, "The staff are very good. I think they do care and we are well looked after", "They've all been very kind to me", "I'm free to walk around the place as I wish", and, "The staff work very hard. They talk to me while they are working and they encourage me to do things." One person told us, "I will miss it here when I have to go home."

We saw that people were informed about what to expect from staying at the centre. The purpose of the service was verbally explained and people were given a 'contract' that set out the terms and conditions of their residency. An information pack about the service was provided in each bedroom and a range of information was displayed for reference. This included a 'customer service charter', staff photographs and names, details of local authority services and other external support agencies, and information on support for people's carers.

Most people who used the service were well able to self-advocate and make decisions about their care. The manager told us no-one had needed to use an independent advocacy service, though this could be arranged if necessary. The service placed an emphasis on consulting people throughout the process of assessing their needs and planning and reviewing care. Direct comments were recorded in summary care plans about the individual's aims and priorities, for example, 'I want to improve my mobility and ability to weight bear'. People and their relatives confirmed they were able to attend multi-disciplinary reviews where they discussed and agreed their care and future discharge arrangements.

The importance of having information about each person's individuality was recognised. Profiles had been developed with each person that gave an overview of their history, personality, interests and likes/dislikes. People's routines, self-care skills and preferences, including whether they wished support from male or female staff, were documented in their care records.

People could give their feedback about the service in a variety of ways, including contributing to weekly service user meetings and surveys. At a recent meeting everyone in attendance had been happy with the food, social activities and felt their privacy and dignity were promoted. We saw people had also given positive comments in suggestions/comments/complaints forms. For instance, one person had recorded, 'I have spent four weeks here and feel better each day. The staff are really devoted, nothing is too much bother'.

People spoke positively to us about their privacy and dignity being respected. They told us, "I've got a key to my room and everyone knocks before coming in", and, "My washing is beautifully cared for." One person told us they chose to spend time in the privacy of their bedroom whenever they wished and said, "They (staff) call in and out all the time and are friendly and chat to me." Another person described the staff as "always polite and respectful" and told us they had been made to feel at ease when being assisted with personal care.

People told us they made everyday choices in daily living and that routines were flexible. Their comments included, "There's no problem if you want to eat later, they'll keep a meal back for you", and, "It's not the same as being at home but I do what I want when I want." Another person told us they felt they had an improved structure to their days and were enjoying having regular meals and the company of others.

During our visits we observed that staff were patient, kind and engaged with people. There was plenty of interaction and we saw staff were mindful of providing discreet support and going at the person's pace. Staff asked permission before giving any support and encouraged people to do things for themselves, where they were able. For example, at lunch people helped themselves to cold drinks from jugs, fresh fruit in bowls and vegetables which were served in tureens. The food looked appetising and extra portions of the main courses and desserts were offered. Some staff sat and had their meals with people and initiated or joined in with conversations. The mealtime was not rushed and was a pleasant and sociable experience.

Good

# Is the service responsive?

## Our findings

People using the service told us that staff were responsive to their needs. Their comments included, "There's always someone on hand to help me", "I am looked after. I am not well this morning, with pains, and they've called for the doctor", and, "Being here has really helped me to become more confident."

The manager told us they learned from situations that arose and adapted the service accordingly. They gave an example of a person with high dependency needs who had been admitted to the centre. Immediate action had been taken to increase staffing and obtain the necessary equipment for the person to enable them to be cared for safely. The circumstances had led to more robust gatekeeping to ensure the service was adequately prepared and able to meet people's needs appropriately.

Each person's needs and any risks involved in providing their care were assessed using a baseline assessment. Further assessments were undertaken by the community rehabilitation team and some people's needs had been extensively assessed by the physiotherapists, occupational therapist and dietitian. People had a summary of their care plans which gave staff an outline of the support they required and separate, detailed care plans.

The care plans were tailored to the individual's needs and were informative about the level of support staff would provide and what the person could do independently. All identified needs were addressed, including physical and mental health, communication, personal care, mobility, care at night, and reducing social isolation. Specific areas of need, such as skin care, were supplemented by a corresponding 'body map' with evidence of dressings carried out by district nurses. Some care plans had been updated to reflect changes in people's needs, though we noted one person's had not and raised this with the manager to follow up with staff.

Staff recorded entries directly into care plans each day, stating progress, the support given and details of the person's well-being. The outcomes of multi-disciplinary reviews and home visits were documented to ensure staff were kept updated about discharge plans. All staff were appraised of people's welfare, and the needs of people newly admitted to the centre, during handovers between shifts. Where people moved on to receive other services, a revised social work assessment and discharge summary were provided to make sure their future care was properly co-ordinated.

During our visits we observed different activities taking place. We saw for example, many people and some of the staff enjoying an exercise session led by the physiotherapist in one of the lounges. Music was played and different seated exercises including kicking a soft ball around the room and 'floor netball' were encouraged. Drinks were served in a break during the session and there was much good humoured conversation and joking between people and the staff. Some people mentioned how stimulating a quiz held the previous evening had been, leading to a person initiating another quiz that people joined in with.

Most people we talked with were happy with the extent of social activities on offer. A typical comment was, "There is always something to do here." However, one person said, "There is nothing to do but stare at the

walls." One person said they would prefer to have a larger television in their bedroom. Some people also told us they would like wireless internet access to help them keep in contact with family and friends and follow their interests online. These comments were relayed to the management team for consideration.

We saw a programme of social activities was planned each week in response to discussion with people at the service user meetings about what they would like to do. Recent examples included reminiscence, quizzes, bingo, a visiting entertainer, and plans for an outing to Beamish Museum. Information about forthcoming activities was clearly displayed in the centre. Staff were allocated to activities each day and completed a diary indicating what had been provided along with the names of people who had participated and declined to take part.

The procedure for making complaints was given to people, displayed and talked about at service user meetings. One complaint had been logged in the past year that had been taken seriously and appropriately responded to. People's comments were also acted on, such as following up a food related issue and providing a folding chair in a person's room for their visitors. Numerous cards and letters complimenting the service had been received from people who had stayed at the centre and their relatives.

Requires Improvement

# Is the service well-led?

## Our findings

At the inspection we found that the registered manager had left the service in October 2014. The provider had not notified the Care Quality Commission (CQC) of this change affecting their registration conditions and about the arrangements for managing the service. They had also failed to ensure applications were made to CQC to cancel the manager's registration and to register the manager who had subsequently been appointed. We have followed up these issues with the provider and will monitor their compliance with this legal duty.

There was a clearly defined management and staffing structure that supported the running of the service. The manager had been in post for 18 months and had a good understanding of their management responsibilities. They were supported in their role with access to, and contact with senior managers, monthly meetings with their peers and quarterly performance meetings.

Within the centre there were two team leaders and health and social care co-ordinators who were accountable for leading shifts on a daily basis. A daily allocation of duties to staff was operated and this was checked by team leaders to make sure all delegated work had been undertaken. Two senior staff had infection control lead roles and there were plans to assign other lead roles in line with staff's skills and interests. For example, the manager told us a staff member would be leading on health and safety after undertaking advanced training. Most staff had completed training on the Care Act 2014, keeping them updated about the duties and powers of local authorities and partner organisations.

The manager acknowledged there had been an unsettling period of time when the centre was threatened with closure. There had also been recent changes made to staff roles and pay, resulting in some staff leaving and increased numbers of new staff being employed. The manager was clear about their vision for the future of the service. They were committed to consolidating and building a cohesive staff team, for new staff to be thoroughly inducted, and in addressing any areas of the service identified as needing improvement.

People using the service told us the manager was very approachable and they would not hesitate to speak with them if they had any concerns. Health and social work professionals who worked in the rehabilitation team at the centre told us, "We work well together with a common goal", "The manager is dynamic and there's pro-active communication between us", and, "We have a healthy working relationship with all grades of staff."

The staff we talked with gave mainly positive feedback about the leadership and support they received. Their comments included, "[Name] is a really good manager", "I'm happy in my work. I like the manager, they get things done", "[The manager] goes round every day, introduces themselves to people and checks how they are", and, "We have a really good care team and work hard." However, two staff said not all of the senior staff were good at providing direction, that care officers were not always given support at busy times, and they felt unable to express their views at staff meetings. The manager took on board these comments and told us they would look towards resolving them.

The service worked in an open and inclusive way with people, providing them with opportunities to give their views. Weekly meetings were held where people were able to give their opinions about the centre, their care, the staff, meals and activities. Comments and suggestions were acted on and details of the action taken were recorded and relayed at the next meeting. The meetings were also used to raise awareness of aspects of the service including the complaints, fire and hand hygiene procedures. At times other relevant topics were included, for instance a community police officer was being invited to talk about the ways people who may be vulnerable could stay safe in their homes. Satisfaction surveys were carried out with people following their stays at the centre. The findings were predominantly positive and there was evidence that people's comments had been appropriately responded to.

Different aspects of the service were monitored through a range of internal checks and audits. These included checking the safety and maintenance of the environment, care records and medicines arrangements. Any areas highlighted were specified for follow up action to be completed within stated timescales. Observations of people's care experiences were conducted by the manager and team leaders, though these were not yet formally documented as part of the quality assurance system. The manager told us their line manager visited the centre regularly and checked on the standards of the service. Written reports of these visits demonstrated a balanced approach and appreciation and praise for staff for their hard work. Support and guidance on developing the service was also provided by a 'service improvement lead'. These measures ensured the quality of the service provided at the centre was regularly assessed and improved.