Lutchmy Care Services Limited

Autumn Vale Rest Home

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 was an unannounced inspection carried out on 28 June and 3 July 2018.

Autumn Vale 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. The service is situated on the outskirts of Portsmouth, close to a bus route and local amenities. Autumn Vale can accommodate up to 25 people and there were 21 people living there at the time of our inspection.

We had conducted our previous unannounced comprehensive inspection of this service on 21 April 2016. Breaches of legal requirements had been found. After the comprehensive inspection, the provider wrote to us to say what they were going to do to meet legal requirements relating to the safe management of medicines. They also explained what action they were planning to take to ensure they would be able to effectively assess the quality of the service.

Following the full comprehensive inspection, we undertook a focused inspection on 17 July 2017 to check whether the service had followed their plan and to confirm that they now met the legal requirements. We found the service had made significant improvements in the 'safe' and 'well-led' domains.

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

People told us they felt safe at Autumn Vale Rest Home. Staff knew the correct procedures to follow if they considered someone was at risk of harm or abuse. They had received appropriate safeguarding training and there were policies and procedures in place to follow in case of an allegation of abuse.

People's safety was promoted as risks that may cause them harm in the service and in the local community had been identified and managed. Appropriate risk assessments were in place to keep people safe. Medicines were managed safely. All staff had received training in the safe management of medicines. The provider had systems in place to store medicines safely.

Procedures in relation to recruitment and retention of staff were robust and ensured only suitable people were employed at the service.

Staff working at the service were suitably qualified and skilled. Staffing numbers and shifts were managed to suit people's needs so that people received their care when they needed and wanted it. Staff had access to information, support and training they needed to provide people with satisfactory care. The provider's training was designed to meet the needs of people using the service. As a result, staff had the knowledge

they required to care for people effectively.

There were policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005. Staff were trained in the principles of the MCA and could describe how people were supported to make decisions. Where people did not have the capacity, decisions were made in their best interests.

People's health and well-being were kept under review and staff liaised closely with health and social care professionals to ensure people received all the support they needed.

Care plans were informative and contained clear guidance for staff. They included information about people's routines, personal histories, preferences and any situations which might cause people anxiety or stress. The plans clearly described how staff were supposed to support people in such circumstances.

People were provided with a range of activities which met their individual needs and interests. Staff also supported people to maintain relationships with their relatives and friends.

People knew how to raise concerns and make complaints. Complaints were recorded, investigated and the outcome was fed back to the complainant.

People using the service and staff were very complimentary about the registered manager of the service. People told us that the manager was accessible and approachable. A positive and open culture was promoted at the service. The provider had effective systems in place to review the quality of the service provided.

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 told us they felt safe. Staff had been trained to recognise and respond to abuse and they followed appropriate procedures.

Safe recruitment practices were implemented and there were sufficient numbers of skilled and experienced staff to meet people's needs.

People were supported by staff who managed medicines consistently and safely. Medicines were stored and disposed of correctly and accurate records were kept.

Is the service effective?

Good

The service was effective.

People received care from staff who were trained to meet people's individual needs. Staff were supported to deliver effective care as they received on-going training and regular management supervision.

The provider acted in accordance with the Mental Capacity Act (2005) Code of Practice to help protect people's rights.

People received the support they needed to maintain good health and well-being. Staff cooperated effectively with health and social care professionals to identify and meet people's needs.

Is the service caring?

Good

The service was caring.

People were treated with respect. Staff understood how to provide care in a dignified manner and respected people's right to privacy and choice.

Staff had developed good relationships with people living at the home and there was a happy, relaxed atmosphere at the service.

People told us they were well cared for.

People were involved in planning their care and support.

Is the service responsive?

Good

The service was responsive.

People using the service had personalised care plans and their needs were regularly reviewed to ensure they received the right care and support.

Activities were meaningful and were planned in line with people's interests.

The service had a complaints procedure that was accessible both to people who used the service and their relatives. When raised, issues had been responded to in an appropriate and timely manner.

Staff provided end-of-life care in a very responsive and compassionate way.

Is the service well-led?

Good

The service was well-led.

There was an open and caring culture throughout the home. Staff understood the provider's values and put them into practice while delivering care to people.

The registered manager was praised both by people and staff. Staff told us they were able to approach the manager to raise their concerns and felt they were provided with good leadership.

The provider had effective systems in place to regularly assess and monitor the quality of service provided to people. On-going audits were used to improve the support people received.

Autumn Vale Rest 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 28 June and 3 July 2018 and was unannounced. The first part of the inspection was carried out by two inspectors and the other part was conducted by one inspector.

Before the inspection we had reviewed the previous inspection reports and other information we had held about the service, including notifications. A notification is information about important events which the service is required to send to us by law.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. At the inspection we checked if the information provided in the PIR was accurate.

During the inspection we spoke with four people who were using the service. We spoke with the registered manager, the deputy manager, a recovery worker and a support worker.

We pathway-tracked the care of five people. Pathway tracking is a process which enables us to look in detail at the care received by each person in the home. We reviewed medication records relating to people who used the service. We saw recruitment files and supervision records for four staff members. We looked at all staff training records and training records. We considered how information was gathered and quality assurance audits were used to drive improvements in the service. We also looked at records relating to the management of the service, such as health and safety files, risk assessments, resident meetings, staff meetings and staffing rotas.

Good

Is the service safe?

Our findings

People told us they felt safe living at Autumn Vale Rest Home. One person assured us, "I do feel safe here. It is really nice, they look after you well". Another person said, "Of course I feel safe. This is the best home I've ever been in".

People were protected from the risk of abuse because staff had a good understanding of the different types of abuse and knew how to report it. Staff told us about the safeguarding training they had received and how they put it into practice. A member of staff said, "I would report to the manager any sign of abuse. If I felt I needed to go higher, I would". Staff were able to describe the reasons for reporting abuse and the means to do it. They were aware of the company's policies and procedures and felt that they would be supported to follow them. Training files showed safeguarding training had been attended. Safeguarding referrals had been made when required.

There was a sufficient number of staff on shift to ensure people were kept safe and able to do the activities that they had planned. This staffing ratio matched the information indicated in the records for managing risks in different situations. One person told us, "There are enough of them to take care about the people living here".

We looked at recruitment records for four staff members and found they had completed application forms which included details of their former employment such as dates. This meant the provider was able to follow up any gaps in employment. Appropriate checks had been undertaken before staff began work; each staff member had two references recorded and checks completed through the Disclosure and Barring Service (DBS). The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

People's records contained information about how to recognise when someone was feeling anxious or experiencing crisis. These indicated actions staff should undertake in such circumstances, and detailed what to record in such events. As this information was regularly reviewed, it was always kept up-to-date which enhanced the effectiveness of the support.

Staff knew how to identify if a person may be at risk of harm and what action to take if they had concerns about a person's safety. People's plans included risk assessments for the following factors: mobility, falls, skin integrity and nutrition. This documentation informed staff about potential risks to each person and how to manage and minimise these risks. Detailed information was provided to staff regarding people's specific needs, for example the need for catheter care. There was clear information about what to monitor for signs of a problem, like blockage or infection. Contact details of district nurses who were providing catheter care were included to facilitate contacting them in an emergency.

People's needs had been assessed and their care was delivered in a way that suited their needs, without placing unnecessary restrictions on them. The service had effective systems to manage accidents and incidents, and to learn from them. As a result, dangerous occurrences were less likely to happen again. This

helped the service to continually improve and develop, and therefore significantly reduced the risks to people.

Innovation was recognised, encouraged and implemented to drive a high-quality service. The service had recently introduced the use of an electronic file system. Staff could enter any health care related information into specially adapted smartphones. The registered manager told us that this allowed staff to record important information about a person's well-being if they did not have a computer or a pen and paper at hand. As the registered manager could access the information entered into the system in real time, they could monitor the running of the service even while being far away from the service. This could also be used by other health care professionals, for example, by an ambulance crew, which would significantly reduce the time of the intervention. There were hard copies of people's care plans prepared for the case of an emergency or power outage.

Medicines were managed, stored and given to people as prescribed. Unrequired medicines were disposed of safely. Medicines that required additional control because of their potential for abuse (controlled drugs) were stored securely. We looked at the medicine administration records (MAR) for six people, and found that these had been completed correctly, with no unexplained gaps. Protocols were in place for people to receive medicines that had been prescribed on the 'as and when needed' basis (PRN) and homely remedies. Staff understood and followed these protocols. Medicines administration training was provided to staff as well as regular checks on their competency and knowledge.

All the incidents and accidents that had occurred had been investigated, recorded and dealt with appropriately. When conclusions had been drawn from accidents or incidents, the findings and actions had been shared through regular supervision, training and relevant meetings.

The environment was clean and well maintained. People's rooms and bathrooms were kept clean. The provider had regular repairs and maintenance work done on the premises. The boiler, electrics, gas appliances and water supply had been tested to ensure they were safe to use. Regular checks and tests were completed to promote safety in the home, such as weekly fire alarm tests, as well as the checks of firefighting equipment.

Good

Is the service effective?

Our findings

People's needs were met by staff who had relevant skills, competencies and knowledge. People using the service said that staff were well-trained and knew their needs. One person told us, "Staff are definitely well trained." Another person said, "They are very well trained, they know what they are doing".

People had assessments of their needs written up before they moved in to the service. People, their families, social workers and other services had been involved in the assessment process. The care plans were reviewed regularly by the registered manager and a formal review was held at least once a year or even more often if necessary.

We looked at the training records which showed staff received on-going training in a range of subjects which included: health and safety, end-of-life care, safeguarding adults, mental health, the Mental Capacity Act, and first aid. If needs for updates arose, they were identified immediately. The registered manager said training was booked in advance to ensure staff's practice remained up-to-date.

New staff were required to undertake an induction process comprising of training, shadowing and observing more experienced staff. The registered manager told us that the induction not only prepared new staff for their roles, but also allowed the organisation to get to know new staff members and identify what role in the service they would best "fit into". The induction process included the new Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. Staff told us the training covered all areas of the role and was relevant.

Staff told us they felt well supported by their line manager and received supervision and annual appraisals. This gave them an opportunity to discuss any changes in people's needs and exchange ideas and suggestions on how to support people best. A member of staff told us, "I have my supervision meetings every three months. You can bring up different issues, you can say how you feel at work. There is an emergency supervision available if you need it".

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. We checked whether the service was working within the principles of the MCA. We saw that people's ability to make decisions for themselves was considered across all aspects of their lives. Staff that we spoke with had a good understanding of the principles of the Mental Capacity Act and best interest decision making for people they supported. A member of staff told us, "The MCA tells us to presume the person has capacity unless assessed otherwise. Any decision taken on behalf of the person must be in their best interest and in the least restrictive form".

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). At the time of our inspection all people had DoLS in place. Staff members described why and how people could be deprived of their liberty and what could be considered as a lawful and unlawful restraint.

Throughout our inspection we saw that people who use the service were supported to express their views and make decisions about their care and support. People were asked to make their own choices and staff respected these. Staff members understood the individual ways in which people indicated their consent to any support offered as some people could not communicate verbally. For example, people were asked for their opinion with the use of gestures and body language. We saw people were asked for their consent before any care interventions took place and each time people were given time to consider options.

People's rooms were personalised and reflected their individual interests and taste. People had chosen décor and which pictures were to be displayed in the communal areas.

People's nutritional needs were assessed and monitored. The care plans included information about people's preferences concerning food and any risks associated with eating and drinking. For example, one person was at risk of malnutrition. Their care plan explained clearly how the person should be supported. This included a letter from a speech and language therapist (SALT) who recommended a soft, moist diet. During the inspection we observed that staff supported the person according to their care plan.

There was evidence of other health professionals' input. We saw that people were supported to attend health appointments with their GP, consultants and district nurses. One person needed regular exercises as part of their rehabilitation but also to build their confidence and maintain their independence. We saw that the person was supported to do the exercises and to go to a swimming pool and it was appropriately recorded.

Good

Is the service caring?

Our findings

People told us that staff were kind, caring and compassionate. They felt that they were listened to and made to feel that they mattered with their individual needs being known and catered for. One person praised staff, "They treat me with dignity and respect, they are very good." Another person said, "They talk to you whenever you want. Talking to someone always helps."

People were treated with respect and their dignity was preserved at all times. Staff showed kindness and compassion whilst providing people with care and support. We saw that staff took time to talk to people to make them feel supported and comfortable at the service. For example, we observed care staff talk to one person and then give them assistance with a drink and a snack. The person appeared to be happy to have a friendly chat with the staff member. There was friendly banter between people who use the service and staff.

Staff promoted people's privacy and we saw they knocked on people's doors to ask for permission before entering their rooms. Staff excused themselves when they needed to leave the room and explained why they had to go and when they would be back. People were addressed by their preferred names. Staff members were aware of the lifestyles people had enjoyed before they moved into the service and had good knowledge about people's relatives, interests and hobbies. As a result, staff were able to provide continued and consistent support to people. This enabled people to maintain their contact with relatives, for example through visits or sharing gifts and cards on special occasions.

People told us they were involved in the planning of their care and could voice their views on how their care should be delivered. One person told us, "I sign my care plans myself. They always ask me if I agree with what is in the care plan".

Staff had a profound knowledge of people they supported. The care records contained information about people's personal histories and detailed background information. This helped staff gain an understanding of what had shaped people to be what they were today and how events in their past that had impacted on them. Staff were responsible for making daily records about how people were supported. They were also obliged to communicate any issues which might affect people's care and well-being to the registered manager, other members of team and healthcare professionals if appropriate. Staff told us this system guaranteed that all information affecting a person's care and support was up-to-date.

People's care plans identified the appropriate individual approaches for each person. Staff knew how to comfort people who were in distress and unable to communicate their needs verbally. Staff explained to us how they read any signs of people's anxiety and described the best ways to comfort people. They said the methods of reassuring people largely depended the individual and could include re-direction, distraction or verbal and non-verbal calming down.

People told us they were able to have visitors whenever they wished. One person said, "Relatives, friends, anyone can come here anytime".

An equality and diversity policy was in place at the service. There were procedures for people's cultural and religious backgrounds as well as people's gender and sexual orientation to be recognised at the initial assessment stage and respected within the service. Staff received training in equality and diversity.

We saw that records containing people's personal information were kept in the main office which was locked and no unauthorised person had access to the room. People knew where their information was and how to access it with the assistance of staff. Some personal information was stored within a password protected computer.

Good

Is the service responsive?

Our findings

Staff were provided with clear guidance on how to support people in line with people's wishes and preferences. Staff showed an in-depth knowledge and understanding of people's care and support needs. All the staff members we talked to were able to describe the care needs of each person they supported. This included individual ways of communicating with people, people's preferences and routines.

The service had prepared person-oriented plans which reflected how people wanted to receive their care and support. Staff said they found the care plans useful and gave them enough information and guidance on how to provide the support people wanted and needed. This meant that staff were able to offer very individualised care. Staff members spoke confidently about the individual needs of people using the service. The records showed people received the support they needed.

People told us that the service was responsive to their needs. This resulted in positive outcomes improving people's quality of lives. One person gave us the following example, "They changed the way I used to be. I do not take painkillers anymore. I go swimming instead and I try to keep healthy. I gave up smoking. [The registered manager] has helped me ever since my friend passed away. Thanks to the support I receive, I've managed to be alright".

Some people had very specific health needs. These were monitored and reviewed regularly to help ensure any changes were identified. Care documentation contained links to further information about particular conditions. This demonstrated the service worked continually to develop the care provided in order to meet people's needs as best as possible.

People had access to a wide range of pursuits which were meaningful to people and reflected their individual interests. Activities were important to people because they improved the quality of their lives and reduced the likelihood of social isolation. One person told us, "I enjoy exercises and swimming. I'm looking forward to this as I can lose some more weight." Another person said, "[The recovery worker] takes us out. There is always something going on." Other activities included organised trips, seaside walks, library visits, café trips, going to church and other social events. The mix of in-house activities and external activities as well as having visitors meant that people were protected from social isolation.

People's needs were met promptly because staff members communicated effectively with one another, both informally and at handover meetings between shifts. Staff confirmed that team communication was good and support was available from the management team.

The Accessible Information Standard (AIS) framework was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. The provider checked at the initial assessment if people suffered from such conditions and recorded any sensory loss or communication difficulties in their care plans. People told us and records confirmed that information was provided to people in the way they could understand it. For some of the people who lived at the service English was not

their native language. The registered provider employed bi-lingual staff who could communicate with people using their preferred languages.

People were able to express their opinions on matters important to them, such as activities, food menu or holidays, at regular house meetings organised monthly. This demonstrated that people were encouraged to share their opinion on the service and were listened to.

People's diverse needs were respected. Discussion with the provider and staff showed that they respected people's differences and diverse needs. There was an equality and diversity policy in place. The equality and diversity policy covered all aspects of diversity including race, sex, sexual orientation, gender re-assignment and religion. Records showed staff had received training in equality and diversity.

There was a satisfactory complaints procedure in place which gave details of relevant contacts and outlined the time scale within which people should have their complaints responded to. Staff told us they knew people well and were able to tell from their behaviour if they were unhappy and might want to make a complaint. People told us and records confirmed that when an issue was raised, it was addressed by the registered provider. One person said, "I complained about the front garden. They said they are going to do it". During the inspection we spoke to the registered manager who told us that there was a plan to renew the front garden. It was also confirmed by relevant records

The service liaised effectively with a palliative care team to deliver end of life care. We saw evidence that the service correctly recognised symptoms of the end of life and provided necessary comfort measures to people reaching the end of their life. For example, when a person receiving end of life care had stopped responding, the service had used a pain assessment tool in order to determine if the pain management was effective. When the person had experienced terminal agitation, the service had contacted the palliative care team in order to increase the dose of medication and prevent the person from pulling the syringe driver out. The service had used dark towels as blood was less noticeable on them and was less distressing for the person.

Good

Is the service well-led?

Our findings

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

There was a clear management structure within the home. We could see from the rota that there was always an accountable member of staff on duty. At shift changes staff met and shared updated information on people's needs. Afterwards, staff members were given roles and responsibilities for the following shift. This provided a consistent accountable approach.

A staffing structure which gave clear lines of accountability and responsibility was also established. Staff were aware of their managers' roles and responsibilities. The morale of staff was high because they could rely on the help and support from their managers. A member of staff told us, "I feel supported by the management. They are really open to us. You can go to them and discuss any issue".

The registered manager was keen on ensuring people's rights and wishes were respected and protected. The registered manager's opinion and assistance were much valued within the service. We saw people and staff sought the registered manager and the deputy manager to discuss issues and express their views as they knew they would be listened to. One person told us, "[The registered manager] is often on the floor. I think he runs this home really well".

Staff said that there was an open culture in the home as they knew their views and opinions were always taken into consideration by the unit manager. They also said they were fully involved in the running of the service and their opinions and suggestions contributed to its enhancement. They were kept informed of any changes affecting the service.

The service cooperated closely with health and social care professionals to achieve the highest possible standard of care for people they supported. People's needs were accurately reflected in detailed plans of care and risk assessments. People's records were of good quality and fully completed as appropriate.

Monthly staff meetings were focused on satisfying the needs of people who lived at the home. Copies of staff meeting notes demonstrated that care and attention had been paid to ensure people who lived at the home were safe and well supported. Staff told us they contributed to the team meeting agenda.

Satisfaction surveys were sent to people who used the service, their relatives, and staff to seek their views on the quality of the service provided. The results of the last survey showed a high level of satisfaction with the service provided. Where improvements were suggested, the service acted on feedback and increased staffing levels and introduced laundry labels.

Policies and procedures were detailed and gave appropriate information to staff, people using the service

and their relatives, and were fit for purpose. We saw that both the policies and the procedures had been reviewed. Moreover, there was a system in place for ensuring staff had read and understood them.

All the incidents and accidents that had occurred had been investigated, recorded and dealt with appropriately. For example, one person had been moved downstairs to a room beside the kitchen so they could be monitored more closely. When conclusions had been drawn from accidents or incidents, the findings had been shared through regular supervision, training and relevant meetings. CQC records showed that the registered manager had sent us notification forms when necessary and kept us promptly informed of any reportable events.

Audits and checks were carried out to monitor the safety and quality of care. The management team had executed detailed audits in various areas. For example, they conducted an infection control audit, a medicines audit, a maintenance audit, a training audit and a night shift audit. After the audits were completed, the registered manager used them to identify areas where improvements been needed and a relevant action plan was put in place. For example, chairs in the dining area had been replaced and the hallway to exit patio area had been plastered and re-decorated.