Pathways Health Care Limited

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Inspection report

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Date of inspection visit:
23 November 2017

Date of publication:
29 December 2017

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected the service on 23 November 2017. The inspection was unannounced. Pathways Health Care Limited 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 a care home service with nursing. Pathways Health Care Limited is registered to accommodate ten people in one adapted building. On the day of our inspection eight people were using the service and the registered manager told us that two of the bedrooms were no longer in use and would not be in the future.

At the last inspection, in October 2015, the service was rated Good. At this inspection we found that the service remained Good. However, the rating for the Responsive domain has changed from Good to Requires Improvement.

The service had a registered manager in place at the time of our inspection. 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.

Risks in relation to people's daily life were assessed and planned for to protect them from harm and they lived in a clean, hygienic service. People were supported by staff who knew how to recognise abuse and how to respond to concerns. We have recommended the provider considers improving the system for analysing incident records to ensure this does not occur again.

Medicines were managed safely and people received their medicines as prescribed. People were supported by staff who sought to understand, prevent and manage behaviour that the service found challenging and supported by enough staff to ensure their personal care needs were responded to in a timely way. People were supported by staff who had the knowledge and skills to provide safe and appropriate care and support. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. People were supported to maintain their nutrition and staff were monitoring and responding to people's health conditions.

People lived in a service where staff listened to them and got to know them. People's support needs were recognised and responded to by a staff team who recognised the importance of respecting people's privacy and dignity. Information about people's needs was shared between services to ensure people would be supported in other settings when needed.

People were supported to participate in activities and to socialise, however this was sometimes restricted due to the availability of staff. We have recommend the provider considers assessing staffing levels to

ensure there are enough staff on duty to enable people to access the community when they wish to.

People lived in a service which met their needs in relation to the premises and adaptions were made where needed. People had access to information in a format which met their needs and were able to raise concerns if they needed to.

People were involved in giving their views on how the service was run and there were systems in place to monitor and improve 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 remains safe

Is the service effective?

Good

The service remains effective

Is the service caring?

Good

The service remains caring

Is the service responsive?

Requires Improvement

The service had deteriorated to requires improvement

People were supported to participate in activities and to socialise, however this was sometimes restricted due to the availability of staff.

People lived in a service which met their needs in relation to the premises and adaptions were made where needed. People had access to information in a format which met their needs and were able to raise concerns if they needed to. People were involved in planning their care and support.

Is the service well-led?

Good

The service remains well led

Pathways Health Care Limited

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.

We inspected the service on 23 November 2017. The inspection was unannounced. The inspection team consisted of two inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved in the service and commissioners who fund the care for some people who use the service. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with one person who used the service. Some people who used the service had limited verbal communication and so we also relied on observations and spoke with the relatives of three people who used the service.

We spoke with three members of support staff, a nurse, a housekeeper and the registered manager. We looked at the care records of five people who used the service, medicines records, staff recruitment and training records, as well as a range of records relating to the running of the service including audits carried out by the registered manager and registered provider.

Good

Is the service safe?

Our findings

People were protected from abuse and avoidable harm. The person we spoke with told us they felt safe in the service. One relative told us their relation was "definitely" safe living in the service. They went on to say that they knew their relation felt safe as they "are always happy to go back when we have been out." Another relative told us they felt their relation was safe and said, "This is the best place [relation] has ever been. [Relation] is much more settled here than in other places." We observed people interacting with staff and they were smiling and comfortable which indicated they trusted the staff.

Processes were in place to reduce the risk of people experiencing avoidable harm or abuse. Staff spoke knowledgably and confidently about what they would do if they thought people were at risk of harm and had received training in relation to this. Records showed the registered manager had made referrals to the appropriate authorities where needed. We noted one incident which should have been referred to the local authority but had not been. The registered manager acknowledged this and assured us these types of incidents would be referred in the future. We recommend the provider improves the system for analysing incident records to ensure this does not occur again.

The risks to people's safety and welfare had been assessed and plans put in place to minimise the risks. For example, one person, who was not previously been at risk of falling, had fallen and sustained an injury. Following this a falls assessment was completed and the support and equipment the person needed to reduce the risk of further falls was put in place. The person was supported to have input from occupational therapy and physiotherapy and the risk was reviewed monthly. Where accidents or incidents had occurred, these were investigated, with changes made to reduce the risk or reoccurrence. Staff told us they were encouraged to report incidents and they received feedback from the registered manager in relation to changes needed and learning as a result of incidents.

Risks to the environment were assessed and there were systems in place to minimise the risks, for example in relation to risks from the water system. There was regular testing and monitoring of this to reduce the risks of legionella. External contractors undertook safety checks on equipment and the premises to ensure this was safe.

There were enough staff to meet the care needs of people who used the service. The person and relatives we spoke with told us they felt there were enough staff to meet the needs of people. One relative told us, "The staff are always around for [relation]." We observed there were adequate numbers of staff on duty to meet the needs of people who used the service. If an individual requested support this was given promptly. The registered manager described assessing people's dependency and planning staffing levels to ensure people were given care and support.

Staff told us they felt there were enough staff to meet the care needs of people who used the service. Records showed that prior to staff being recruited the registered manager carried out checks to ensure applicants were suitable to work with people who used the service. The registration of qualified nurses was checked routinely to ensure they were up to date.

The person we spoke with told us they were given their medicines when they should and relatives told us they were happy with the way staff managed their relation's medicines. We observed staff administering the medicines and saw they followed safe practice. Records showed there were clear medicine management systems in place to ensure people were protected from the risks associated with medicines. People's records showed they received their medicines when they needed them. We found that medicines were stored and administered safely.

There were systems in place to manage the control and prevention of infection. The person we spoke with and people's relatives told us they felt the service was clean and hygienic. One relative told us, "If it wasn't I would have told them." We observed all areas of the service looked clean and hygienic and there was equipment in place which would reduce the risk of the spread of infection such as colour coded cleaning equipment and disposable hand towels in toilets and bathrooms. Staff received training to understand their role and responsibilities for maintaining high standards of cleanliness and hygiene in the premises. Staff had access to policies and procedures on infection control that meet current and relevant national guidance. Cleaning staff were employed for part of the week and on other days support staff undertook cleaning tasks. Support staff were not always completing the records to show they had carried out the cleaning and the registered manager assured us they would address this following our visit.

Good

Is the service effective?

Our findings

People's physical, mental health and social needs were assessed and their care and support was planned and delivered in line with legislation, standards and evidence-based guidance. The registered manager told us the provider had a good clinical team who notified the service of any changes in best practice guidance and that if a new health need was identified the management team researched this to ensure they were following current best practice. One person's care plan referenced the NHS strategy for Learning Disability, 'Valuing People' (2001) as a basis for the interventions in the care plan. There was a NHS diabetes food plan, with suggestions for each meal, in the care records of a person with diabetes to enable staff to assist the person to maintain a healthy balanced diet. Recognised risk assessment tools to assess the level of risk to people in relation to nutrition, pressure ulcers and falls were also used throughout the service. There were records in place to ensure people received consistent person-centred care and support when they moved between different services such as external activities and the hospital.

People living in the service had varying levels of ability to verbally communicate and to understand written documents. The registered manager had ensured that people had access to information that enabled them to understand their care needs and the health services available to them to ensure people were not unduly discriminated against. For example, a wide range of accessible 'easy-read' documentation was in place. The assessment of people's diverse needs to ensure there was no discrimination, including in relation to protected characteristics under the Equality Act was not yet fully embedded in the service. Assessment records included some of the characteristics but not all of them. The registered manager told us this would be developed and incorporated into the assessment process.

People were supported by staff who were trained to support them safely. The person we spoke with and the relatives all said they felt staff knew what they were doing. We observed staff supporting people and saw they were confident in what they were doing and had the skills needed to care for people appropriately. Staff told us that in addition to mandatory training they were able to ask for any training they felt they needed. One member of staff told us that when a person was admitted to the service with physical nursing needs the manager accessed additional training for them. They gave an example of a person with insulin controlled diabetes and said they had accessed training through their local GP surgery and also had input from a dietician.

Training records showed that staff were given regular training to ensure they retained and developed their skills. Staff were given an induction when they first started working in the service and all staff had completed the care certificate and we saw evidence of the most recently recruited member of staff completing this. The care certificate is a set of national standards for staff working in health and social care to follow and equip them with the knowledge and skills to provide safe, compassionate care and support.

People were cared for by staff who received feedback from the management team on how well they were performing and to discuss their development needs. Staff told us they had regular supervision from the registered manager and were given feedback on their performance and we saw records which confirmed this.

People lived in a service which met their needs in relation to the premises. There was signage in place written in an easy read format with pictures and symbols to support people with a learning disability to orientate themselves. People who needed a mobility aid were able to access the areas of the service they needed to. Communal areas were accessible and furnished in a homely style and there was large a garden area which was accessible from the lounge. The whole of the garden was accessible for those with reduced mobility and provided a safe and pleasant outdoor space. Staff told us the area had recently been equipped with swings and a trampoline for people's use and a relative commented positively on the improved garden and said that people using the service liked using the equipment and the space for ball games.

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 were supported to make decisions on a daily basis and we observed people decided how and where they spent their time and made decisions about their care and support. Where people's capacity to make certain decisions was in doubt, assessments were carried out and if the person was assessed as not having the capacity to make a decision, a best interest's decision was made which ensured that the principles of the MCA were followed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications for DoLS where appropriate and the service had complied with the condition attached to one person's authorisation.

People were protected from the use of avoidable restraint. There were care plans in place which detailed how staff should respond to people's behaviour when it challenged them and this was planned for in the less restrictive way. Staff had received training to ensure they understood how to support people safely and there were positive behaviour plans in place to guide staff in recognising triggers of behaviour and prevent behaviour from escalating.

People were supported to eat and drink enough. We spoke with people about the food and they told us they had enough to eat and we observed people were given regular drinks. People's nutritional needs were assessed regularly and there was information in support plans detailing people's nutritional needs. We saw staff had noted when one person's weight had changed and sought support from health professionals, updated the person's care plan with the advice given and were following the recommendations. For example if the person did not eat much of their meal, staff were to give them a drink which was fortified with calories and vitamins. On the day we visited we saw this happened in practice.

People were supported with their day to day healthcare. We saw people were supported to attend regular appointments to get their health checked and if people were unwell staff sought prompt advice from their GP. We saw there was a range of external health professionals involved in people's care, such as the dietician, psychologist and the Speech and Language Team (SALT).

Good

Is the service caring?

Our findings

The person we spoke with told us they felt staff were kind and caring. The relatives we spoke with were positive in their comments and one said, "They (staff) seem to care. They care about each resident individually." They went on to say, "I am very happy with it (the service) and [relation] seems very happy." Another relative told us, "The staff are nice. [Relation] is socialising more due to the environment here."

We observed staff interactions with people and we saw staff were kind and caring to people when they were supporting them. People looked relaxed and comfortable with staff and observations and discussions with staff showed they clearly knew people's needs and preferences. It was one person's birthday on the day we visited and staff had brought balloons in which the person was clearly interested in. Staff made a fuss of the person throughout the day and several staff and visitors came and sang happy birthday. There was also a party with a buffet in the evening for the person, their relatives, other people using the service and staff.

Relatives and staff told us that people's independence was supported. One relative said, "[Relation] has more independence here and [relation's] well-being has improved." They described people being allocated housekeeping tasks such as helping staff with the laundry to promote their life skills. Staff described people participating in everyday tasks such as assisting staff in preparing part of the meals. For example, one person cut up vegetables and another put the prepared vegetables in the pan.

The person and relatives we spoke with told us they felt people's choices were listened to and acted on. One relative told us, "Staff communicate with [relation] to get their choices." We observed people's choices were respected on the day of our visit. One person did not like to eat in the main dining area and preferred to eat alone and we saw this was respected on the day we visited. Some people were unable to make choices and contribute to some areas of their support, such as the development of the food menu. A new menu was being developed and staff told us they were trying some different meals to assess whether people enjoyed them, before deciding whether they remained on the menu, or were removed. Where people could not verbalise their choices, their preferences, based on information received from previous placements or their relatives were captured in detail in their care plan. People had been supported to choose how their bedrooms was decorated and furbished.

People had opportunities to follow their religious beliefs. People's religion was assessed upon admission and where people expressed a wish to follow a certain faith this was respected and planned for to enable them to attend their local place of worship. We spoke to the registered manager about the use of advocacy services for people, an advocate is a trained professional who supports, enables and empowers people to speak up. The manager told us no one in the home was currently using this service but information was available for them should this be required.

People were supported to have their privacy and were treated with dignity. The person who used the service and the relatives we spoke with told us they felt staff were respectful. We observed people were treated as individuals and staff were respectful of people's preferred needs. Staff were mindful not to have discussions about people in front of other people and they spoke to people with respect. Staff told us they were given

training in privacy and dignity values as part of their induction package and records showed dignity was discussed at staff meetings. The registered manager told us there were two dignity champions and that they used bi-monthly staff supervision sessions to discuss how staff had met the dignity values. Guidance on privacy and dignity in healthcare for people with a learning disability was displayed in the office for staff to read. We found people's personal information was respected, for example it was managed and stored securely and appropriately.

The registered manager told us that people's relatives and friends were able to visit them without any unnecessary restriction. We observed and spoke with relatives visiting during the inspection who confirmed this. One relative we spoke with told us, "We can visit any time. I am made very welcome." Another relative told us they were made to feel welcome and said, "Look I had a cup of tea in my hand as soon as I walked through the door."

Requires Improvement

Is the service responsive?

Our findings

Although people were supported to get involved in activities in the service they were not able to access the community as regularly as they could due to staffing levels not enabling this. One relative told us, "The staffing levels have not been increased since the adults with wheelchairs have moved in. They need more care I have noticed [relation] has not been going out as much and it is the same with others too." Staff confirmed this and told us that although they felt people had plenty to do and received the personal care they needed, the number of staff on duty restricted how often people could access the community.

Staff described one young person who constantly wanted to go out into the community but was only able to do so two or three times a week. One person needed two staff to take them on an activity in the community once a week and this impacted on other people having staff support to access the community. Staff told us that the needs of people had increased and that it was late morning by the time they had given people support with personal care. This impacted on the time available to support people to access the community.

The support needs of one person who used the service had increased significantly recently due to behaviour which may challenge others. The registered manager was in the process of liaising with the funding authority to get funding for one to one staffing for this person; however in the meantime staff needed to give the person one to one which impacted on the amount of staff available to support other people to access the community. Additionally staff were responsible for cleaning the service three days a week when the housekeeper was not at work and also prepare meals for people. This further impacted on the time available for engagement with activities in the community.

We recommend the provider assesses staffing levels to ensure there are enough staff on duty to enable people to access the community when they wish to.

People were supported to be active whilst in the service and were given some opportunities to socialise in the community. One person told us they felt they had enough to do to keep them occupied. They described enjoying knitting and watching films and said they did this regularly. One relative said, "[Relation] does more here than they have ever done. They go horse riding, on holidays and they are encouraged to try new things." They told us the garden had been changed for the better saying that it was used for ball games and that their relation liked the swing. They added, "In summer, everyone is always out there." Records showed people had been supported to attend social activities in the community such as a disco and pub lunches. One person enjoyed outdoor sport and had recently been supported to go sailing and to do archery.

People's care plans provided information about activities individuals liked to participate in during our visit we saw people participating in a range of activities on a one to one basis. We saw a person using wooden building bricks, another person accessing the garden, and then watching a DVD. A third person was enjoying colouring on a blackboard.

People and their relatives were involved in planning and making choices about their care and support. The

relatives we spoke with told us that they felt they were involved in their relation's care and support, involved in care plan reviews and that staff kept them updated about any changes. One relative told us, "They (staff) keep me informed all the time." A member of staff said, "There is a lot of family involvement here and they have input into the discussions about the care provided and the person's care plans." People's care plans were written in an easy to read format to facilitate their involvement in the development and review of their care. Where people were able, they signed consent to their care plan and there was evidence of them and their relative's involvement in a quarterly review of the care plans. If people were unable to sign then it was documented that they had been involved.

People were supported by staff who were given information about their support needs. People were assessed prior to admission to check that their needs could be met. Care plans were then written to give staff the information they needed to meet the needs of the individual. We saw that people's care plans contained information about people's physical and mental health needs and guided staff in how to support them. For example, two people were at risk of choking and there was detailed guidance for staff to follow to minimise the risk and what to do if the person did choke. The care plan of one of these people informed staff that they needed to prompt the person to eat slowly and to not overfill their mouth with food. We observed staff following this plan in practice when supporting the person at lunchtime.

The provider had taken steps to identify accessible information needs during the assessment of people's care and this was clearly detailed in people's care plan. Easy to read information was available in a range of documents. This included information about how people should expect to be treated, the complaints policy and a guide to the service. Care plans had also been written in an easy to read format with pictures and short sentences. One person had needs arising from their limited verbal communication and there was a detailed communication plan in place which described the signs the person used and what they were communicating. Where people were unable to communicate verbally there was a care plan in place which provided information for staff on how to tell whether the person was in pain and the type of pain the person was likely to experience. The care plans contained information about the amount of information people could understand and how staff should give information to maximise their understanding. The service used communication systems using signs, symbols and pictures as a way of communicating with people with a learning disability such as autism spectrum disorder, also known as ASD.

Technology was used to support people where this was identified as a need. The Speech and Language team had been involved in the care of one person to support the person to communicate. They had recommended the person be given access to an electronic tablet with communication applications. This had been purchased for the person and staff had supported them to use this. It had not been effective for the person and so staff had reverted back to the use of sign language with the person and had received training in this.

People knew what to do if they had any concerns and relatives told us they knew about the complaints procedure and felt they would be able to raise concerns freely. One relative told us, "I have never had any issues." They went on to say that they had seen the complaints procedure and if they did have any issues they would speak with the registered manager and felt they would be listened to. Another relative told us they had not been in agreement with an aspect of their relation's support and they had spoken with the registered manager and this had been changed.

The registered manager told us they had not received any formal complaints since we last inspected the service and so we were unable to assess how well complaints would be responded to. However staff were aware of how to respond to complaints and the registered manager had systems in place to deal with complaints if they arose. There was a complaints procedure in the service so that people would know how

to escalate their concerns if they needed to.

We saw that people and their significant others had been supported to develop a plan for when they reached the end of their life. These were written in an easy read format which people could understand. Staff described the end of life care provided for a person a few months prior to our visit. They said the person wanted to stay at the service if possible and with input from the person's GP this was achieved and the person passed away at the service. They said they were only admitted to hospital when necessary for them to receive treatment which could only be provided in hospital.

Good

Is the service well-led?

Our findings

There was a registered manager in post and the person and relatives we spoke with told us the registered manager was approachable and that there was an open culture. One relative told us, "She (the registered manager) is always available and able to answer questions. If she is not sure then she will make sure she finds out." We saw people responded positively to the registered manager when she was speaking with them. We found the registered manager was clear about their responsibilities and they had notified us of significant events in the service. The previous rating given to the service was on display as required.

The service promoted and supported fairness, transparency and an open culture for staff. Staff were made to feel valued and this motivated them to do their job well. Staff told us the registered manager was supportive and one member of staff described the registered manager staying after their normal hours if an incident had occurred. Another member of staff said the manager was, "always about." Staff said they could telephone the registered manager at home out of hours and there was a rota for management cover at night and the weekend. Staff felt there was an open culture in the service and one member of staff "It is relaxed and it feels homely. We do all work well together." Staff told us that people's diverse needs were considered and met.

Staff understood their roles and what they were accountable for. There were meetings held for staff of different designations such as care staff, kitchen staff and nursing staff. The records of these showed that staff had an opportunity to make suggestions for improvement and staff told us that these were acted on.

People and relatives were regularly asked for their views on the quality of the service being provided. There were meetings held for people who used the service and the notes from these were written in an easy read format. The notes provided evidence that people were consulted about the activities in the service, the menus and asked for suggestions on improvements. Satisfaction surveys were distributed on an annual basis and we saw the results of the survey from 2016 and saw the results were positive overall. There were also forms in the main reception of the service called 'How are we doing' for people to complete giving feedback on the quality of the service. The management team carried out audits on a regular basis to assure themselves of the quality of the service. Any issues that were identified were then acted upon, such as addressing maintenance issues in the service.

The registered provider ensured the operations manager carried out frequent audits of the service, which were based on the five key questions, is the service safe, effective, caring, responsive and well led. This included an annual full review of the service and compliance visits. Where areas of improvement were noted there was an action plan put in place and a return visit was made to assess if the improvements had been made. The systems used to assess the service included an action plan which was updated to reflect ongoing improvements.