

National Centre for Young People with Epilepsy NCYPE - College Residential Services Lingfield

Inspection report

The National Centre for Young People with Epilepsy
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Date of inspection visit:
20 February 2018

Date of publication:
25 April 2018

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

The National Centre for Young People with Epilepsy provides specialist education and residential provision for children and young people with neurological conditions, learning and physical disabilities. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Up to 110 young people can be accommodated across the provision for further education. There are 15 houses, with between six to 12 young people living in each house. At the time of the inspection 84 people were living in the houses.

At the last inspection on 21 July 2015 the service was rated 'Good.' At this inspection we found the service remained 'Good.' At a focus inspection on the 3 March 2017 we made a recommendation that the registered manager ensures that staff are aware of the times and needs of a person and when they require one to one support. During this inspection we found that the registered manager had actioned this recommendation. Staff were aware of which people required one to one support.

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

People told us they felt safe living at the service and that staff treated them well. Staff were aware of the procedures to follow if they had any suspicions or witnessed abuse. There was a safeguarding lead person who monitored safeguarding at the service and was available throughout the day to people, staff, relatives and visitors. Risks had been identified and assessed for each person to help keep them safe and to live their lives as independently as possible. There was sufficient staff deployed to attend to the needs of people. Medicines were managed in a safe way and the recording of medicines was completed to show people had received the medicines they required. A thorough recruitment process was in place to ensure only suitable staff were employed at the service.

Staff continued to receive training, regular supervision (one to one meeting) and annual appraisals that helped them to perform their duties. Staff understood the Mental Capacity Act 2005 (MCA) principles. Staff had followed the legal requirements of the MCA where restrictions were in place. Staff supported people to eat a variety of freshly prepared foods. People had access to all internal and external healthcare professionals and their involvement was sought by staff to help maintain people's good health.

Staff respected people's privacy and dignity and involved them in making decisions about their care. People were able to choose how they spent their time and could freely access all communal areas of the service. People's relatives and visitors were welcomed and there were no restrictions of times to visit.

Documentation that enabled staff to support people and to record the care they had received was up to

date and continued to be regularly reviewed. People and their relatives were involved in the reviewing of their care. People took part in a variety of activities that interested them. A complaints procedure was available to people, relatives and visitors. Complaints received had been resolved in accordance with provider's complaints policy.

There was a positive culture within the homes, between the people that lived there and the staff. People told us that they could talk to staff and they would always listen to them.

The provider had an effective system in place to monitor the quality of care and treatment provided in each of the homes. Staff were asked for their views about how the service was run during staff and daily handover meetings. People and their relatives continued to be involved in the running of the service and their feedback was sought. Staff told us that they felt supported by the management of the service. Staff who worked across organisations communicated well with each other to deliver effective care, support and treatment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Staff were knowledgeable about the process to be followed if they suspected or witnessed abuse.

There were sufficient staff deployed at the home to meet people's needs. Staff were aware of people's individual one to one support needs.

Risks to individual people had been identified and written guidance for staff about how to manage risks was being followed.

Accidents and incidents were recorded and monitored by staff to help minimise the risk of repeated events.

The provider had carried out full recruitment checks to ensure staff were safe to work at the service.

People's medicines were managed, stored and administered safely.

Good ●

Is the service effective?

The service remains Good.

Good ●

Is the service caring?

The service remains Good.

Good ●

Is the service responsive?

The service remains Good.

Good ●

Is the service well-led?

The service remains Good.

Good ●

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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 20 February 2018 and was unannounced.

The inspection was carried out by six inspectors, two specialist advisors in nursing care and two experts-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 gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

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.

As part of our inspection we spoke with five people, two relatives and eighteen staff members. We spoke with the registered manager, nurse manager, lead nurse and lead person for safeguarding. We looked at the care plans for sixteen people, medicines records, accidents and incidents, complaints and safeguarding's. We looked at mental capacity assessments and applications to deprive people of their liberty. We reviewed audits, surveys and looked at evidence of activities taking place at the home.

We looked at six staff recruitment files and records of staff training and supervision, appraisals, a selection of policies and procedures and health and safety audits. We also looked at minutes of staff meetings and evidence of partnership working.

Is the service safe?

Our findings

People and their relatives told us that they felt safe living at The National Centre for Young People with Epilepsy (NCYPE). One person told us, "Yeah, I feel safe living here, the staff are good and treat me well." A relative told us, "It is absolutely 100% safe here. [Family member] feels very safe and able to speak to staff."

At our last inspection of March 2017 we made a recommendation that the registered manager should ensure that staff were aware of the times when a person would require one to one support. During this inspection, through discussions with staff and observations, it was clear that people were provided with one to one support as and when required. Staff were knowledgeable about the individual support needs of people.

People continued to be protected from abuse because staff understood their roles in keeping people safe. The provider had a safeguarding policy and procedure in place that provided guidance to staff that helped them to ensure people were protected from harassment and discrimination. Staff told us they had read and understood the policy and procedures and were able to explain to us what this meant for people. The provider told us in their PIR that the service had suitable policies and procedures in place to enable, develop and encourage good practice and a dedicated team were in place to provide advice and support as required. We found this to be the case. Staff told us they received training in regard to safeguarding people every year and records we saw confirmed this.

Staff understood the correct safeguarding procedures to follow should they witness or suspect abuse. They were aware that a referral to an agency, such as the local authority's adult services safeguarding team should be made in line with the provider's policy. One staff member said, "I would make sure something was done if I thought someone wasn't being treated well." Another member of staff told us, "I make sure no one has got any marks or bruises. If I saw any I would report it to the manager as a safeguarding concern."

People were kept as safe as possible because potential risks had been identified and assessed. Each person had risk assessments in place to help them maintain their independence. For example, medicines, travelling safely in the car, scalding, management of seizures, safety whilst using the internet and behaviours that may challenge. Assessments had been completed to identify and manage any risks of harm to people around the home for example, infection control and fire. Staff understood their responsibilities around maintaining a safe environment for people and keeping equipment clean. Equipment such as mobile hoists were regularly serviced and cleaned to make sure they were safe to use. Staff wore appropriate personal protective equipment when giving personal care.

There were enough staff to keep people safe and meet their individual needs. The registered manager told us that they used a deployment tool that determined the numbers of staff required for each of the fifteen houses for the needs of people. Managers are assigned to each house and it is the responsibility of these managers to keep the registered manager informed of the numbers of staff required at all times. Staff told us that there were always sufficient staff on duty to safely meet the needs of all people. We observed that staff were appropriately allocated to people who required 1:1 support throughout the day. People and their relatives told us that there were enough staff. One relative told us, "It's never been understaffed to the

extent that there was a risk. The staff are always very aware of where the people are in the homes."

People were protected from being cared for by unsuitable staff because safe recruitment practices were followed before new staff were employed. All the required documentation, including a full employment history, references and Disclosure and Barring Service (DBS) checks had been obtained for new staff. The DBS helps providers ensure only suitable people are employed in health and social care services.

Medicines were administered, recorded and stored safely. People's medicine records contained photographs of them which assisted staff to administer the right medicines to the right person. The records also included the contact details of the person's prescribing GP. People received their medicines when required and as they were prescribed by their GP. The nurses followed guidance from the Royal Pharmaceutical Society that ensured medicines were administered, recorded and stored safely. All medicines received into the service and those being returned to the pharmacy were clearly recorded. Staff had competency assessments where their knowledge and practice was checked. People told us they always received their medicines on time and they knew what their medicines were for. We found that the MARs records in 14 of the 15 houses were correctly signed, however we noted in one house that there were five omissions of signatures. We discussed this with the registered manager who immediately followed this up.

Since our inspection the registered manager informed us that the medicines had been fully audited and no discrepancies were found with the count which would mean that no medications were missed. The registered manager also informed that the person who had dispensed these medicines had put a red dot on the MAR as per the medicine policy, but had omitted to go back and sign the MAR record after the administration of the medicines. This was subsequently addressed.

People were protected against the spread of infection within the service. People lived in an environment that was clean and hygienic. Each house we visited was clean and hygienic and staff maintained appropriate standards of infection control. Domestic staff were employed in each home and support staff also contributed to keeping the home clean. The provider had a lead infection control nurse. The provider had an infection control lead who carried out regular audits of the service. The most recent audit had not identified any immediate concerns.

Lessons were learned and improvements were made when things go wrong. When people had accidents or incidents these were recorded and monitored by the registered manager to help keep people safe. Records of accidents and incidents were detailed and included the action staff had taken, the outcome and any lessons learned. These were discussed with the staff team, and when necessary, with other agencies so that lessons could be learnt and action plans to help prevent a repeat could be put in place.

Is the service effective?

Our findings

People's needs and choices were assessed and care, treatment and support was delivered in line with current legislation. For example, NICE guidance to enable effective outcomes for people to be achieved. The registered manager told us that people's needs were always assessed before they moved into the service. The registered manager said people attended a whole day assessment before a decision was made to confirm a placement. The assessment included an educational and residential assessment and meetings with relevant professionals. The registered manager told us, "Parents are very much involved as they know their family member best and we want to work in partnership with them." This was confirmed during conversations with relatives. One relative told us, "We had a pre admission assessment. We came for an open day visit and they had very rigorous tests that we were all involved in."

People received effective care from staff who had the skills, knowledge and understanding needed to carry out their roles. People and their relatives spoke positively about staff and told us they believed they were skilled to meet their needs. The provider told us in their PIR that staff had received all the mandatory training as required and we found this to be the case. Other training provided included positive behaviour support, understanding autism, anaphylaxis (dealing with severe allergic reactions) and epilepsy. Records viewed confirmed this training had been undertaken by staff. Staff told us what they had learned from their training, for example, positive behaviours, one member of staff told us that they had learned how to de-escalate situations, to know what triggers would cause these types of behaviours and to talk to the person in a calm manner. The nursing team had lead roles and additional training for diabetes, gastrostomy (a feeding tube), asthma, constipation, infection control, immunisation and well man and woman.

People were supported by staff that had supervisions (one to one meetings) with their line manager. Staff told us that they had regular supervisions and they could talk to the registered manager at any time. Records maintained in staff files confirmed that regular supervisions took place. One house manager told us, "Supervisions happen every six weeks." One member of staff told us they discussed their roles, training, the environment and people living at the service.

New staff attended a comprehensive induction which included three days of training before being assigned to the home in which they were to work. Staff then shadowed colleagues to understand how people's care should be provided and were assigned to an experienced colleague as a mentor. Each new member of staff had to be observed and signed off as competent five times before they were able to provide people's personal and intimate care. The registered manager told us that staff had to successfully complete the Care Certificate and all mandatory training during their probationary period. One member of staff told us, "The induction was amazing."

People were supported to ensure they had enough to eat and drink to keep them healthy. A choice was offered for every meal and alternatives were also available. People's dietary needs and preferences were documented and known by the cook and staff. One person told us, "The food here is very good, it is all healthy eating. I can always ask for a different meal if I do not like what is on offer." This person also told us that they had a 'suggestion food' list in their house where all people could put requests.

People's care plans recorded their likes, dislikes and dietary requirements. For example, one person's care plan detailed very specific instructions from a dietician and a Speech and Language Therapist on the safe and correct oral feeding methods. It was recorded that this was an area that required a high degree of attention. This person was very dependent on care staff for their nutritional and fluid intake and required one to one help to be fed. We saw that staff had been working to increase this person's food intake at mealtimes and food charts for the previous two months showed that this person was now maintaining their target weight.

We observed staff assisting people at lunchtime. Staff showed patience and knowledge of people's needs and preferences to maximise the mealtime experience. For example, one member of staff had followed the instructions from the specialist for one person which stated, 'you must not hold their chin' and 'wait for them to be ready'. The member of staff provided the person with individual support at all times during the mealtime that was in accordance with their care plan. Staff also were aware of people's cultural needs regarding food. For example, one person was a Muslim and only ate Halal meat. We noted these needs were met by the provider in a culturally sensitive manner.

People continued to have access to all healthcare professionals that supported them to live healthier lives. Records confirmed that people were able to access a wide variety of core and specialist services both on-site and externally. For example, social workers, educational psychologists and consultant child and adolescent psychiatrists.

People lived in an environment that that was adapted to meet their needs. Specially adapted seating and wheelchairs were being used. The houses we visited were on one level and people had their own en-suite facilities and there were adapted baths to help meet people's needs.

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. Where people lacked capacity to make certain decisions, appropriate assessments had been completed to ensure the requirements of the Act were met. Mental capacity assessments and best interests decisions were recorded and in people's support plans. The mental capacity assessment for medical interventions was an overarching one. However, the registered manager told us that a further assessment and best interest discussion would take place at the time if people actually required a medical intervention.

Staff had an understanding of the Mental Capacity Act (2005) including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. We saw staff asking for people's consent before giving care and support throughout the inspection.

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People and their relatives told us that staff were caring and kind people. One person told us, "Staff are really good, I have good fun with them." A relative told us, "Staff are absolutely caring, tremendously so. [Family member] can talk to staff at any time and they listen to what [family member] has to say." Another relative told us, "Staff are always thorough in her handover information to me and this is very reassuring."

We observed good and positive interactions between staff and people living in all the houses we visited. Staff showed respect for individual people and spoke kindly to them. One member of staff stopped what they were doing to give people time and attention and focused on their needs. Staff were vigilant to people's moods and anticipated their needs and they had good knowledge of each person.

We observed one member of staff talk to two different people as they returned from college. These interactions were very effective and caring in that the staff member listened to them and their issues and then responded to them in a friendly but firm manner which encouraged them to take responsibility themselves. The staff member told us that their aim for people was to enable people to be independent. We noted there was a strong emphasis on promoting people's independence wherever possible. For example, when people asked staff to retrieve items for them from the kitchen, they were politely encouraged to do this themselves.

People were supported to express their views about their care and treatment and making decisions about their care plans. One person told us, "I am involved in decisions about my care, staff discuss my care plan with me." Care plans reflected individual preferences, personalities and home life. There was an understanding that people may wish to do new things too and the ways in which individuals communicated their choices (for example those who were non-verbal) was recorded. For example, one person would make a specific expression if they did not like the food, and would gesture to inform that they wanted to eat their food by themselves.

People were supported to maintain their independence. For example, a peer support group was in place for the young people to meet once a week. This is a group run by the young people living at the service for those who want to learn about their epilepsy and how they could help themselves independently and have more control in their lives. Staff told us that they encouraged people to do as much as they were able to by themselves, but they [staff] were always available to provide advice and support when required.

People's privacy and dignity were promoted by staff. People told us that staff always knocked on their doors and staff called them by their preferred names. A member of staff told us that they have discussions with people about how to maintain their privacy. They stated, "People are reminded to keep the doors closed when they are having showers and that we are always nearby should they require any help." Staff also told us that it was important to knock on bedroom doors, not just to walk in uninvited.

Is the service responsive?

Our findings

People continued to receive care that was personalised to their needs. People told us they knew about their care plan and it met their needs. One person told us, "I have a care plan and my key worker discusses this with me at least weekly. We talk about what has been going well and set new objectives." Relatives told us that they had been involved with the pre-admission assessment and the care plan.

Care plans continued to be person centred and included information about people's needs, life histories and goals and objectives. Care plans had been produced from the pre-admission assessments and had been reviewed regularly. People's choices and preferences were documented. There were extensive personal and social histories in the care plans and it was possible to 'see the person' in the plans. Some people had complex needs, such as complex epilepsy, autism and muscular dystrophy. People's care plans demonstrated that staff had communicated with specialist professionals to ensure people received care and support that met their needs. For example, one person had complex epilepsy that required close monitoring. A protocol was in place for seizure management, written by the nursing team. The individual had a percutaneous endoscopic gastrostomy PEG and this was clearly recorded in the care plan. This is a medical procedure in which a tube is passed into a person's stomach through the abdominal wall to provide a means of feeding when oral intake of food is not adequate. The parents had funded a research project using a new monitoring system to help staff identify silent seizures so staff could respond more quickly. Staff we spoke with were knowledgeable about the people they were caring for.

People had a range of activities they could be involved in. These included activities such as art clubs, discos, bowling, external clubs, yoga and sessions within the service. People went shopping at a local town. One person used their iPad a lot and they had attended an 'internet safety' session. People had celebrated Chinese New Year and one person was in a drama group where they were rehearsing for an Easter performance. All of the people we met attended college during the day where they studied subjects such as life skills, relationships, photography and horticulture. There was also a very active social scene with educational and leisure trips across the country and beyond. In one house on the day of our visit we were told all staff and people were going to the pub for a drink that evening.

There was a complaints procedure available to people, relatives and visitors and this was displayed at the service. The complaints procedure included all relevant information about how to make a complaint, timescales for response and who to go to if they were dissatisfied with the response. People and their relatives we spoke to told us they knew how to make a complaint but had not needed to. Where people had complained there was evidence of an appropriate investigation and responses to the complainants was made within the timescales as recorded in the complaints procedure. We noted that seven complaints were upheld and ten were partially upheld. Complaints were discussed with staff during meetings so lessons could be learned from them.

The provider had received twenty five compliments during the last twelve months. These included compliments from external professionals and families of people living at the service.

No person living at the NCYPE was receiving end of life care. The registered manager told us that if this ever arose then plans to meet this need would have to be discussed with the person's family and the local authority. If a young person developed a terminal illness during their placement a best interests meeting would be held with the placing authority, care manager/social worker and parents and they work with their external consultant to ensure an appropriate transition to a suitable placement was made.

Is the service well-led?

Our findings

There was a registered manager at the service. 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 positive culture within the home, between the people that lived there and the staff. People and relatives told us that it was a happy place to be. One relative told us, "We do think it's well led. The house manager is excellent, I haven't met the registered manager yet but [family member] knows her and has made them all Christmas cards with chocolate. We haven't made feedback yet but [family member] has only been here since September 2017. They do encourage us though. They [people] can have a normal life here, they are treated as individuals."

Staff told us that the service was well managed. The provider told us in their PIR that the service provided good leadership and management and staff felt supported, encouraged and listened to and we found this to be the case. One member of staff told us, "The registered manager provides good leadership for the service and was supportive to people and staff. She is very approachable. She is a very visible manager. She's great, I have no complaints." Another member of staff told us, "Personally, I think it's well run and people are happy living here."

Staff told us that team meetings took place but it was sometimes difficult to find time to hold these as often as they would like. Staff told us that the service had a good team that supported one another and cared for the people who lived there. One senior member of staff told us, "We do a lot of work to promote a team environment, supporting one another. We try to encourage a positive environment for staff. We always thank them for what they have done."

Quality assurance systems were in place to continuously monitor the quality of the service being delivered to people. We looked at audits undertaken by the provider. In addition to individual house audits, in areas such as infection control, there were monthly service observation visits carried out in each house by senior staff. These looked at areas such as staff attitudes, maintenance and furnishings, health and safety and quality of care. Actions plans were produced as a result of these with timelines attached. These in turn were analysed and managed by the provider's governance group at regular meetings.

There were also 'Residential Homes inspections' carried out in each house every school term. These included areas such as student welfare, house records and files, nutrition, hydration and health and the use of support documentation. Any identified issues were discussed with staff.

People and their relatives continued to be involved in the running of the service and their feedback was sought. Surveys had been undertaken to ascertain the views of people, relatives and associated stakeholders about how the service was run. We looked at a range of surveys, carried out to gauge the views of people and their representatives. Satisfaction surveys were conducted by way of questionnaires sent to people on a rotational and regular basis. These revealed a high level of satisfaction, particularly in the timing and quality of care and support, in addition to staff attitudes.

People benefitted from staff who worked across organisations and communicated well with each other to deliver effective care, support and treatment. There was evidence within the care plans that staff worked closely with other on-site healthcare professionals that helped to ensure that people received effective care from staff from different professions. For example, occupational therapy, physiotherapy, speech and language therapy, GP, dieticians, audiology and psychiatrists. Each week, clinical multi-disciplinary team meetings were held to discuss the health and wellbeing of individuals.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken.