Seashell Trust

Royal College Manchester

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 the 19 and 21 March 2016. We last inspected the home in July 2013. At that inspection we found the service was meeting all the regulations that we reviewed.

Royal College Manchester is an independent specialist residential and day college. The educational aspects of the college are regulated by OFSTED. It is the accommodation, care and support provided on site for people who require nursing or personal care which is regulated by the Care Quality Commission.

At the time of our inspection the service was registered to provide personal care for 40 people with severe and complex difficulties. These included a number of people who used the service with autistic spectrum disorder and multisensory impairment; all had communication needs and many presented with challenging behaviour.

The college is part of the Seashell Trust and is located on a large secure site in Cheadle, Manchester, which it shares with Royal School Manchester. It is referred to as 'Seashells'. When we inspected there were 24 people in residential placements with 16 people registered with the short break unit. This unit supports people for a few hours per day and/ or longer stays.

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. The registered manager was present throughout the inspection.

At the time of our inspection the service was nearing completion of a large and extensive programme of rebuilding. The older accommodation had been decommissioned and all residential people who used the service were in the process of transferring to new purpose built housing houses, each house accommodating up to four people. Each person had their own bedroom with en-suite facilities, and access to a communal lounge and kitchen/dining area. All the houses had been designed in a way to meet the complex needs of the people who live in them and had been planned to ensure the safety and security of people and to minimise the risk of accidental injury. The majority of residential people who used the service had moved and settled into their new homes, and it was anticipated that the last group, along with the short break unit, would be moving within the month following our inspection.

The people who used the service had complex needs and communication difficulties which meant that we were unable to speak to anyone who used the service; we contacted their relatives who told us that they were very happy with the care their relative received. One parent told us "[The] care whilst at Seashell Trust has always been to the highest of standards. Support has been excellent throughout the past three years."

We saw that suitable arrangements were in place to help safeguard people from abuse, there was a

safeguarding policy in place and all members of staff were aware of the whistle-blowing procedure.

Infection control measures were in place and when we looked around the houses we saw that all areas were well lit, clean and warm.

Equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions.

The service had a fire risk assessment and we saw that an evacuation plan had been drawn up for each person dependent on their needs for support in the event of an emergency.

People were cared for by sufficient numbers of suitably trained staff. We saw staff received the training and support required to meet people's needs well. Staff spoke highly of their training and said this prepared them well for their role.

The staff we spoke with had an in- depth knowledge and understanding of the needs of the people they were looking after. We saw that staff provided respectful, kindly and caring attention to people who used the service.

All staff had been trained in medicines management and there were appropriate arrangements were in place for monitoring and administering medicines, but we found that the system for ordering medicines and liaising with general practitioners (GPs) was bureaucratic and cumbersome, and could lead to delays in responding to changes in medicines. This has been recognised as a concern by the registered manager and plans to streamline the system were currently being implemented

People's needs were assessed and care and support was planned and delivered in line with their individual care needs and preferences. People had detailed, individualised support plans in place which described all aspects of their support needs.

People were supported by staff who treated them with kindness and were respectful of their privacy and dignity. Staff were vigilant to needs; people were offered choice in how they were supported and were involved in day to day decisions about their care.

Staff were trained in the principles of the Mental Capacity Act (2005), and could describe how people were supported to make decisions to enhance their capacity and where people did not have the capacity; decisions had to be made in their best interests.

Although specific dietary needs were taken into consideration, we saw that meals were prepared in the individual houses, and the quality of food would be dependent on the skills and knowledge of the individual care workers preparing the food. We found that provision of food across the separate houses was inconsistent and did not always promote a healthy balanced diet. This has been acknowledged by the service and at the time of our inspection work had begun to review the quality and nutritional value of meals.

All residents had their own activity plan with a timetable of activities drawn up by the key worker in partnership with the residential student. The service had a wide range of resources for use by the residential people who used the service, including a fully equipped gym, swimming pool and 'Gamelan' Room equipped with a range of timpani and wind instruments to provide sensory and aural stimulation. Each house had a separate activity room; some had been adapted into sensory rooms, others provided safe areas

or study areas to allow for the needs of the residential people who used the service

The service had clear aims and objectives, and to help ensure that people received safe and effective care, systems were in place to monitor the quality of the service provided and there were systems in place for receiving, handling and responding appropriately to complaints.

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.

Sufficient suitably trained staff who had been safely recruited were available at all times to meet people's needs. Suitable arrangements were in place to help safeguard people from abuse.

Houses were secure and designed in such a way as to minimise the risk of accident or injury.

All houses were clean and procedures were in place to prevent and control the spread of infection.

A safe system of administering medicine was in place but the system for ordering medicines was not efficient.

Is the service effective?

Good

The service was effective.

Where people were being deprived of their liberty the registered manager had taken the necessary action to ensure that people's rights were considered and protected.

Staff received sufficient training to allow them to do their jobs effectively and safely and systems were in place to ensure staff received regular support and supervision.

The standard of food provided in individual houses was variable.

Is the service caring?

Good

The service was caring.

Staff had an in- depth knowledge and understanding of the needs of the people they were looking after. We saw that staff provided respectful, kindly and caring attention to people who used the service.

Care was focussed on the individual and delivered in a way that suited their needs and preferences.

Is the service responsive?

Good

The service was responsive.

People's care records contained detailed information to guide staff on the care and support to be provided.

The service provided a broad range of activities to meet the individual social needs of the people who used the service.

The registered provider had systems in place for receiving, handling and responding appropriately to complaints.

Is the service well-led?

Good

The service was well led.

The service had a manager who was registered with the Care Quality Commission (CQC).

Systems were in place to assess and monitor the quality of the service provided and arrangements were in place to seek feedback from relatives and users of the service.

The registered manager had notified CQC, as required by legislation, of any incidents that had occurred at the service

Royal College Manchester

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 19 and 21 March 2016 and the first day was unannounced.
The inspection team consisted of one adult social care inspector.
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. We also reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

During this inspection we were not able to have a conversation with the people who used the service; their complex needs meant they could not meaningfully communicate with us. We did however contact a number of close relatives and spoke directly with three parents, and received email correspondence from a further three.

We also contacted a number of service commissioners and received written feedback from five service commissioners.

We spoke with the registered manager, Interim Head of Service, two senior care staff and two care staff members. We looked around all areas of the home, looked at how staff cared for and supported people, looked at food provision, three people's care records, four medicine records, four staff recruitment records, the staff training plan and rota, and records about the management of the home. We also had access to the electronic recording systems used by the service to store care plans, reviews and summary sheets relating to people who used the service, and personnel records for staff.

Good

Is the service safe?

Our findings

When we spoke with relatives of people who used the service they told us they felt the service was a safe place. One person told us "I had some misgivings before, but these were dispelled as soon as I saw the place. It is so safe for all the people, and the staff know them so well, they keep them out of harm's way."

Immediately prior to our inspection the service had held a 'safeguarding awareness week" where people who used the service were helped to consider any issues which might affect their safety and 'safeguarding trees' were on display which indicated comments and responses. The majority of these reflected a positive view, for example "I know I am safe", or "my care workers know how to look after me".

We saw that suitable arrangements were in place to help safeguard people from abuse and that all members of staff had access to the whistle-blowing procedure entitled "Do The Right Thing". Whistleblowing allows staff to report unsafe or poor practice. Inspection of the training plan showed all staff had received training in the protection of adults as part of their induction to the service.

There was a safeguarding policy in place and available to staff which was in line with local authority safeguarding board guidelines. These provided guidance on identifying and responding to the signs and allegations of abuse. Systems were in place to increase awareness of safeguarding issues. Each section of the organisation, had a Designated Safeguarding Officer, and if the person in Adult Social Care was not on duty, a rota detailing to whom report could be made was accessible to all staff. All concerns are logged with protective measures recorded, and the information may trigger a safeguarding alert to the local authority in line with the local arrangements. We looked at the records for safeguarding and saw that alerts were routinely recorded, and appropriately investigated.

An electronic system was in place for recording all accidents and incidents including peer on peer incidents, self-injury and abuse of staff. Body maps were produced if required. This system allows for good analysis, and a behaviour co-ordinator used this information to identify any trends or patterns. In addition Team Leaders would be asked to review behaviours in other houses to provide a further level of scrutiny and determine if any issue has been overlooked through customary practice. We saw that there had been 25 incidents noted in the past month with appropriate action taken and information passed to the relevant authorities including the local authority and CQC.

Access to the site was secure, with a gated entry system and logging in facilities for all visitors, who were required to wear a visitor's identity badge whilst on the site. This meant that the identity of anyone within the grounds could be challenged and ensured the safety of people who use the service and staff.

Residential people who used the service lived in secure housing houses which had been designed to meet specific needs. When we visited the service it was in the process of redevelopment. The older accommodation had been decommissioned, and to promote the idea of independent living, new purpose built housing houses had been built to accommodate the people who used the service. By using individualised designs the diverse needs of people who used the service could be better accommodated, for

example, bungalows for people with difficulty mobilising; or room separators to accommodate people on the autistic spectrum who may have difficulty with social interaction, providing a safer environment in which to live and learn.

Areas around the housing houses were safe and staff would escort people who used the service across the campus.

Each house was secured by electronic fobs. Anyone wishing to enter had to ring the doorbell and, following staff ascertaining their identification and valid reason for requiring access, they were allowed into the house. This helped to keep people safe by ensuring the risk of entry by unauthorised persons was reduced. There was also a safety unlocking system in place on the front door; used to help prevent people who were considered as being at risk if they went out alone, from leaving the premises.

Houses were designed to minimise risk, for example, under floor heating meant that there were no exposed radiators or pipes which could present a risk of burns. Rooms were fitted with tracking hoists where necessary; this prevented risk of obstructions or cluttered walkways. Kitchens were designed with integral sliding gates to prevent people who used the service from entering cooking areas and exposure to kitchen risks if not supervised. In addition smoke alarms and sprinkler systems had been fitted in all houses. Televisions were secured in locked cabinets with reinforced plastic covering, which allowed unrestricted viewing, this ensured that they could not be knocked over, thrown or smashed, minimising the risk of avoidable injury.

Hazardous equipment was generally stored safely, but we saw one cupboard in one house was unlocked. This contained toiletries such as shampoos, sanitary equipment etc., which could be a hazard if used incorrectly. We asked the senior on duty in the house about this and they agreed that this was an oversight and locked the cupboard to ensure there would be no unauthorised access.

We looked around all areas of the houses and saw the bedrooms, dining room/ kitchen, lounges, bathrooms and toilets were well lit, clean and warm. Care staff took responsibility to ensure general standards of cleanliness through the day and a cleaner was assigned to each house one day each week.

We saw infection prevention and control policies and procedures were in place and that infection prevention and control training was undertaken by all staff. Colour coded mops, cloths and buckets were in use for cleaning; ensuring the risk from cross-contamination was kept to a minimum.
Each house had a secure laundry area off the kitchen equipped with a washing machine and tumble drier. A separate garage attached to each house was used for storing large equipment when not in use, such as mobility scooters or wheelchairs to prevent unnecessary hazards and obstructions.

We looked at the documents that showed the equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This helps to ensure the safety and well-being of everybody living, working and visiting the home.

We found systems were in place in the event of an emergency. There were fire risk assessments in place and we saw that personal emergency evacuation plans (PEEPs) had been developed for the people who used the service. These plans explain how a person is to be evacuated in the event of an emergency evacuation and take into consideration a person's individual mobility and support needs. They were kept in each person's care record with a copy held in a central file that would be more easily accessible in the event of an emergency arising. The service also had a business continuity plan in place. The plan contained details of what needed to be done in the event of an emergency or incident occurring such as a fire or utility failures.

We saw that the service had a robust staff recruitment process in place. The registered manager informed us that they request a good standard of English and Maths but do not insist on qualifications in care, as they believed that that this might exclude people with other life skills, which could be of benefit to the people who used the service. We spoke to one staff member who informed us that they had had no previous experience in care, but had a thorough induction and ongoing training including a qualification in the 'Skills for Care' Care Certificate. This is a set of standards that social care and health workers follow in their daily working life. It gives workers a good basis from which they can develop their knowledge and skills.

Recruitment procedures gave clear guidance on how staff were to be properly and safely recruited. This helped to protect the safety of people who used the service. We looked at four recruitment files. These contained proof of identity, an application form that documented a full employment history and accounts for any gaps in employment, a medical questionnaire, a job description, three references and the interview notes. We saw there was a reference verification process in place. This was to ensure that the references suppled were genuine. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

There were enough staff to meet the needs of the people who used the service. Inspection of the staff roster and our observations showed there were sufficient suitably qualified and competent staff available at all times to meet people's needs. When we spoke with staff they told us that they felt the staffing level was sufficient to meet the needs of residential people who used the service. We saw that each person, due to their disability and subsequent behaviour was supported by a staff member on a 1-1 basis during the daytime hours. Extra support within each house was also available. Prior to admission each prospective student was assessed and staff would be deployed according to the support needs of people who used the service and the specific skills of the staff to provide the required support. Staffing calculations also provided 'non-contact' time for staff at all levels to receive training, supervision and deal with administrative duties.

We saw that senior staff undertook 24 hour 'on-call' duties on a rota basis to deal with any issues which may arise and ensuring that staff were always supported. Staff on duty were supplied with two- way radios so they could request assistance from other staff within the home in the event of a crisis or emergency arising.

When we spoke with the registered manager she informed us that staff are encouraged to consider a person centred approach to risk. At the time of our inspection all staff were completing a survey to consider how they might respond to given situations, for example, should a person with Down Syndrome be allowed to go horse-riding, or should staff allow a person who has epilepsy to have a bath unattended? By raising the questions this will offer greater consideration and understanding of the issues and how to manage risk on an individual basis.

The care records we looked at showed that risks to people's health and well-being had been identified and these were reviewed on a three monthly basis. We saw that detailed plans were in place to help manage the identified risks. Assessment considered the hazards and risks in relation to the person, task and environment and identified control measures to minimise/ prevent the occurrence of risk.

The service accommodates people who used the service with a range of complex and profound learning difficulties and/or disabilities, some of whom have behaviours which can be challenging and lead to self-injury or injury to others. The home has adapted a proactive rather than a reactive response to challenging behaviour. A staff member told us "I think the formalised training is very good, but our monitoring is also good, so we look for signs of agitation and are able to stop things from getting too far". We saw that where people had behaviours which were challenging staff built a profile of antecedents to enable them to

recognise signs of agitation and intervene with planned strategies to prevent the behaviour reaching a crisis point.
We looked at the restraint policy which gave clear guidance on the use of restraint in line with Department of Health guidelines on restrictive practices. Restraint is the act of restraining a person's liberty, preventing them from doing something they wish to do. The policy gave clear guidance on the various forms of restraint, when restraint could be considered, how it must be seen as a 'last resort' and be time limited. Care plans disseminated information about antecedents and known preventative strategies, and records documented the level and stage of intervention, and any following responses. We noted that when restraint was required this was recorded and actions reviewed.

A separate medical centre completed all orders for medication. Staff from each house would need to inform the medical unit of any medicine needs and this was then ordered via the medical centre. Medicines were delivered to the medical centre and then staff would be required to pick this up to take back to the individual houses. This meant the system for managing medicines was cumbersome and not streamlined, and could lead to delays in dispensing medication. Further complications could arise with this system, for example, the registered manager told us that where people who used the service returned from their home with a change in medication, either after a long weekend or at the start of term time, the information about the new dosages could be lost. This did not allow for a quick response to changes in need. The registered manager and the Interim Head of Services recognised these difficulties and were looking to improve the system for ordering, delivering and administering all medication. The service was in the process of restructuring the role and function of the medical unit and looking to implement an electronic system so each house could take responsibility for ordering and dispensing medications, which would lead to greater accountability, better liaison between the care workers and families and closer monitoring and management of medicines.

We saw that once medicines were delivered to the individual houses these were appropriately managed with systems for the receipt, storage, administration and disposal of medicines. We also checked the medicine administration records (MARs) of four people who used the service. We saw that records included a picture of the individual to minimise the risk of giving medicines to the wrong person. The MARs we looked at showed that staff accurately documented on the MAR when they had given a medicine. This showed that people were given their medicines as prescribed; ensuring their health and well-being were protected. Some people were prescribed medicines to be taken as required or 'PRN' e.g. paracetamol. We observed one person was given some paracetamol in accordance with the correct procedures and properly recorded on the MAR sheet. We found the medicines were stored securely and the system in place for the storing and recording of controlled drugs (very strong medicines that may be misused) was safe and managed in accordance with legal requirements.

All staff are given mandatory training in administering medicines. In addition to a full day training further e-learning is given to underpin knowledge and booklets available in all houses for such issues as timely remedies, legislation etc. Training includes administration routes and use of buccal medicines for people with epilepsy. This is a solution which is placed against the sides of the gums and cheek so that the medicine is absorbed directly into the bloodstream. Staff complete a practical workbook and are assessed over five observations. All must complete refresher training on a yearly basis and if this has not been completed they are not permitted to administer medicines. Staff are encouraged to report medication errors and where there are three errors in a six month period staff are asked to repeat their training and demonstrate their competence. This system ensured that staff kept up to date with any changes in medicine administration and ensured that people received their medication from staff who were appropriately trained.

Good

Is the service effective?

Our findings

A relative informed us "All the staff are kind and caring, they have the necessary skills and knowledge to provide the specialist support needed. If required, they are always willing to undertake specific training to meet [my relative's] individual needs".

We looked at how staff were supported to develop their knowledge and skills. One member of staff told us: "This is a really good place for learning, we have a really good induction at the start and we learn from each other and ask questions. There is always something new to learn and we are continually being offered new training".

We were shown the induction programme that all newly employed staff had to undertake when they first started to work at the home. It contained information to help staff understand what was expected of them and what needed to be done to ensure the safety of the staff and the people who used the service. The first week of employment was spent in the classroom covering mandatory issues including infection control, food handling, etc. with further e learning to consolidate their training. All new starters irrespective of role attended workshops on disability awareness, autism and protecting adults from abuse. New care staff covered such topics as behaviour management, people handling and personal care, audiology and record keeping. For a further week new staff 'shadowed' the experienced staff to enable them to see how care and support was provided to people. During their probation period of six months each new recruit is provided with a mentor to provide on-going support, on the job training and assistance. We were shown a system in place, which supports the continuous professional development of staff including e learning, work handbooks etc. Every twelve weeks staff would be observed by a senior person for fifteen minutes to monitor their interactions with people who used the service. An electronic monitoring and recording system is in place to monitor and manage training/supervision appraisal and progress of staff, allowing close monitoring of staff performance. All staff are helped to complete appropriate and nationally recognised qualifications in care such as NVQ or the Care Certificate. This is a professional qualification which aims to equip health and social care staff with the knowledge and skills which they need to provide safe and compassionate care.

Staff rotas had been organised so that one day each week a full complement of staff was available to attend team meetings or training sessions on specific topics. The service was proactive in its approach to training, for example when a new person had been admitted into the service who required tracheostomy care, all staff received training in this, not just the staff members who would support the individual. The service has commissioned an eleptologist nurse to provide regular training and updates around epilepsy care and support. The registered manager told us that the Training Supervisor had established good links with local businesses, and used their expertise to provide on-going training, such as using the chef from a local business to enhance diet and nutrition training. By the end of their first year all staff would be expected to have reached a level of competence in behaviour de-escalation techniques and to have attained Introductory Level BSL (British Sign Language). This is a 12 week introduction to signing and includes deaf awareness. As an incentive to complete the course staff who do not pass will be asked to pay for their own training.

After one year, all staff will be expected to specialise in either deaf awareness or working with Challenging Behaviour. 50% of staff will continue to study sign language to level 3 BSL standard, whist the other 50% will increase their knowledge as 'Intervenors': this is a course designed to increase knowledge around challenging behaviour and self-harm particularly supporting people with multi-sensory impairments, and examines communication techniques and methods of support.
All staff are supported to reach level 3 Skills for Care.

A discussion with the registered manager and some of the staff showed they had an in depth knowledge and understanding of the needs of the people they were looking after. One member of staff told us "Although they may not be able to communicate very well we really try to get to know them, by watching and listening we get to understand them and their needs. We seek input from parents who really know them well, and we keep in close communication, especially if they have gone home for the weekend: there is a good exchange of information both ways. This view was echoed by the parents we contacted, who told us that the service liaised effectively and maintained good communication with them.

The Service also employs a family link worker who supports positive relationships between home and the service, and will provide advocacy services when required. They also keep families informed of wider issues, and have set up conferences for example to look at changes in legislation, such as Mental Capacity or personal budgets.

We were told that there were regular 'handover' meetings between the staff at the start and end of each shift, and with the college staff before and after the people who used the service attended college. We witnessed two handover meetings during our inspection and saw information about activities carried out by people who used the service was noted and passed on to staff starting their shifts, with any instruction for further task to be carried out. Handovers help to ensure that staff are given an update on a person's condition and behaviour and should ensure that any change in their condition has been properly communicated and understood.

All Houses had regular staff teams which allowed for consistency in approach and helped to develop a sound all round understanding of the needs and wishes of the people who used the service. Team meetings were held every month. In addition all house Team Leaders would meet every six weeks with emergency meetings if needed. These meetings ensured that communication of issues and concerns were reported and noted, and action taken to minimise any problems occurring.

Records we looked at showed that systems were in place to ensure that all staff received regular supervision meetings. Staff we spoke with confirmed that this information was correct. Staff had an individual structured supervision session with their senior worker every 6 -8 weeks. Supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. In addition a senior member of staff will complete and record a direct observation of their intervention and work with people who use the service on a regular basis. Each member of staff has a yearly appraisal which will review the previous year's objectives and set new objectives for the forthcoming year. This is reviewed after six months and staff are encouraged to meet their objectives with a financial bonus for all staff who meet targets.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We checked whether the service was working within the principles of The Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 Mental Capacity Act. The

application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The Mental Capacity Act 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.

When we spoke with staff and the registered manager they all showed a good understanding of mental capacity and consent. We saw that capacity assessments had been completed on all people who use the service; all the people who used the service were assessed on admission to the service and if it was appropriate a DoLS authorisation would be sought with further consideration of any restrictions which might be needed, such as control of finances; environmental restraint, electronic surveillance medical restraint or physical restraint.

The registered manager showed us that there were systems in place to monitor, record and liaise with supervisory bodies (local authorities) from across the country, The registered manager told us and we saw information to show that applications to deprive people of their liberty had been submitted to the relevant supervisory body. Capacity assessments had been completed to determine why people needed a DoLS authorisation. This helped to make sure that people who were not able to make decisions for themselves were protected.

From our observations and a discussion with the registered manager it was evident that none of the people who used the service were able to consent to either, some or all, of the care provided. We were told that if an assessment showed the person did not have the mental capacity to make decisions then a 'best interest' meeting was arranged. A 'best interest' meeting is where other professionals, and family members decide the best course of action to take to ensure the best outcome for the person using the service. Each of the case files we looked at included best interest checklists, with rationale for decisions made clearly recorded.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We saw that food was stored safely; fridges and freezers were well stocked, with evidence of stock rotation and use by dates were displayed. We saw that where people had specific dietary requirements this was acknowledged and meals were prepared accordingly, and if there were any specific health issues food intake was monitored and weight checked on a regular basis.

Each house had a weekly shopping budget based on the needs of the people who used the service, and menus were planned on a weekly basis with people who used the service encouraged to assist in meal planning and preparation. This meant that meals should have been designed to meet individual preferences and dietary requirements. However, reliance on care staff to determine menus meant that meals could be unimaginative or lacking in variety. Quality of food would be dependent on the skills and knowledge of the individual care workers preparing the food. Provision of food across the separate houses was inconsistent, and there was not always any consideration of meal provision in college, which meant that some people who used the service would have similar meals at college and at tea time.

Some of the houses displayed pictorial meal plans in the kitchen, but not all. In some houses healthy options were encouraged, and attention to meal preparation was displayed, for example, on the weekly menu in one house there was a note requesting that staff ensure that all ingredients were used in food preparation. This would ensure that meals were balanced and would help support the people who used the

service to develop their skills when assisting with meal preparation. However, this was inconsistent across the separate houses. Menus were not always followed so there was no way of accurately checking the quality of food provision.

When we spoke to the registered manager about this she acknowledged that this has been an issue, and has tasked a Team Leader to review the quality and delivery of meals across the residential establishment. This person has begun a food audit in all the houses, considering choice, variety, and nutritional content, and is drawing together a small working party to look at compiling a "Seashells Cook Book" drawing on the experience and knowledge of care staff.

In addition the service has produced "safer food better business" booklets to support and record nutritious and balanced meals, and the Training Team have commissioned the chef from a large local business to demonstrate and teach practical cookery skills to the staff.

At the time of our inspection most of the people who used the service had transferred from the services older buildings to the new houses. People who used the service had been involved in choosing their own rooms and had been given the opportunity to consider colour schemes and choice of furniture and decorations,

Each house accommodated up to four people; each person had their own bedroom with ensuite facilities designed to meet specific needs, for example some had walk in showers; others had tracking hoists with mobility and bathing aids. Bedrooms were spacious and equipped with ¾ size beds, a desk; and bedroom furniture which was securely fitted. Lounge areas were large and well furnished, and a large modern kitchen provided an eating area and separate food preparation area.
A separate room in each house had been designed specifically to meet needs. For example, sensory rooms for people who had sensory difficulties, "soft" areas for people who had behaviours which challenged others, or quiet areas for individual reflection or 1:1 support. We saw one house had used this room as an area for study.
A new short stay and respite unit had also been built to the same high specification, but at the time of our inspection short term needs were still met in the older part of the grounds with plans to transfer over the Easter break.

People were supported to maintain good health through a separate medical unit open during college hours from Monday to Friday. This was staffed by two nurses and a health care assistant, who were responsible for liaison with general practitioners (GPs) and families. Any medical concerns were reported to the medical centre, who would follow up with appropriate referrals to GPs and other medical professionals, such as district nurses, consultants and therapists to ensure good health was maintained.

Good

Is the service caring?

Our findings

The parent of one of the residential people who used the service told us "I can tell how happy [my relative] is at Seashells. When it is time to go back after a weekend stay they can't wait to be going". Another said "We are very pleased with the care and more importantly [my relative] loves being there. The staff are so kind and attentive".

All the people who used the service had complex and complicated needs, which meant that they could not meaningfully communicate with us. However we observed staff treating people with empathy and understanding. We saw good staff interaction with people who used the service, for example on the first morning of our visit we saw three staff interacting with three people who used the service, encouraging appropriate activity, movement and stimulation. It was clear that the people who used the service were enjoying the activity, and the atmosphere was relaxed and friendly. Staff were vigilant, and knew the limits to individual's attention span, and sought to provide stimulation and support in a timely way. As staff were assigned to work in individual houses they had a good understanding of the needs of the people who lived in the house and delivered care and support in a way that met people's individual needs.

When we discussed the needs of particular people who used the service with staff they all demonstrated an in depth knowledge of the person and their behaviours for example; opening or shutting doors; tastes for specific fruit, or bathing habits. Staff had evolved and developed appropriate methods to give meaningful responses and to minimise excessive behaviour in a calm and patient manner, and learnt how best to communicate with the people in the service.

People appeared content and happy in their surroundings and looked happy and relaxed. With support and guidance we saw one person baking a cake. We observed that respectful, kindly and caring attention was given to the person from the staff member supporting them. Another person had been nominated and accepted to attend the Queen's Garden Party to help celebrate her 90th birthday. We observed staff discussing this with the person in a manner that they could understand, and helped make plans to prepare the person for the day. Staff were vigilant to needs, and remained observant, we observed one person who has a habit of placing things in their mouth begin to chew on a scarf. The member of staff present calmly and politely instructed the person not to do this explaining why the behaviour was inappropriate in a way the person understood.

The primary aim of the organisation is educative, but it gives equal merit to social needs and meeting daily living support needs and activities in a person centred way. Through discussion with families, assessment documents and vigilance staff get to know and understand the needs of individuals. We saw that staff responded specifically to the individual needs of the person they were supporting. Staff we spoke to demonstrated a clear understanding of this, and recognised that they had a caring responsibility which involved nurturing and encouraging the young adults to maximise their independence. One care worker told us "We have to assist them, not tell them what to do. I am here to provide support, not to be in charge. We help them to make decisions and even if it isn't in our interests we respect people's choices".

The service has a volunteer co-ordinator who recruits volunteers to work with individual people who used the service, and will help to support them if necessary. Volunteers are able to assist people in many ways; such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them. This helped to protect the people who used the service form having their needs overlooked and provided them with opportunities to become less dependent on paid staff.

Individual privacy was respected and recognised as a need particularly for people who had difficulty with regard to social interaction. All the people who used the service had their own rooms and some of the houses were designed to ensure that personal space was provided to ensure people's privacy is respected at all times.
Written care plans were kept securely in an office in each house. There were IT systems in place which were accessible to staff across the organisation to store other information such as case files, risk assessments and personal details. This allowed for effective home management and information sharing. Although this meant that it could be viewed by other members of staff who may not need to have access to this information, a robust confidentiality policy across the organisation minimised the risk of any breach in confidentiality

Good

Is the service responsive?

Our findings

The Interim Head of Service informed us that whilst the overall purpose of the organisation is based on educational needs they recognise that they need to meet residential requirements. When considering applications from prospective students who may require personal care and accommodation the service follows a multi-disciplinary approach, but the decision to accept somebody into the service is based at a residential level, and some applicants are turned away if their educational needs can be met but their care needs cannot. The registered manager told us that she would visit the prospective student and complete detailed and thorough assessments before a person was admitted to the service. Further visits would be undertaken and where possible the individual would be invited to spend time in the service before moving in. This would ensure that the person's personal care needs could be met and give both the person and the staff an opportunity to get to know each other before the decision was made.

A care plan would be drawn up and a key worker would be appointed to work closely with the person and liaise with the family and any professionals involved in the person's care. As staff got to know the individual, the care plans would be refined with greater attention to detail, we found that all information, where possible was produced in picture format to enable the staff teams to communicate and involve the people who used the service with their support plan. The support plans contained goals that people who used the service were working towards such as communication skills and independent living skills.

We looked at three care records. These contained information about each person which was comprehensive and contained sufficient detail to guide staff on the care and support to be provided. Care files began with a short person centred summary "About Me", which provided good information about the person's strengths and difficulties they experienced. Further in depth information gave a full picture of the individual including their support network, likes and dislikes, their personal care and daily routine preferences for example "please wake me by gently tapping my arm and tell me it's time for college".

Care records also showed that risks to people's health and well-being had been identified, although one record we looked at did not have any signatory for consent to medical treatment. The records should have been reviewed by staff every six months to ensure the information was fully reflective of the person's current support needs, but we saw in one care plan that the latest review had not been recorded. However when we spoke to staff we were informed that this had been an error in the recording system, and the review had taken place but no changes were noted, but the system had not transferred the information onto the new review record.

Methods of communication were noted and followed up. Where signing was the primary form of communication all staff within the house would be competent signers and we were informed that the residential service employed four staff who had profound hearing loss as care assistants or night care assistants who were able to communicate effectively with people with profound hearing loss.

The service also supported people on a short term basis in a separate unit which catered for up to sixteen people who used the college facilities as during the day, but also required respite support from a few hours

after college to 4-5 nights or a full week. This unit does not take emergency admissions which allows for good planning. Staffing in this unit is based on individual need and adjusted according to occupancy levels. Staff on this unit told us that they provide a safe environment which provides a pathway between home and the college, and staff work closely with families to maintain regular routines.

From our observations and discussions with the registered manager and staff it was apparent that the people who used the service did not, in the main, have the capacity to be involved in the planning of their care. We were told that families were invited to care reviews to discuss the care planning and support provided. Reviews were held twice in the first year and then once in each subsequent year.

We saw that the service responded to day to day issues and was flexible in routine where this was appropriate. For example on the first day of our inspection people in one house had got up late and so lunch was made at a later time. A member of staff commented to us that this would not be a positive step in all the houses particularly where people living with autism required a more rigid approach. Staff were open to new ideas and innovative ways of intervening to support the people who used the service. One member of staff told us how they had used Photoshop applications on a computer to assist a person who was concerned about their appearance and wanted to change hairstyle. By imposing a photograph onto different hair styles the person was able to choose the style, they liked. There was also a "walking dog," which was popular with the people who used the service, and could support people, particularly on the autistic spectrum, to increase their confidence in open and public places. Walking dogs can help people who have difficulties communicating or interacting with other people and can help to improve social interactions and movement, as well as providing comfort and relieving anxieties.

All residents had their own activity plan with a timetable of activities. This was displayed in picture format in their bedrooms and covered up to sixteen activities each week. Activities were determined by personal choice, decided in advance by the key worker in consultation with the individual, but could be changed depending on the needs and mood of the residential student. Common activities included baking, hand massage, physical and sensory activities. The grounds contained a large gym and swimming pool, which were frequently utilised along with a popular gamelan room, which has a full set of percussion and gamelan instruments: these are metallic musical instruments which can resonate and vibrate, stimulating the senses of touch and hearing. During the first morning of our visit we saw staff taking people out for a walk. We observed one person planning a trip with their carer; using sign language and physical prompts they agreed the route and purpose. The person was encouraged to collect their shoes and coat and get ready for the walk, again with verbal prompts and use of appropriate sign language.

We were told the cultural and religious backgrounds of people were always respected, for example, Halal and Kosher meals would be provided; there was a visiting chaplain and a Muslim volunteer had been recruited to pray with people of the same faith. The service strives to meet all cultural needs, but we received some feedback from a care commissioner who was disappointed that the staff were initially unable to speak to the person they had placed in their first language and that this may have hindered the person's progress. We saw that the service had provided some support each week from an Urdu/Punjabi speaker, and we were informed that the service had taken steps to address this issue and appointed a new member of staff.

We looked at how the service managed complaints. Before a new person entered the service a welcome letter would be send to their legal guardian outlining the service and facilities. There was a service user guide provided in different formats including an easy read format and picture book. The guide included a section on how to make a complaint and made reference to the complaints procedure. The registered manager kept a log of all complaints and recorded investigation, responses, and an outcome. An additional

section considered any lessons learnt from the complaint, and used complaints as a way to develop and improve the service. At the time of our inspection there were two outstanding complaints which were being addressed within expected timeframes.

All the staff we spoke to recognise that the service is not a long stay residential placement with people living in the service for 2-3 years. Care plans were designed to support people to maximise their independence and work to develop life skills to support them through their adult lives. A member of staff told us "We will always offer a good transition plan to support people to progress and settle in a new place". A social worker told us "They appear to be a proactive organisation. They communicate well with me and have already arranged one MDT [Multidisciplinary Team Meeting] with another planned in the next few weeks. They appear realistic about future options for him and open to suggestions about a transition to other services if this is in his best interest."

The goal of the service is to support people to maximise their independence and we saw evidence of good arrangements to provide a smooth transition for when people leave the service. We spoke to a staff member about how they support transition and they told us "When you work with someone for two to three years you get attached. It's hard to let go, but it's what we are here for. It's all about making sure they are ready for the next step, but we try to stay in touch; this is an important milestone and we hope a positive experience". Another staff member told us that they support friendships which develop, and had arranged regular social meetings between a person who left the previous year with a person who was still a resident at the college.

A care commissioner told us "I have found that the college supports transition and makes sure that local authorities plan this. While this can feel like additional pressure at times, I think it is good that they push us on this and make us accountable, and that the college considers what will happen next for the people who used the service and how the college can support them into the next step".

Good

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act that the manager of a service like Royal College Manchester is registered with the Care Quality Commission. When we visited the home had a registered manager who has been registered since August 2014. The registered manager was present throughout the inspection. She had a clear and visible presence across the site, and was respected by all the people we spoke to.

Discussions with the registered manager and staff showed they were clear about the aims and objectives of the service. This was to ensure that the service was run in a way that supported the need for people to have their human rights protected and to be cared for safely in the least restrictive way. We were told by the Interim service manager that the organisation centres around the school and college, and the ethos is therefore one of learning. The registered manager and the staff we spoke to recognise that there is a difference in the role of the college and the residential service but told us that education does not stop in college: "We can't be a sitting service; we want to be a continuum of further education". The aim of the service is to enhance skills and ensure that people do not become too dependent, so interventions with people who use the service can be a learning experience for the person. We saw this in practice; care staff worked to enhance skills in a person centred and enabling manner, for example, helping a person who used the service to use the search engine on their personal computer to find a piece of music they were singing, or we observed a visually impaired person being encouraged to walk short distances without assistance.

The service encourages openness and transparency, and views mistakes as an opportunity for learning. For example we spoke to one care worker who informed us how they mistakenly gave the wrong medication to a residential student. Although they followed the correct protocol to ensure that the person came to no harm, the incident triggered an investigation during which the care worker was suspended from administering medication and then completed a refresher training course before being put back on the medicines rota. The care worker informed me that that this had proved a valuable lesson and ensured that they took further care when administering medicines.

There had been a restructuring of the tiers of management over the 18 months prior to our inspection. One person told us that this had lowered morale and in their opinion some staff had become "Disaffected by the review, and review of review." They said that "A lot of staff have struggled and feel that it was the way it was implemented, but I believe it was all planned properly."
When we spoke to the registered manager about this she informed us that over the past year there had been a high staff turnover, which was due in part to the management restructure. 17 staff had left over the past year. At the time of our inspection however there was one vacancy, with a further person awaiting background checks.

One family member we contacted told us that recent changes with staffing teams "Had not helped in terms of continued reassurance for them self", but we did not see any evidence that this had affected the delivery of care. The staff we had discussions with spoke positively about working at the home. One staff member told us they believed there was a good team ethos, all staff worked well together and management

responded well to the needs of staff and of the people who used the service. They told us "I've been here about a year and I wasn't sure at first but I am now. We work well together, and question practice to look at how we can do things better. We provide a valuable service".

The service had effective systems for sharing and passing on information. The management structure of the whole organisation included an Executive Leadership Team and a strategic group which agreed key objectives and reviewed feasibility for new ideas, encouraging growth and development. An Operational Management Group for all Heads of service meets eight or nine times a year. The registered manager told us that this helped to review the quality of service delivery as it affected day to day events for the people who used the service by ensuring close collaboration and decision making. This in turn ensured heads of service were able to make decisions affecting their part of the service with reference to the impact on the rest of the service, so the whole organisation worked as a team. There is close scrutiny from the Executive leaders as well as the Board of Governors for the Trust, increasing accountability for actions.

The people who used the service were helped and encouraged to produce a newsletter which was available in picture format. This allowed people who used the service an opportunity to develop their skills and provided an effective method of communication and information sharing.
Team leaders meetings were scheduled every six weeks, and this would be followed by House Staff Meetings. Staff we spoke with confirmed that this information was correct. Staff meetings are a valuable means of motivating staff and making them feel involved in the running of a service.

Systems were in place to monitor the quality of the service to ensure people received safe and effective care. The registered manager produced an annual report for the Board of Governors and we were told that regular audits/checks were undertaken on all aspects of the running of the service. We looked at some of the audits that had been undertaken, such as the draft food audit and audit of risk analysis. We were also shown an in-depth monitoring report that had been undertaken on all aspects of care within one of the houses. This focused on the environment and delivery of care and included an audit of their risk assessments, medication and care plans. An action plan showed where improvements were needed and what action had been taken to date to address any identified issues. All identified actions had been completed within timescales.

The service regularly sought feedback from relatives and people who used the service with surveys sent out annually. Any returns were analysed and reviewed for areas of improvement, and a report published which described any proposed actions culminating form the response. We looked at the recent responses to the survey which were all positive about the care received.

The families we contacted about the service generally believed that they had been listened to. For example, we were told by a parent that "Any concerns, issues or queries have always been listened to and dealt with efficiently," and another told us "My views have always been listened to and there is always opportunity to communicate with residential staff on a daily basis." However another parent told us that they had asked for some clarification from the service regarding a concern, and having been told that someone would get back to them, they were not given the information they had requested. A commissioner also told us that although the service was working well there had been some general worries expressed by the family regarding communication of information. Both the commissioner and the parent told us that since this was raised the level of communication had improved.

The organisation had developed good links with local businesses, and this had led to practical improvement to support people with disabilities and sensory impairments, for instance, one firm had developed equipment such as spray bottles to indicate the day of the week for people with visual impairments for use

in the houses, others provided practical work placements, and the chef from a local business had agreed to come in to provide practical support and help with food skills.

We checked our records before the inspection and saw that accidents and incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.