United Response

United Response - 85 Highfield Avenue

Inspection report

85 Highfield Avenue
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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 which took place on 02 November 2016.

United Response 85 Highfield Avenue is a residential care home which is registered to provide a service for up to six people with learning disabilities. There were six people living there on the day of the visit, including one person who was in hospital. The service offers accommodation in a domestic sized house, over two floors. Only people who are physically able have their rooms on the first floor which is accessed via a staircase. A stair lift is available for emergencies.

There is a registered manager running 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.

People were kept safe from harm or abuse by staff who had been trained in safeguarding vulnerable adults and health and safety policies and procedures. Staff understood how to protect people and followed the relevant procedures. General risks and risks to individuals were identified and action was taken to reduce them. There were enough staff, on duty to ensure people's needs were met and they were supported safely. The recruitment procedures were robust and made sure, that as far as possible, staff were safe and suitable to work with the people who live in the home. Medicines were given safely, in the right amounts and at the right times by trained and competent staff.

People's health and well-being needs were met by staff who responded effectively to people's changing needs. The service sought advice from and worked with health and other professionals to ensure they met people's health and well-being needs.

Peoples' human and civil rights were understood, and upheld by the staff and registered manager of the service. The service understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and consent issues which related to the people in their care. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who may not have capacity to do so. People were supported to make as many decisions and have as much control over their lives as they were able to.

People's care was provided by kind and caring staff who were attentive and knowledgeable. Individualised care planning ensured people's equality and diversity was respected. People were provided with activities, according to their needs, abilities and preferences.

People's care was overseen by a registered manager who listened and responded to them and others. The registered manager was described as approachable and supportive. The quality of care the service provided was assessed, reviewed and improved, as necessary.

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.

Staff knew how to keep people safe. They had been trained so they knew what to do if they thought people were not being protected from abuse.

Risks to people's health and safety were identified and any necessary action was taken to make sure they were reduced.

Staff were trained to give people their medicine safely.

There were enough staff on duty, to meet people's needs and keep them safe.

Only staff, who had been checked and were suitable and safe to work with the people in the service, had been employed.

Is the service effective?

Good

The service was effective.

Staff met people's individual needs and helped them to stay as happy and healthy as possible.

Staff made sure people's rights were upheld and they met the legal requirements if people were not able to make certain decisions for themselves.

People were helped to make as many choices and decisions about their daily lives, as they could.

Staff were trained to meet the individual and specific needs of the people in their care.

Is the service caring?

Good

The service was caring.

People were happy to be living in the home.

People were supported by kind and caring staff. They were

treated with respect and dignity at all times.

People's individual needs and lifestyle choices were recognised and respected.

The service made sure that people's communication methods were understood so staff could respond to people in the way they preferred.

Is the service responsive?

Good

The service was responsive

Staff helped people with their care in a way which met people's current and immediate needs. They took into account people's personal choices and preferences.

Staff helped people to keep their relationships with families and others who were important to them.

People were supported to choose and participate in activities that met their needs and helped them to enjoy their lifestyle.

Is the service well-led?

Good

The service was well-led.

The service was well managed and staff felt supported by the registered manager to offer the best care to people.

The registered manager knew people and their needs well and made sure staff met them.

People, staff and others involved with the service were listened to and their ideas and views were acted upon, if possible.

The quality of care the service was providing was monitored and action was taken to develop the service to meet the needs of people.

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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 was unannounced and took place on 02 November 2016. It was completed by one inspector.

Before the inspection the provider sent us a provider information return. 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 looked at all the information we have collected about the service. This included notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law.

We looked at four care plans, daily notes and other documentation, such as medication records, relating to people who use the service. In addition we looked at records related to the running of the service. These included a sample of health and safety, quality assurance, staff and training records.

During our inspection we observed care and support in communal areas of the home and used a method called the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We interacted with three people who live in the home and spoke with two. People had limited or no clear verbal communication. We spoke with three staff members and the registered manager. We spoke with or received comments from two relatives of people who live in the service, after the inspection visit. We requested information from other professionals but did not receive any responses. We looked at information held about the six people who live in the service and observed the care people were offered throughout the

duration of our visit.

Good

Is the service safe?

Our findings

People told us or indicated, by smiling and nodding, they felt safe in the service. People were relaxed and comfortable to approach staff and the registered manager to indicate or ask for support or interaction. Relatives, of people who lived in the service told us they were confident that people were safe and well-treated.

People were kept safe from all forms of abuse. The staff team received regular training in safeguarding adults and were able to describe, in detail, how they would recognise and deal with any concerns. They were fully committed to protecting the people in their care and were aware of the provider's whistle blowing policy. They knew who to contact, outside of the organisation, should this be necessary. However, staff told us they were confident that any of the management team would react immediately to any concerns reported. There had been two safeguarding issues since the last inspection in January 2014.These had been appropriately dealt with and the appropriate authorities had been informed.

People were protected from any financial abuse. Each person had a financial file and financial care plan. The registered manager was the benefits appointee (was able to ensure people received their correct benefits) for five people and the sixth person's finances were dealt with by the Court of Protection. The service kept personal monies and bank accounts for five people and requested money from the solicitors working on behalf of the Court of Protection for the sixth person. Receipts were kept for all expenditure and there were robust audits in pace to ensure people's money and property was handled correctly.

People, staff and visitors to the service were kept as safe from harm as possible. Staff were trained in and followed the service's health and safety policies and procedures. Health and safety policies had been updated in January 2016. Health and safety and maintenance checks were completed at the required intervals. These included vehicle checks, legionella checks, fire alarm maintenance and thermostatic mixing valve checks. The provider's health and safety advisor had completed a positive audit of the service on 07 March 2016. The service was awarded a two star (requires improvement) rating, for food hygiene, by the environmental health department in 2016. The recommendations required were completed before the environmental health officer visited for the return inspection.

People and staff were protected by generic health and safety risk assessments such as moving and handling and stress and well-being. A comprehensive emergency plan (called a disaster plan) for the service had been developed. It included a pen picture of each individual and areas such as a full evacuation resulting in the necessity for alternative accommodation. There were clear and easy instructions for staff to follow in the event of an emergency situation occurring.

People were further protected by individual risk assessments and risk management plans. Risk management plans were incorporated into the person centred support plans. These advised staff how to offer care and reduce any risks relevant to the individual. Examples included food and drink, accessing the community and making pudding. People had an individual emergency and evacuation plan, tailored to their particular needs and behaviours.

The service recorded accidents and incidents and investigations into their cause. However, some were not detailed and it was not always clear what action had been taken in response to the investigation findings. Care plans showed that actions such as a care plan review had been undertaken as a result of an accident or incident. However, these were not cross referenced or connected with the accident and incident recording. The registered manager undertook to review the recording system to ensure the necessary information to instruct staff how to minimise the risk of further occurrence was clear.

People were given their medicines safely by staff who were trained to follow the medication administration processes and procedures. Their competency to administer medicines was tested before they were allowed to carry out this duty. The service followed an up-to-date medicines administration policy and procedure which had been reviewed in January 2016. One medication administration error had been reported in the previous 12 months. The service used a monitored dosage system (MDS) to assist them to administer medicines safely. MDS meant that the pharmacy prepared each dose of medicine and sealed it into packs. People had detailed guidelines for the use of any PRN (to be taken as necessary) medicines. These were kept in people's individual care plans and in the medicine cupboard. Any allergies people suffered from were clearly recorded in medicine files and on care plans.

People were offered care by staff who were suitable and safe to work with them. The provider's recruitment processes made sure the necessary safety checks on prospective applicants were completed prior to appointment. These included Disclosure and Barring Service (DBS) checks to confirm that employees did not have a criminal conviction that prevented them from working with vulnerable adults. Detailed application forms included full work histories and interviews were held. Appropriate references were taken up and verified prior to candidates being offered a post.

People's needs were regularly assessed and met by enough staff to keep them safe. Staff members commented, "There are always enough staff to care for people safely." There were a minimum of two staff during the day and one sleeping in staff. The registered manager was in the process of applying for waking night staff as people's night time needs were increasing. Any shortfalls of staff were covered by staff working extra hours and bank or agency staff. The registered manager tried to use regular agency staff who knew people. Recruitment of staff was noted as being extremely difficult in the area. The registered manager could increase the number of staff in the event of special activities or emergencies.

Good

Is the service effective?

Our findings

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. Plans of care included appropriate information and ensured staff knew how to meet people's individual identified needs. The plans included a summary (a one page profile) of the important aspects of people's care. These described, more briefly, people's needs and gave staff quick and easy access to important information about them. Relatives, of people who live in the service, told us they were confident that people received good care.

People had a separate detailed health care plan which noted all aspects of their health needs. These included a record of treatment, a medical profile and a health action plan. The health action plan included information such as, "My big health issues" and "Other health things I need help with." A hospital passport which contained information the hospital staff would need to provide appropriate care for the individual had been developed. Referrals were made to other health and well-being professionals such as psychiatrists, dietitians and specialist consultants. People were supported to attend specialist appointments and regular check-ups and the staff team followed any advice given by other professionals such as speech and language specialists.

People were supported with their rights by staff who understood issues of consent and the Mental Capacity Act 2005 (MCA). The 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 when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and the least restrictive option. Staff had received Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DOLS) training and were able to demonstrate their understanding of the Act.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called DoLS. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive people of their liberty were being met. The registered manager had made six DoLS referrals, four of which had been authorised by the local authority (the supervisory body). Two applications were being considered. Applications were made appropriately and met legal requirements. Best interests meetings were held, as necessary and records were kept of who was involved in the decision making process.

People were encouraged and supported to make as many decisions and choices as they could. People's individual communication methods were identified and understood and staff were able to interpret their choices and decisions if they were unable to verbally communicate. People's agreement to the care plans noted how people had given/shown they consented to it and who else was involved in helping them to make the decision. A staff member described how they encouraged people to make their own decisions. They said they made sure they got to know people, built a relationship with them, gave people time and space and used proper phrasing and communication methods. Care plans included a detailed decision

making profile which advised staff how to present the question, the best time to ask it and how the individual communicated their decision. Additionally there was a list of decisions people were likely to make in their life and what support they needed to make them.

People who had behaviours that may cause distress or harm to themselves or others were well supported by the service. They had excellent detailed behaviour plans which supported staff to help them to reduce the anxiety and distress which may result in such behaviours. The support measures made it clear why they were in place and what was expected from them. The service did not use any form of physical restraint although staff were trained in breakaway methods to ensure their safety. Staff focussed on using early intervention and distraction techniques.

People were offered food they liked and were able to choose their own food if they did not like what was on the menu. People were encouraged to be involved in food preparation, when possible. If people had any specific needs or risks related to nutrition or eating and drinking, these were included in care plans. The service sought the advice of dietitians or speech and language therapists, as necessary and offered food in the way they were advised.

People's needs were met by staff who had access to appropriate training to develop the skills and knowledge they needed to meet people's needs. Staff told us that they had, "Good training opportunities." They said that they received training up-dates at the correct intervals and could request training in areas where they felt they needed more knowledge. Training was delivered by a number of methods which included computer based and classroom learning. Specific training was provided to support staff to meet people's individual diverse needs. This included epilepsy and dementia. New members of staff received a comprehensive induction which equipped them to work safely with people. The service used the care certificate framework (which is a set of 15 standards that new health and social care workers need to complete during their induction period) as their induction tool.

People were supported by a staff team who were well supported by a registered manager and management team. Staff received one to one supervision approximately six times a year. Staff confirmed that they were supervised regularly but because of the shortage of staff they had not received an annual appraisal. The registered manager told us that the lack of appraisals had been identified as an omission by her manager and that she was in the process of organising them. However, performance and training issues were identified at supervisions and any necessary action was taken. We saw that staff who needed to retrain in particular areas had been identified and were given the appropriate support. Staff told us they felt well supported by the registered manager in their day to day work. However, some staff felt they could be supported more effectively with their personal development. This was not evident from staffing records and other staff did not share this view.

Good

Is the service caring?

Our findings

People were supported by a caring and committed staff team. People told us or indicated by smiling that they liked living in the home. One person told us that staff were kind.

People's privacy and dignity was maintained at all times. Examples included staff discreetly asking people if they needed to meet personal care needs. People were encouraged to adjust their clothing to maintain their privacy and dignity and to close toilet doors. Care plans included how staff should support people's privacy and dignity when offering care.

People were treated with respect. Staff interacted positively with people, communicating with them throughout the duration of the visit. People were spoken to as equals and encouraged to join in with social 'chit chat'. Staff used appropriate humour and physical touch to communicate with and comfort people, as necessary. Plans of care included positive information about the person and included areas such as, ''Gifts and talents."

People received care and support from staff who had built relationships with them and generally knew them well. Agency staff who had not had time to build relationships with people were provided with simple and easy to read information to help them to support people in the way they preferred and chose. Staff were able to describe what support each person needed and how they gave that support. People were very comfortable with staff and were able to express or display their needs and preferences to them.

People had excellent communication care plans (called a communication profile) to ensure staff understood them and, as far as possible, they understood staff. The plans described, in detail, how people made their feelings known and how they displayed choices and preferences. For example plans listed the words an individual used for specific things, a person's hand gestures and body movements. They also noted how staff would know when people were displaying particular emotions and states of well-being or distress. For example if people felt relaxed, happy, sad or angry. People's identified methods of communication were used to inform staff how people felt about the care they were receiving and the service, in general.

People's equality and diversity needs were met by staff who knew, understood and responded to each person's diverse physical, emotional and spiritual needs. One of the service's aims was, "To ensure people had the same rights and opportunities as others." Staff adhered to this principle in their everyday work. Care plans included any special needs people had to support their culture, religion or other lifestyle choices. For example if people had particular physical needs these were met to enable people to have the same opportunities as everyone else.

Good

Is the service responsive?

Our findings

People's needs were responded to by a staff team who were able to recognise when people needed or wanted help or support. Staff were able to recognise when people needed assistance, however the need was expressed. We saw staff responding to body language and behaviour as noted in people's communication profiles. For example when one person made particular sounds staff would sit with them and use appropriate physical touch to calm them.

People were encouraged and supported to maintain and develop relationships with people that mattered to them. Care plans included a relationship map which recorded people's family, friends and other important people. Contact with families was maintained as far as possible.

People, relatives, social workers and other relevant services were involved in an initial assessment of the person prior to them moving into the service. Detailed care and support plans were developed from the assessment. Each person was allocated a key worker, a key worker is a named member of staff who was responsible for ensuring people's care needs were met. Care plans were reviewed a minimum of six monthly and whenever the need arose. For example, people were ageing and their needs were changing quickly. The service responded to any newly identified or changed needs and care plans were amended accordingly. The landlord of the service had refurbished a bathroom and created a wet room (at the request of the registered manager) to meet the needs of people undergoing the ageing process.

People's care was totally person centred and care plans were personalised. People's care plans ensured that staff were given enough information to enable them to meet specific and individualised needs. Care plans included sections called, "Activities I like and dislike.", "Good day, bad day" and "How I like and need my support." A plan called, "What's important for and to this person" noted small things such as, "[Name] likes putting sauce away and taking used plates to the kitchen." The plan detailed how staff were to support them to achieve these tasks to include them in daily living activities.

People were provided with a flexible activities programme which responded to their choices, moods and well-being, on a daily basis. Some people had some set activities such as music therapy. However, these could be interrupted if staff or drivers were not available to provide transport. The registered manager told us this issue would be resolved when new staff (who had been recruited) started work. Staff sickness in the home had also caused transport issues. People were offered outings and day trips. Some activities were provided in the home such as guinea pigs being brought in for people to hold and stroke. People were taken for shopping trips and to participate in community activities, as they chose. People's needs were changing quickly and the service was responding to people's altered abilities and interests.

The service had a robust complaints procedure which was accessible by people, their friends and families and others interested in the service. An easy read version of the complaints procedure was available to people and gave them the best chance to understand the process. It was clear that people would need support to express a complaint or concern. Staff were able to identify if an individual was unhappy or distressed and investigate the cause. The service had not recorded any complaints during the preceding 12

months. Relatives of people told us they had, "absolutely no concerns about the home or the care".

Good

Is the service well-led?

Our findings

People received good quality care from a staff team who were led by an experienced and qualified registered manager. The registered manager was registered under the new legislation in 2010 and held management and care qualifications. She was registered to manage two homes with the support of a deputy manager. Relatives of people told us they knew the registered manager well and were confident they would be told if there were any issues for their family member. They said she was very involved in people's care and knew their family member well. Staff described the registered manager as supportive and very approachable. One staff member told us, "My experience and knowledge is acknowledged and valued."

The service had a variety of ways of listening to the views of people staff and other interested parties. People had six monthly reviews which recorded people's satisfaction with the service and what outcomes had been achieved. People's families, friends or advocates were asked for their views, via an annual questionnaire and collected informally when contact was made with the service. Staff views and ideas were collected by means such as team meetings and 1:1 supervisions. There had been three team meetings in 2016 due to staff shortages. Generally team meetings were planned to be held monthly. The last team meeting was held in May 2016. The registered manager advised these would become more regular once the new staff were in post.

People benefitted from a good quality service which was monitored and assessed to make sure the care offered was maintained and improved. There were a variety of auditing and monitoring systems in place. Examples included health and safety checks, regular financial audits and medicines checks. A quality audit was completed every three months by a manager from another service. The three monthly audits included areas such as staff awareness of safeguarding and Deprivation of Liberties, records checks and risk management checks. Additionally practice observations were completed approximately every three months and comments were recorded about the way staff worked.

The registered manager told us that the area manager visited the home every four to six weeks although they did not always complete a record of the visit. People who lived in other services called, "Quality Checkers" visited the service regularly to make comments on the care the service was proving to people. They looked at the service from the point of view of the people who lived there. Additionally an annual review looking at all aspects of the service was completed. The last review was completed in September 2016. This looked at the various audits and quality assurance processes and produced an action plan, if necessary. Actions taken as a result of listening to people and staff and reviewing the various quality assurance processes included providing a wet room, introducing guinea pig visits and applying for waking night staff.

People's records accurately reflected their individual needs, they were detailed and up-to-date. They informed staff how to meet people's needs according to people's preferences, choices and best interests. Records relating to other aspects of the running of the home such as audit records and health and safety maintenance records were, generally, accurate and up-to-date. Records, in general, were of good quality, well-kept and easily accessible. The registered manager understood when statutory notifications had to be

sent to the Care Quality Commission and they were sent in the correct timescales.