Quest Haven Limited

Quest Haven Limited - 31 High Street

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 inspection took place on the 31 May 2016 and was unannounced.

Quest Haven 31 High Street is registered to provide accommodation with personal care for up to three people. At the time of our inspection there were three people living at the service all of whom had a Learning Disability. People required minimal support with staff encouragement and prompting as they were able to attend to most of their own personal care needs.

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

People told us that staff were kind and they felt safe living at the service. Staff had received training in relation to safeguarding. Staff were able to describe the types of abuse and the processes to be followed when reporting suspected or actual abuse.

Staff had received training and supervisions that helped them to perform their duties. New staff received a full induction to the service which included training.

Where there were restrictions in place, staff had followed the legal requirements to make sure this was done in the person's best interests. Staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure decisions were made for people in the least restrictive way.

People were positive about the care provided and their consent was sought. People told us that staff treated them with respect and any help with personal care was done in private.

People's care and health needs were assessed and they were able to access all healthcare professionals as and when they required.

People's nutritional needs had been assessed and people were supported by staff to eat and drink as and when required. The menus provided a choice of meals and people were able to choose a meal that was different to the menu choices. People told us they liked the food and that they cooked meals with the help from staff.

Documentation that enabled staff to support people, and to record the care and treatment they had received, was up to date and regularly reviewed. People had signed their care plans and were involved in writing and reviewing their plans of care. People's preferences, likes and dislikes were recorded and staff were knowledgeable about the care needs of people.

Relatives and friends were encouraged to visit and there were no restrictions to when people could visit.

Staff showed kindness and compassion and people's privacy and dignity were upheld. People were able to spend time on their own in their bedrooms.

There were enough staff to ensure that people could undertake their activities and to meet the assessed needs of people. Staff encouraged people to be independent and to do things for themselves, such as cooking and cleaning.

People told us they were able to have talks with staff. People told us they were able to raise concerns and make complaints if they needed to.

Staff at the service worked in line with the provider's values that ensured people received effective care. Staff were also aware of the whistle blowing procedures and would not hesitate to report bad practice.

Quality assurance processes were in place to monitor and improve the service.

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 were aware of how to recognise and report any allegations of abuse.

There were enough staff to meet people's needs. The provider employed staff to work at the home that had been appropriately vetted.

People's medicines were managed safely.

Accidents and incidents were managed and monitored to see how they could be reduced.

Is the service effective?

Good

The service was effective.

People were involved in decisions about their care and they had enough food and drink of their choice.

Staff received appropriate training and were given the opportunity to meet with their line manager for support.

Where people's liberty was restricted or they were unable to make decisions for themselves, staff had followed legal guidance.

People had involvement from external healthcare professionals as well as staff to support them to remain healthy.

Is the service caring?

Good

The service was caring.

People told us they felt they were looked after by staff.

People's care, treatment and support was planned and delivered in line with their care plan.

People's privacy and dignity was respected.

Staff were knowledgeable about the people they cared for and were aware of people's individual needs and how to meet them.

Is the service responsive?

Good

The service was responsive.

Where people's needs changed staff ensured that people received the correct level of support.

People were able to go out and take part in activities that interested them, including maintaining their relationships with family and friends.

People knew how to make a complaint and a complaints procedure was available at the service.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place who was registered with the Care Quality Commission.

Staff felt supported by the registered manager.

Quality assurance processes were in place to monitor and improve the service.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 May 2016 and was unannounced. The inspection was undertaken by two inspectors.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by Care Quality Commission (CQC) which included notifications, complaints and safeguarding concerns. A notification is information about important events which the service is required to send us by law. We asked the provider to complete 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 use this to inform our planning and inspection.

During our inspection we had discussions with two people who used the service, one member of staff and the registered manager. We observed how staff cared for people and worked together. We read care plans for two people, medicine administration records, mental capacity assessments for people and Deprivation of Liberty Safeguards applications. We looked at three staff recruitment files and supervision and training records. We saw some audits that had been undertaken, minutes of staff meetings and a selection of policies and procedures.

At our last inspection of June 2014 we found the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 that related to the safety and suitability of premises.

Good

Is the service safe?

Our findings

People felt safe living at the home. People told us they felt safe with staff who looked after them. One person told us, "Yes, I feel safe here. Staff look after me Okay." Another person told us, "Staff never hurt me; if they did I would tell the manager."

People benefitted from a safe service where staff understood their safeguarding responsibilities. Staff records confirmed they had received training in relation to safeguarding that included whistle blowing. Staff knew the different types of abuse and what to do if they suspected or witnessed abuse. One member of staff told us, "I would report any safeguarding incident to the manager straight away." Staff also stated that people would talk to them if they felt they had been mistreated by staff. The home had a safeguarding policy that was reviewed in January 2015. This included the different types of abuse and the processes for reporting, including the details of the local authority safeguarding procedures.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. Risks to people's personal safety had been assessed and plans were in place to minimise these risks. For example, one person told us, "I like to go to the shop and get my paper. (Staff member) comes to make sure I'm alright." This person's care records contained risk assessments that covered a variety of day to day activities, including going out in the community. This identified risks to the person when out in the community and provided staff with information on how to support this person safely out in the community. During our inspection this person went out with staff support and purchased their newspaper. This showed that the member of staff understood the risk assessment and what action to take to minimise the risk for this person.

When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. Accidents and incidents were being documented and outcomes were identified. For example, in the last year there had been two minor altercations between two people. We saw care records had been updated following these incidents detailing how staff should approach one person and how to identify when they were becoming agitated. There had been no recorded incidents of a similar nature since. This meant that themes would be identified and monitored.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. The provider had a contingency plan which guided staff in the action to take should they need to evacuate the home. For example, extreme weather, fire or flood. People would be evacuated to another service owned by the provider that was very close by. This meant people's care would continue with the least disruption possible in the event of an emergency.

There were sufficient numbers of staff deployed at the service to meet the needs of people. The PIR informed that there were two members of staff on shift when all people were in residence and one waking night staff. We observed these staffing levels during our visit. People living at the service required minimal support with staff encouragement and prompting as they were able to attend to most of their care needs independently. Extra staff were available as required for example when people required transport to day

centres, external appointments and external activities. The duty rota recorded times when extra staff were required. People told us that staff were always available if they needed them. The registered manager told us that they were supernumerary to the duty rota and they were present at both services they managed every day. The registered manager and the deputy manager covered the on-call duties. Staff told us they never use agency staff as they cover any staff absences between the staff team.

Safe recruitment procedures ensured that people were supported by staff with the appropriate experience and character which included two written references, proof of the person's identification, employment history and a check with the Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support service.

People's medicines were stored, administered and disposed of appropriately and securely. One person told us, "I get my medicines when I should have them." Staff told us that they had been trained in relation to the safe administration of medicines; training records confirmed this training had taken place. Where people had, 'as required (PRN) medicines, protocols were in place which contained information on the PRN medicines they required, what may trigger the need for it and the maximum dosage they could take.

The service had a medicines returns book. This was used to return unused and out of date medicines to the dispensing pharmacy so they could be safely destroyed. The pharmacist had signed the book for each return.

Good

Is the service effective?

Our findings

People spoke positively about the care provided by the staff. One person told us, "Staff know how to help me and what I like doing." Another person said, "Staff always talk to me and they listen."

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff told us that training provided at the service was good and they were provided with regular updates. One staff member told us, "We are always being offered training and if I wanted anything specific I would ask. I am currently doing the NVQ level 3." Staff had received all the mandatory training. The staff records we looked at confirmed this. NVQ levels 2 and 3 had been undertaken by some staff. This showed us that staff received guidance and training that helped them to carry out their roles.

Staff told us they had undertaken induction training when they commenced working at the service. A new member of staff told us they were undertaking the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Certificated workbooks were used and these covered subjects such as safeguarding adults, basic life support, working in a person centred way and health and safety. One member of staff was able to inform us what they had learnt from their medicines training. For example, they must check the MARs to ensure that people were administered the correct medicines and correct dose at the stated times. They told us they waited until people had swallowed their medicines before they signed the MARs and only administered medicines to one person at a time.

People were supported by staff that had supervisions (one to one meeting) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One member of staff told us, "I have supervisions with the registered manager, usually every three months." We saw records of supervisions in staff files. Topics discussed included staff training and development, quality of their work, their professional conduct and discussions about their work with people at the service.

Decisions were made in people's best interest and staff had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). 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 so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager ensured that mental capacity assessments were carried out to determine if a

person had capacity to make a specific decision. If they did not have that capacity then best interests meetings took place. If people were being restricted in their best interests for example by being unable to leave the home unaccompanied then DoLS authorisation applications had been submitted and received by the local authority. The manager told us, "We have a training matrix to see who has completed MCA training and I am arranging training for those who need it." We saw that some staff had received MCA training. Staff were aware that people could make their own decisions and choices were offered by staff. Staff were also aware of who had a restriction placed upon them. We observed one person who had a specific restriction being supported by staff to access the community safely in line with the guidance as recorded by the local authority.

Information about the five principles of the MCA were displayed in the office as a reminder to all staff. Staff told us they always offered choices to people and they would not do anything without asking their permission. For example, we noted that one person was asked by staff if they were ready for support with a particular personal care need. The person said, "Yes."

People were always able to make their own choices and decisions about their care. People told us they were able to 'lots of things' for themselves. For example, one person told us they helped with the cooking and shopping for food. Another person told us they helped to keep the house clean. People told us they enjoyed doing the things they wanted to do. One person told us, "I go to bed at night and get up when I want to. I like to get up at seven o'clock every morning." We observed people preparing their own food and bringing it through to the lounge to eat. This matched the information recorded in care plans we looked at that stated people could prepare meals and drinks with supervision.

Staff supported people who could become anxious and exhibit behaviours which may challenge others. Staff told us that they do not use physical restraint at the service and no one currently displayed behaviour that challenged others. Staff told us they had received training in Non-abusive psychological and physical intervention (NAPPI). This is accredited training with the British Institute of Learning Disabilities (BILD). Staff stated that they would talk to the person in a calm manner when they become agitated and they would follow the guidance recorded in people's care plans for their individual behaviours.

People were supported to have sufficient to eat and drink. One person told us that the food was nice. Another person said, "I like the food we have here." People told us they also had take away meals from different take away outlets. One person told us they sometimes went to the pub for their lunch which they enjoyed. Menus included meat, fish, pasta and vegetables. We observed people being offered a choice of food to eat. Daily records of meals each person had consumed were maintained at the service. Staff told us they monitored the food people ate and monthly weights were undertaken. If there were any concerns then appointments would be made with the person's GP.

The PIR informed that people had access to all healthcare professionals that included psychiatrists, community psychiatric nurses and GP. Care records contained input from healthcare professionals. For example, one person was prone to gum disease. Regular appointments with the dentist were documented with any instructions recorded. This person had a plan developed to encourage tooth brushing and during our inspection we observed this person being supported to brush their teeth. The person was very aware of their oral needs and was able to tell us the exact date of their next dental appointment.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received and that the staff were helpful. One person told us, "Staff are good and they help me." People told us they liked being at the service with the staff because they helped them every day. For example, they helped them to do activities they liked to do.

We observed positive interactions between people and staff. It was clear that the people who lived at the service got on well with the staff who supported them. Throughout our visit we saw staff and people interacting with each other in a kind and relaxed way. Staff waited for people to respond during conversations and staff encouraged people to make choices. For example, when a person had asked if they could do a certain thing staff asked, "What do you think, you make the decision." People had access to all communal parts of the home including the kitchen. We saw people in the kitchen making meals and drinks. Staff supported people as and when they required support.

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. People's individuality was recognised by staff. Staff were knowledgeable about the people they cared for and were aware of people's individual needs and how to meet them. They were aware of people's likes and dislikes and preferences. Staff told us they regularly looked at care plans to ensure they kept up to date with any changes to peoples' needs.

People were treated with kindness and compassion in their day-to-day care and staff communicated with them effectively. For example, one person liked to be kept informed of what was happening throughout the day. Their care records stated that they could become anxious if not given definite times for things. During the inspection, we heard staff responding to this person in a way that was kind and patient and also in line with what was recommended in their care plan.

People's privacy and dignity was promoted. Staff told us they always knocked on people's bedroom doors and waited for a response before entering, we saw this happened in practice Staff told us that people were only required the minimum of support as they were all very independent with their personal care needs, however, if support was required then this would be attended to in the privacy of people's bedrooms and bathrooms. This confirmed the information provided in the PIR that people have the right to privacy and dignity and this was respected at all times. We observed this throughout our visit.

Staff would not permit us to look into one person's bedroom as the person was not present at the service to ask their permission. This showed us that staff respected people as individuals and would only act with their consent.

People's care was not rushed. For example, one person was allowed to take their time whilst attending to their oral healthcare needs with staff prompts.

People were able to spend time on their own if they wished. People told us they could stay in their

bedrooms with either the door opened or closed. One person told us, "I like to listen to my CDs in my bedroom." They proudly showed us their collection of music CDs.

Staff told us that family and relatives could visit at any time. People told us their family members visited them when they wanted to. There were no restrictions when relatives or friends could visit the service.

Good

Is the service responsive?

Our findings

People told us they knew about their care plans, but they called them 'protocols.' One person told us they look at their protocols and staff asked them if they wanted to write anything in them.

People's needs had been assessed before they moved into the service to make sure their needs could be met. Care records showed that detailed assessments were carried out before people came to live at the home. Care plans had been written from the information in the pre-admission assessment. This meant that staff had access to the detailed personal information they required to support people in a way that they need or preferred. The assessments we saw covered health needs and daily living activities along with people's likes and dislikes.

Where people's needs changed staff updated care plans appropriately. For example, one person had a particular healthcare need that required monitoring through regular visits to a healthcare professional. The person's care plan had been regularly updated after each of these visits.

Care, treatment and support plans were personalised. Care plans were thorough and they reflected people's needs and choices. For example, one person told us that they enjoyed musicals. During our inspection this person was listening to 'Willy Wonka and the Chocolate Factory' in their bedroom. The care plan for this person contained details of their favourite music and their likes and dislikes.

Care plans contained a 'How to Help Me' page which contained condensed information for staff on what people liked and didn't like. This meant that staff could learn the most important things about people before supporting them.

Care plans contained pictures and every care plan had an Easy-Read contract that had been signed by people. We also saw easy read versions of activity timetables and care plans. This meant that people could be involved in planning their own support because they had access to information in a way that suited their communication needs. It also meant people were assisted to understand their routines.

One person told us, "Staff help me to go out. I like living in Horsell and visiting the shops. I go to the cinema and bowling." Another person told us, "I can choose what activity I want to do. I like going for pub lunches and to the cinema." The PIR informed that people's presence was felt in the community through enabling people to attend local colleges, visit the local pub, cinemas, restaurants and leisure centres. We noted that people had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. One person goes out to work every day at a local community centre. People were supported to use community facilities and participate in community events

We saw activity timetables which detailed outings and hobbies people were engaging in. Timetables contained pictures and reflected the hobbies of people that we spoke to. The timetables included cleaning tasks so that all people were contributing to maintaining the home environment. This empowered people

and gave them ownership over their home.

People knew how to raise a concern or make a complaint. People told us they would talk to the manager if they wanted to make a complaint, but they stated they had never had to. Staff also demonstrated understanding of supporting people to raise concerns. One member of staff told us, "If people are unhappy we talk to them. We report concerns to the deputy or the manager". Staff told us they would report concerns to the registered manager and would follow the whistle blowing policy if they had concerns about bad practice.

The provider had a complaints procedure that was available to people and visitors to the service. It included the timescale for responding to complaints and the contact details for the local ombudsman. The registered manage had a book for the recording and monitoring of complaints, however, no complaints had been made.

Good

Is the service well-led?

Our findings

People, relatives and stakeholders were encouraged to give feedback about the service. The registered manager told us that a survey was undertaken last year but only one was returned for the whole service. Comments in the returned survey were positive and no concerns or issues had been raised.

At our last inspection we made a requirement in relation to the safety of the premises. The provider information return (PIR) informed that the environment had been fully redecorated and was hazard-free. This was confirmed during our visit. All carpets and net curtains had been replaced and identified issues had been repaired. People told us they chose the colours for the bedrooms and that they were happy with how the home had been decorated. The environment was clean and tidy and checks had been undertaken to ensure the safety of the premises and equipment used. For example, electrical equipment (PAT) and annual testing of fire extinguishers.

There was an open culture at the service. Staff told us they felt supported by the registered manager. Staff stated they had daily handover meetings and regular staff meetings. This provided opportunities for staff to discuss the service and provide update on individual people's needs. For example, healthcare appointments. Staff told us that they had regular supervisions where they could discuss ideas about the home. We saw minutes of these meetings that included discussions about the service, for example, staffing, people living at the service and staff training. We observed staff and people talking to the registered manager throughout the day.

The service had a whistle blowing policy and procedure that was available to staff. Staff told us they had read this policy and they would report any concerns they had about inappropriate staff behaviours to the registered manager.

The provider had a set of values and vision for the service and these were on display. They included treating people with care, compassion and supporting people to use the community. Staff were working within the values for the service. We observed staff interacting with people in a quiet and respectful manner, asking them for their views, offering choices and attending to the requests made by people. People accessed the community every day and the house did not stand out as a care home within the community.

The manager is registered to manage two services belonging to the provider which are very close to each other. The registered manager was aware of and kept under review the day to day culture of the service. The registered manager told us that they monitored the professional behaviours of staff to ensure they were working in professional way. The registered manager told us that they were currently focussing on recording and the importance of recording. The care records we looked at were clear and up to date. The registered manager told us they were at the both services each week and shared the on call duties with the deputy manager. This meant that senior staff were always available to provide support as and when required.

The service was quality assured to check that a good quality of care was being provided. We saw regular audits had been undertaken. The quality audits we looked at had not identified any issues. However, the

registered manager told us, and it was recorded in the audits, that they were still waiting for planning permission to extend the property so all bedrooms could include en-suite facilities and have a conservatory built. The PIR informed that monthly inspection visits were conducted by the directors. Any identified issues would be addressed. For example, the environment had been redecorated and the home was monitored during the monthly visits to make sure it was kept clean. A sample of audits we looked at included care plans, risk assessments, MARs, maintenance records, fire alarms, emergency lighting and monthly fire evacuation practices. We noted that daily records were well written and had been audited. These audits extended to checking records of visits by healthcare professionals and maintenance records of work identified and carried out at the service and having discussions with people and staff. No issues had been identified in the provider audits we looked at. However, the PIR informed that the provider was to invest in a Care Management Software that would enhance the on going monitoring of the quality of service being delivered, and improve communication between management, staff and people living at the service.

Staff knew the procedures for reporting accidents and incidents. Staff told us they reported all incidents and accidents to the registered manager and these would be discussed during staff meetings. Staff told us this helped them to reduce the risk of repeated accidents. Records of accidents and incidents were maintained at the service.

Policies and procedures were in place to support staff. We saw a number of policies and procedures that were available to staff. These include medication, safeguarding, Mental Capacity Act 2005, deprivation of liberty and nutrition and hydration. Staff told us they had read the policies and procedures that provided guidance to them. For example, procedures to be followed when administering medicines to people.