Speciality Care (Rest Homes) Limited

Ash Street

Inspection report

23 Ash Street
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14 September 2016

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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 announced inspection was conducted on 13 & 14 September 2016.

We gave the provider 48 hours' notice that we would be coming as service is a small home for adults with adults with learning disabilities and we wanted to be sure someone would be in.

Ash Street is part of Arden College that provides specialist further education for young people aged 16-25 years of age with learning disabilities. Ash Street can provide accommodation for three young adults aged over 18 who attend the college and there are support staff 24 hours per day. Accommodation can be term time only and outside of term time if required. At the time of our inspection there were three people living at the home and attending the college.

The inspection was conducted by an adult social care inspector.

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.

We spoke to family members of people living at the home who told us they felt their relative was safe and well cared for. People we spoke with told us they felt safe and staff knew what actions to take if they thought that anyone had been harmed in any way.

There were safe procedures in place to ensure staff were recruited and checked to ensure they were suitable to work with vulnerable adults.

Procedures relating to the safe storage and administration of medication were in place in the home and checked regularly to ensure no errors had occurred.

Arrangements were in place to check the safety of the building by external contractors and a log of these were kept on file for us to check.

Staff understood the need to respect people's choices and decisions if they had the capacity to do so. Assessments had been carried out and reviewed regarding people's individual capacity to make care decisions. Where people did not have capacity, this was documented appropriately and decisions were made in their best interest with the involvement of family members and relevant health care professionals. This showed the provider understood and was adhering to the Mental Capacity Act 2005.This is legislation to protect and empower people who may not be able to make their own decisions.

The provider was meeting their requirements set out in the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the Mental Capacity Act (2005).

People's bedrooms were individually decorated to their own tastes. People who could not communicate verbally were encouraged to express their views through physical gestures, body language, Makaton and British Sign Language.

People were supported to purchase and prepare the food and drink that they chose. People who lived at the home, their relatives and other professionals had been involved in the assessment and planning of their care. Care records were detailed and gave staff the information they required so that they were aware of how to meet people's needs.

There was a complaints procedure in place and people felt confident to raise any concerns either with the staff, the deputy manager or the registered manager.

Staff were trained and skilled in all mandatory subjects, and additional training which was taking place within the organisation at the college. Staff we spoke with were able to explain their development plans to us in detail and told us they enjoyed the training they received. Staff told us they could approach the management team anytime and ask for additional support and advice.

Staff said they benefited from regular one to one supervision and appraisal from their manager. Staff spoke highly about the registered manager.

Managers were able to evidence a series of quality assurance processes and audits carried out.

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.

People were given their medications safely and in accordance with their needs.

Risk assessments were in place and encompassed both education and social aspects of people's lives and helped minimise harm.

Staff were able to explain what safeguarding was and what steps they would take to ensure people were protected from harm and abuse.

Is the service effective?

Good

The service was effective

Staff sought the consent of people before providing care and support. The home followed the principles of the Mental Capacity Act (2005) for people who lacked capacity to make their own decisions.

People got plenty to eat and drink and were supported to prepare meals and snacks for themselves.

Staff were trained and told us they enjoyed their training. Staff underwent regular supervision and appraisal. Induction took place for new staff, as well as shadowing opportunities.

Is the service caring?

Good

The service was caring.

Relatives of people living at the home told us the staff were caring.

Information was available for people about advocacy services if they required it.

All of the staff we spoke with told us they enjoyed their jobs and

liked supporting the people who lived in the home.

Is the service responsive?

Good

The service was responsive.

People's care plan reflected how they needed to be supported and contained information relevant to that person.

Information was available in different formats to support people to understand what it meant.

There was a complaints procedure in place; people at the home told us they knew how to complain.

Is the service well-led?

Good

The service was well-led.

The service manager worked as part of the staff team and was very well known in the home.

Relatives and staff spoke positively about the service manager.

There were quality assurance systems in place, which regularly checked the records and other documentation relating to how the service was run.

There was a procedure in placed for collecting people's feedback to take on board people's views to improve the service.

Ash Street

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 13 & 14 September 2016 and was announced.

The provider was given 48 hours' notice because the location was a small care home for younger adults who are often out during the day; we needed to be sure that someone would be in.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all of this information to plan how the inspection should be conducted.

Before our inspection we reviewed the information we held about the home. This included the Provider Information Return (PIR). A PIR 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 the care records for the three people living at the home, three staff personnel files and records relevant to the quality monitoring of the service. We looked around the home, including people's bedrooms, the kitchen, bathrooms and the lounge areas. We spoke to three staff members, the registered manager, the service manager and the relatives of two people living at the home. We asked if we could speak to one of the people living at the home, but they were not home. Another person was not able to communicate with us, however we spoke to their relative.

Good

Our findings

Relatives told they felt the service was safe. One relative said, "Yes it's good actually. We always know it is safe." Another relative said, "Oh yes, I think so."

We reviewed three files relating to staff employed at the service. Staff records demonstrated the deputy manager had robust systems in place to ensure staff recruited were suitable to work with vulnerable people. The deputy manager retained comprehensive records relating to each staff member. Full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person and ensuring each person had two references on file prior to an individual commencing work.

The deputy manager also requested a Disclosure and Barring Service (DBS) check for each member of staff prior to them commencing work. This enables the registered manager to assess their suitability for working with vulnerable adults.

We looked at how medicines were managed and found appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines. There were three people in receipt of medicines at the time of our inspection. Medication was delivered pre packed which meant people's medicines had been dispensed into a monitored dosage system by the pharmacist and then checked into the home by staff on duty. Arrangements were in place for confirming people's current medicines on admission to the home. Corresponding Medication Administration Records (MAR) charts were provided and all the MAR's were checked and were complete and up to date.

Medicines were stored securely which helped to minimise the risk of mishandling and misuse. Auditing medicines reduced the risk of any errors going unnoticed and therefore enabled staff to take the necessary action to rectify these. Training records showed staff responsible for medicines had been trained and a regular audit of medicine management was being carried out. Where new medicines were prescribed, these were promptly started and arrangements were made with the supplying pharmacist to ensure that sufficient stocks were maintained to allow continuity of treatment.

We looked at the adult safeguarding policy for the home and asked the staff about their understanding of their roles in relation to safeguarding. Staff were clearly able to demonstrate an in depth knowledge of the procedures they would be expected to follow to keep people safe from abuse. One staff member said, "I would go to the service manager." Another member of staff told us about their training, and posters on the

office wall in the home detailing the action they would be expected to take.

Accidents and incidents were accurately recorded and were subject to assessment to identify patterns and triggers. Records were detailed and included reference to actions taken following accidents and incidents. This was then discussed at a managers meeting which occurred every week.

We also asked staff about whistleblowing. All of the staff we spoke with told us they would not hesitate to use this policy if they felt they needed too.

We checked to see if the relevant health and safety checks were regularly completed on the building. We spot checked some of the certificates, such as the gas and electric and found they were in date. The three people who lived at the home had a personal evacuation plan (PEEP) in place that was personalised to suit their needs.

Risks were appropriately identified and assessed. For example, one person required support when in social situations with strangers. This person's risk assessment explained the nature of the risk and how the staff should respond when the person was displaying this type of behaviour. When we spoke to the staff they confirmed the strategies documented on the person's risk assessment.

Good

Our findings

We asked people's relatives if they thought the staff had the right skills and knowledge to support their family member. One relative said, "Well, I believe they have, there is nothing that would make me think otherwise." Another relative said, "Yes.".

We spoke to a staff member who had been recruited recently and they confirmed they had completed their training and had undergone an induction in line with the care certificate. The care certificate requires new staff to undertake a programme of learning and be assessed by a senior colleague before being considered competent to work independently.

Staff received all essential training, which was classroom based. This system was managed by the provider, in a range of areas. For example, fire, manual handling, food hygiene, infection control, safeguarding, The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards [DoLS], food and nutrition and medication. Some of this training took place in Arden College.

Staff had supervision meetings with their manager and staff records confirmed that staff had received supervisions at least every 6 - 8 weeks.

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 (DoLS). The DoLS provide a legal framework to protect people who need to be deprived of their liberty in their own best interests.

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. Consent was clearly documented in peoples files were they were able to consent, and we saw consent was obtained in accordance with the principles of the MCA from people who were legally able to do so.

All the staff team had received training in the principles associated with the MCA and the DoLS. We found

staff understood the relevant requirements of the MCA and put what they had learnt into practice. The service manager had applied for DoLS authorisations appropriately for some people who lacked capacity and was waiting for them to be authorised. We saw application's had been made to the relevant authority for consideration.

We saw examples were best interest's processes had been followed, and decision making was clearly documented. For example, we saw in some instances, staff would make some decisions for a person who had no verbal communication or cognitive ability to understand. These were decisions such as what the person would wear daily or small purchases the person made.

Consent was well documented in people's files as well as learner agreement which was used both at the home and in the college.

We looked at the provision for planning and preparing meals. The communal kitchen was located on the ground floor and there was a menu in place which people had chosen themselves. People could have food and drink when they wanted.

We saw people were supported to maintain their physical health and there was documentation, which showed that a range of healthcare professionals regularly visited people, and people were supported by staff to attend regular appointments and check-ups.

We saw one person's bedroom which was decorated according to their own tastes and preference's. Pictures and symbols were used to help support one person who could not communicate verbally to engage with the staff with regards to their support needs, such as 'food,' 'toilet,' 'bath' and 'shower.'

Good

Our findings

Relatives of people who lived at the home told us that the home provided a caring service for their family member. One relative said, "They are fantastic" and "The staff are very nice." Another relative told us, "The staff do a good job." One member of staff said, "It's a nice place to work." We asked the staff what they felt the home did well, three staff members said "We care about them and work as part of a team."

Staff gave us good examples of how they support people to maintain their dignity and independence. One staff member said, "I'll knock on their room door, I would not just barge in." Another member of staff said, "I'll always ask them if I can do something to help them."

We saw people's records and care plans were stored securely in a lockable room, which was occupied throughout our inspection. We did not see any confidential information displayed in any of the communal areas.

We saw from looking at care plans that the person receiving the care or their family member had signed them. When we asked relatives if they had been involved in their care plans, people confirmed they had.

For people who had no family or friends to represent them contact details for a local advocacy service were available. People could access this service if they wished to do so, however there was no one accessing this service at the time of our inspection.

Relatives told us they felt they were listened to and staff acted on their views and opinions. A relative said, "They call me every week, I am not local, so they keep me updated."

Good

Our findings

We saw that throughout the home, displayed on the walls, was information for people regarding how to complain. The information was presented in pictorial format, including pictures of the service manager and staff members as staff who people could go to if they had a complaint. There were no complaints to review as the service had not received any formal complaints recently.

We looked at how social activities were organised. There were photographs around the home which showed people on holiday with staff engaging in various activities. There was a large garden and the staff and people's relatives told us that the home had parties and barbeques.

Care plans contained background information about each person, including their histories and any hopes or aspirations they had for the future, most of which were written with the involvement of Arden College. For example, one person was non-verbal and the college had been communicating with the home to find out what signs and gestures the person uses at home and what they mean, so they can encourage the person to continue this when they were in college. This is a good example of the college and the home working collaboratively to ensure the person receives consistent care to promote communication skills.

We saw that the home and the college worked together to help the person find suitable work placements to help integrate them into the wider community. The registered manager of the home, who is also the principle of the college told us, "It is important that people are taught life skills while they are here [college] in case they wish to move on in the future and live independently, or for some people, they may move to supported living."

We saw that reviews were completed at least every six months with people and we saw that action points from reviews were clearly recorded with what help they would need to achieve their goals.

Good

Our findings

There was a registered manager in post. They had been in post for a number of years.

The service manager was mainly responsible for the day to running of the home and they supported us through our inspection.

Relatives and staff we spoke with were very complimentary about the service manager. One relative said, "He is nice." A staff member told us "[Service mangers name] is great." Someone else said, "They are are very supportive."

The service demonstrated good management and leadership. Staff were asked for their views about the service through team meetings and supervisions. We saw evidence of this in the team meeting minutes and the staff member we spoke with explained the supervision process. The staff member told us, "I am regularly supervised and we have team meetings."

The service manager demonstrated an ability to deliver high quality care and regular audits took place to assess the quality of the care delivered. They demonstrated this by showing us outcomes of audits, which had been undertaken and any remedial action the manager had taken following these audits. Records confirmed that audits had been conducted in areas such as health and safety, including accident reporting, manual handling, premises, food safety, medication, and risk assessments. Where action was required to be taken, we saw evidence this was recorded and plans put in place to achieve any improvements required. There was also an external audit which took place in the service by the provider's own quality assurance team.

We saw that surveys had been sent to people and families to ask for feedback, however we also saw that feedback was gathered weekly by the staff who phoned families and updated them. Weekly keyworker meetings were also held with the people who lived at the home. These methods were appropriate for the size of the service. All feedback was well documented.

The home had policies and guidance for staff to follow. For example, safeguarding, whistle blowing, compassion, dignity, independence, respect, equality and safety. Staff were aware of these policies and their roles within them.

People's care records and staff personal records were stored securely which meant people could be assured

that their personal information remained confidential. The registered manager understood their responsibility and had sent all of the statutory notifications that were required to be submitted to us for any incidents or changes that affected the service.