FitzRoy Support

Bainbridge Close

Inspection report

5a & 5b Bainbridge Close
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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

Bainbridge Close is a Supported Living Service and provides a domiciliary care service to 15 people living in five different bungalows. Two of the bungalows are adjacent in Bainbridge Close, North Walsham and the other bungalows are in Blofield Heath, Gressenhall and Norwich. The service provides 24 hours care to people who are living with learning and physical disabilities. The service's registered office is at Bainbridge Close.

The service had been developed and designed in line with the values that underpin the CQC guidance, Registering the Right Support, and other best practice guidance. These values included choice, promotion of independence and inclusion. People with learning disabilities and autism who lived in the home could live as ordinary a life as any citizen.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good. There was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People were kept safe because staff understood safeguarding principles. They conducted robust risk assessments and ensured that identified risks were mitigated.

Medicine management was safe and steps had been taken to minimise the risk of errors.

People were supported by sufficient numbers of staff that had been recruited safely and had checks undertaken to ensure they were suitable for their role. Staff were trained and competent to fulfil their roles.

People were encouraged to eat a varied diet that took into account their nutritional needs. People were supported to access healthcare professionals when needed to maintain their health and wellbeing.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People received a service that was caring. Staff knew people's needs well and were responsive and supportive. Staff treated people with dignity and respect. Staff promoted people's independence.

Staff were provided with the necessary support and encouragement to ensure people received good quality care.

Quality assurance systems were effective and the service showed that it learnt lessons and made improvements when things went wrong.

The service sought feedback from various sources to drive improvement and worked well with partner agencies.

Some notifiable incidents had not been reported to the Care Quality Commission.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Bainbridge Close

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 comprehensive inspection took place on 10 and 11 December 2018. We gave the service 48 hours' notice of the inspection visit. This was because the location is small and we wanted to make sure that staff, the registered manager and the people using the service would be available for our visit. We visited one of the bungalows in Bainbridge Close. As the properties are owned by a housing association our inspection focused on the care provided. We did not assess the safety of the buildings. The inspection was carried out by one inspector.

Before we carried out this inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us in the last year. A notification is information about events that the registered persons are required, by law, to tell us about. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provide to give some key information about the service, and about the improvements they plan to make. We also made contact with the local authority quality assurance team and local authority safeguarding team for their views on the service.

During our inspection we spoke with the registered manager, two support workers and a senior support worker. The people who used the service were unable to tell us about their experiences so we observed the care and support some people received in their home. We also spoke with the family members of three people living in different sites who were supported by the service.

We reviewed the care records for three people who used the service, including their medication administration records. Records in relation to the management of the service were also reviewed. These included staff recruitment and training records, accident and incident records and the home's quality auditing systems.

Good

Is the service safe?

Our findings

Following our last inspection of this service in July 2016, we rated safe as good. At this inspection we have continued to rate safe as good.

People's relatives told us that their family member's were well cared for. One relative told us, "I am confident [person] is in safe hands here". Clear and detailed risk assessments were in place which provided information about how to support people in a safe manner and mitigate any risks. For example, one person's moving and handling risk assessment provided detail relating to a number of different types of transfers such as getting in and out of bed, accessing the swimming pool and getting in and out of their mobility transport. The risk assessments we examined balanced safety with supporting people to be independent wherever possible. Staff were able to describe how to keep different people using the service safe.

People were protected against health and safety risks. The service undertook routine maintenance testing of appliances within the premises and equipment used to help care for people. Personal emergency evacuation plans gave succinct and clear information of how staff should support people in the event of an emergency such as a fire. The service had contingency plans in place and clear protocols to follow in the event of an emergency. We saw evidence of regular cleaning schedules for furniture, rooms and equipment and the premises looked visibily clean. We observed staff maintaining standards of infection control whilst preparing lunch for one person. A file for one person contained clear instructions about how to mitigate the risk of the spread of an infection that they had at the time.

Staff were clear about the procedure for reporting accidents and incidents and we saw detailed records relating to such events. Four medication errors and two accidents had been reported over the past 12 months. The service took appropriate action following each incident.The records showed that the incidents were investigated promptly. Staff told us that incidents were discussed with management and follow-up actions were taken as needed. For example, a person's risk assessment was reviewed after one incident and, in light of the medication errors, a new procedure for staff to follow when administering medication was implemented. This demonstrated that the service learnt lessons if incidents arose and took action to prevent them from reoccurring.

The registered manager told us that as a result of medication errors, medicine rounds were now completed by two members of staff. One person administered medication before signing a Medication Administration Record (MAR) and the other person watched the administration and countersigned a photocopied version of the MAR chart. Both members of staff also checked and confirmed the stock of medication held was correct at the point of administration. The MAR charts we viewed had been completed correctly, indicating that the people had received their medication as intended by the prescriber. Medicines were stored safely. One of the support workers we spoke with was responsible for the monthly ordering, collection, and disposal of medication and they also undertook stock checks. Six monthly competence assessments took place to ensure staff remained safe and competent to manage people's medication. There were protocols in place for people who took medication 'as required', which were followed correctly.

The staff we spoke with were aware of how to recognise signs of abuse and knew how to report safeguarding concerns to the local authority safeguarding team. All members of staff had undertaken recent safeguarding training. The service made four safeguarding referrals appropriately, two of these related to accidents and two related to medication administration errors. Two other medication errors had not been reported as safeguarding concerns. The registered manager explained that in one case the person had just been admitted into hospital. The other case involved a medication recording error which the registered manager did not realise they needed to refer as a safeguarding concern.

The service employed sufficient numbers of staff to ensure that people's needs were met and that they maintained continuity of care. We were told that certain staff members were employed to provide care only in people's homes and other staff members accompanied people when they undertook activities in the community. This ensured there were sufficient numbers of staff to provide one-to-one or two-to-one care for people as needed. We saw that staff turnover had been quite high and the service relied on bank and agency staff to cover shifts each week. The service used the same two support workers from one agency and bank staff who were familiar with people's needs and the care environment. Agency and bank staff provided care only in people's homes.

Safe recruitment practices were followed before new staff, including bank staff, were employed to work with people. All staff had reference checks undertaken and Disclosure and Barring Service (DBS) checks were carried out. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This process assured the provider that employees were of good character and had the skills and experience to support people living at the service. There was a robust process for introducing staff to people, which involved shadowing an experienced member of staff and reading all relevant care records. This ensured new staff fully understood how to communicate with people and provide them the care as they wished. The registered manager told us all new staff, whether permanent, bank or agency, followed this process.

Good

Is the service effective?

Our findings

Following our last inspection of this service in July 2016, we rated effective as good. At this inspection we have continued to rate effective as good.

People's needs and choices continued to be assessed in line with current best practice. People's physical, mental health and social and emotional needs were documented in detail, and staff were familiar with people's likes and dislikes, demonstrating that the service had assessed how to care for people holistically.

Staff continued to benefit from a structured induction and introduction to each of the people they worked with. New staff were required to undertake the Care Certificate, which is a set of induction standards that care workers should be working to. Staff also shadowed experienced support workers until they fully understood people's needs and communication styles. Staff told us their induction and support from colleagues had prepared them well for their role. We saw that all staff attended supervisions, entitled 'support and development' meetings on a regular basis. Supervision offered staff the opportunity to discuss their work, receive feedback on their practice and identify training and development needs.

The provider's online training system ensured that every member of staff remained up to date with their training. Refresher training was mandatory within specified timeframes. The programme of online training was accompanied by regular onsite observational competency assessments for manual handling and medication administration. Additional specialist training was organised when needed. For example, a specialist nurse trained staff how to safely administer food to a person who had difficulty swallowing.

People's nutritional needs continued to be met. One person's care file contained a person-centred nutrition and dietetic care plan and staff we spoke with were clear about what they could and could not eat. We observed a member of staff preparing lunch with this person and saw that they were offered choice as to what they ate. We saw person-specific menu plans which offered a balanced, healthy and varied diet. We also observed clear records relating to the administration of liquid meals to a person. A member of staff told us that another person was capable of making choices about their food and liked to sometimes have lunch out in a fast food outlet. People's weight was regularly monitored.

Care files contained clear and detailed action plans which provided essential information about people's health needs, medication, communication styles and their care preferences should they need to be transferred to hospital. The service worked with a number of health and social care professionals to ensure that people's health and wellbeing was promoted. A member of staff told us that the service was working with an occupational therapist to establish whether a custom-made alternative to a wheelchair could be designed for one person. A relative told us, "The staff get [person] to see dentists. They are mindful of their needs. They work with other agencies."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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

decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. Applications to deprive someone of their liberty must be made to the Court of Protection if the location is not a care home.

Assessments of people's ability to make decisions and consent to care were made in accordance with best practice procedures and clearly recorded in care files. Where necessary, best interests decisions were made and recorded appropriately. They were also reviewed regularly. The registered manager told us that that an application to deprive one person of their liberty had been pending for several years.

Staff had received training on the MCA and cared for people in accordance with its principles. We saw from care files that people were encouraged to make their own decisions where possible. Care plans detailed how the person communicated their choices and how staff could support them to make choices. Support workers we spoke with confirmed they sought people's consent to undertake tasks and involved them as much as possible in the activity being undertaken. We observed this happening when a staff member helped a person to prepare and eat their lunch. Staff knew which aspects of their care people were unable to make decisions about. If staff needed to act in people's best interests, they described how they would support people to remain safe and well in a manner that imposed minimal restriction.

Good

Is the service caring?

Our findings

Following our last inspection of this service in July 2016, we rated caring as good. At this inspection we have continued to rate caring as good.

The staff we spoke with talked about the people they cared for with compassion and they showed a real desire to promote their wellbeing and happiness. All the relatives we spoke with said the staff were very caring and kind. One relative told us, "The staff are very lovely, part of the family." Another relative told us, "[person] is loved, the staff genuinely see them as a person and as an individual."

We observed one member of staff preparing lunch with a person. The staff member demonstrated a kind, inclusive and patient approach and it was clear the person trusted and felt at ease with them. The person smiled and laughed during their interactions. They communicated through facial expressions and hand signals and the member of staff had a clear understanding of the messages they wanted to convey.

Staff knew individual people's communication styles, personalities and preferences very well. Each person had a keyworker which promoted the development of a close and trusting relationship. One member of staff told us that by reading people's care plans and spending time with them, they formed a close understanding of how to provide personalised care. A support worker told us, "You get to know the person to know the different things, you get to know when something is not right." Relatives we spoke with confirmed that staff were very in tune with their family members. One relative told us, "The staff members know [person] very well, their body language and facial expressions, they (staff members) know if anything is upsetting them." Staff said they used different strategies to aid communication, such as showing people items and using uncomplicated language to help identify their wishes. Pictoral aids were also used to help ensure people's care was delivered in the way they wanted.

People attended monthly key worker meetings which gave them an opportunity to review their care, discuss and agree plans for the month ahead. There were clear records of the discussions and it was evident that people were encouraged to participate as much as they were able to in the meetings.

Independence and choice were promoted. A relative told us, "If they want to cut [person]'s hair and [person] doesn't want it, they leave it. They (staff members) leave it up to them." A member of staff gave an example of how they encouraged a person to be involved in activities. They told us, "Things [person] can do they have the choice to get involved in. I always encourage things that [person] can do, for example, we were writing xmas cards - [person] was holding the pen, and wrote lines on the card. When they were finished, I wrote in the cards and we then sent them out."

Staff understood the importance of treating people with dignity and respecting people's privacy. They explained how they ensured that personal care was delivered in private and that people were covered appropriately at all times. We observed staff addressing people respectfully and acknowledging each communication signal.

Good

Is the service responsive?

Our findings

Following our last inspection of this service in July 2016, we rated responsive as good. At this inspection we have continued to rate responsive as good.

Files contained clear and detailed care plans for each aspect of care and support that was required. Communication care plans provided staff with detailed information so they knew how to interpret facial expressions, body language and sounds. They also guided staff how to respond in a way that the person understood.

Care plans enabled staff to deliver safe and effective care in a way that mitigated any identified risks and accommodated the person's preferences. We saw an example of a person's cultural and religious needs clearly documented and their support plans reflected how these should be incorporated into the person's care.

In care files we saw a document entitled 'Things that are important to me'. This gave guidance to staff on how to ensure the person was supported to live, dress and eat in the way they wanted. We spoke with one person's relative who told us that they felt the service met their family member's needs and that care was delivered in a way that respected their wishes. They told us, "The service do a lot with them. [person] is always really happy and jolly. [person] is always kept clean and well groomed. From what we have seen [person] seems really happy there." We saw that people living in one house wanted their carers to be a particular gender and a member of staff confirmed that this care preference was met. A relative also told this was the case.

People were empowered to make choices and to have as much control and independence as possible. Staff told us they involved people in decisions about what they were going to eat and some people helped do the weekly food shopping. People had recently been able to choose Christmas presents for relatives and send cards of their choosing to family members.

People were encourraged and supported to follow their interests and to take part in social activities. Staff told us about the array of activities that people were able to undertake, including going swimming, attending multi-sensory activities, going shopping, attending parties, going out for lunch and going out on boat trips. We saw evidence of this in care files and by looking at photographs in people's home. A staff member told us that people all received a set number of hours of one-to-one care or two-to-one care to facilitate these outings. A relative told us, "with close supervision and with two members of staff, [person] does horse riding about once a week, and they love sailing on the broads which they do frequently. [person] rides in the car and walks in the country and helps select things when they go shopping. The staff keep [person] as occupied as possible."

We saw that people's care plans and support needs were regularly reviewed. Staff members told us that updates on people's health and support needs were recorded in the 'read and sign' file, which they referred to at the beginning of each shift. They also routinely read each person's daily file and communication book.

There was a complaints policy in place. The relatives we spoke with felt they had no reason to complain but they knew how to do so. One relative told us, "I know that if I did have a concern, I could go to them and tell them and they would listen." We reviewed the service's complaints book and saw that no complaints had been received since the previous inspection.

End of life care planning was undertaken in consultation with people's relatives and in accordance with the service's policy. At the time of the inspection, no one at the service was receiving end of life care. We were told that, should the need arise, people's wishes would be discussed with them, their family and any health and social care professionals to ensure full support would be provided.

Good

Is the service well-led?

Our findings

Following our last inspection of this service in July 2016, we rated well led as good. At this inspection we have continued to rate well led as good.

The service made four safeguarding referrals but these were not reported to the Care Quality Commission. Two of the referrals related to accidents which resulted in a person sustaining harm. The registered manager telephoned the Care Quality Commission to discuss one of these incidents. The other two safeguarding referrals related to medication errors. One of the errors involved a person being given the wrong medication and the other involved a stock reconciliation discrepancy. Neither of these incidents resulted in any harm.

We recommend that the registered manager ensures they are routinely meeting their obligations to report all notifiable incidents to the Care Quality Commission.

The service had a registered manager 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.

Staff members we spoke with said they felt well supported by the deputy and registered managers. They told us that they had regular supervison and annual appraisal and staff meetings were held on a regular basis. Staff felt valued and listened to and a staff member told us that suggestions to improve care delivery were welcomed and acted upon. There was a good morale amongst staff, who appreciated the open and supportive working environment. One member of staff told us, "We work well as a team. A few times when we've really pulled together and shown that we can work together." The member of staff explained this related to an incident where a person became unwell and required immediate attention.

The registered manager told us that they felt supported by the provider and that there was clear direction and support. They felt felt empowered to make service-level operational decisions.

Quality assurance checks were undertaken to ensure that care was delivered at a high standard and that people could remain safe. The service would benefit from implementing additional checks to ensure the Care Quality Commission is informed of all notifiable incidents. Where incidents and accidents occurred, there was evidence that the registered manager understood their duty of candour. We saw that relatives were informed if anything went wrong and kept up to date. A relative confirmed this, telling us, "On the odd occasion [person] had slightly the wrong medicine, the wrong dose, I got a call to let me know."

Relatives told us they were able to provide feedback on the service via an annual questionnaire. We were told that health care professionals were also invited to give their views annually. Questionnaires were co-ordinated centrally by the provider. Relatives felt they could provide input locally to the service and that they views would be acted upon. One relative told us, "I'm confident that they would act on it if I had a suggestion or idea."

There continued to be measures in place to develop and improve the service, including regular meetings with people who used the service, staff and communication with health care professionals. The registered manager understood the value of recognising good performance and demonstrated good people management skills, telling us, "It is about talking to the right member of staff about change because they will pass it on in a positive way to colleagues." The service worked well with specialist teams and external agencies to deliver a high standard of care.