

Jemini Response Limited

Jemini Response Limited - 17 Jerome Close

Inspection report

17 Jerome Close
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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

Jemini Response Limited - 17 Jerome Close is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. 17 Jerome Close provides social and residential care for up to three people with learning disabilities and autism. On the day of our inspection there were three people living in the home. People had a range of complex care needs associated with living with autism and some had overlapping conditions such as ADHD, bi-polar disorder and epilepsy. Jemini Response Limited - 17 Jerome Close is owned by Jemini Response Limited and has three other homes in the South East.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

This comprehensive inspection took place on 16 October 2018 and was announced. The service had a registered manager. 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.

At our last inspection we rated the service good. At this inspection we identified a breach of regulations so the overall rating is now requires improvement. Although the care provided was good, the records that demonstrated the running of the service were not up to date or accurate. The provider had recently identified that the systems for monitoring the service were not effective and had started to put in place better systems to monitor the service. We were given assurances following the inspection that these would be tightened up further. However, as care planning and record keeping had not been up to date or accurate, time was needed to fully implement these changes and embed them into everyday practice.

There were enough staff who had been appropriately recruited, to meet people's needs. Staff had a good understanding of the risks associated with supporting people. They knew what actions to take to mitigate these risks and provide a safe environment for people to live. Staff understood what they needed to do to protect people from the risk of abuse. Incidents and accidents were well managed. People's medicines were managed safely.

People's needs were effectively met because staff attended regular training to update their knowledge and skills. Care staff attended regular supervision meetings and told us they were very well supported by the management of the home. People were encouraged to make decisions and choices. They 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 were treated with dignity and respect by kind and caring staff. Staff had a good understanding of the care and support needs of people and had developed positive relationships with them. People were supported to attend health appointments, such as the GP or dentist. Professionals spoke positively about the service. One health care professional told us, "Staff appear caring and seem to be able to manage clients and their complexities well and with compassion." People had enough to eat and drink and menus were varied and well balanced.

Staff had a very good understanding of people as individuals, their needs and interests. People were supported to take part in activities to meet their individual needs and wishes. This included trips to the local parks, theatres, cafes and restaurants.

The environment was clean and well maintained. The provider had ensured safety checks had been carried out and all equipment had been serviced. Fire safety checks were all up to date.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

There were safe procedures for the management of people's medicines.

Staff had a good understanding of the risks associated with the people they supported and knew how to recognise and report abuse.

Thorough recruitment checks were carried out and there were enough staff to meet people's needs.

Is the service effective?

Good ●

The service was effective.

Staff sought people's consent before providing all aspects of care and support. Staff received specialist training to support people effectively.

People told us support was provided in the way people wanted to receive it.

The management team and staff understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good ●

The service was caring.

People were cared for by staff that were kind and patient and treated them with dignity and respect.

Staff were committed to promoting people's independence and supporting them to make choices.

Staff adapted their approach to meet people's individual needs and to ensure care was provided in a way that met their particular needs and wishes.

Is the service responsive?

The service was not always responsive.

Care plans did not give up to date and accurate guidance on how to meet people's needs.

People received care tailored to their preferences. People were supported by staff that knew them well including their likes and dislikes.

Daily records demonstrated that people received person-centred care.

There was detailed guidance on how to communicate effectively with each person.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led.

Record keeping was not always accurate or up to date. This had been identified before our inspection and systems were being developed to improve this.

Staff felt their views were listened to. The registered manager was available and they could talk to them at any time.

Requires Improvement ●

Jemini Response Limited - 17 Jerome 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 16 October 2018 and was announced. The registered manager was called two working days before our inspection to let them know we were coming. We did this as the location was a small care home and people are often out during the day. We needed to be sure that someone would be in. When planning the inspection, we took account of the size of the service and that some people at the home could find visitors upsetting. As a result, this inspection was carried out by one inspector.

Before the inspection we reviewed information we held about the home. This included notifications of events that had affected the service such as any safeguarding investigations. We did not ask the provider to complete a Provider Information Return as this inspection was brought forward due to concerns found at a sister service. 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.

People were not able to tell us their views of life at 17 Jerome Close so we observed the support delivered in communal areas to get a view of the care and support provided. This helped us understand the experience of people living at 17 Jerome Close.

We spoke with the provider, registered manager, senior carer, carer and the home's administrator. We spent time reviewing records, which included one care plan in full and aspects of two care plans. We looked at two staff files, staff rotas and training records. In addition, we viewed documentation related to the management of the service such as incidents, quality assurance and meeting records. We also 'pathway tracked' the care

for two people living at the service. This is where we check the care detailed in individual plans matches the experience of the people receiving care.

Following the inspection, we requested further documentation from the registered manager in relation to staff meeting minutes, satisfaction surveys, end of life care plans, contacts for professionals and information about mental capacity assessments. We also received feedback from four health and social care professionals.

Is the service safe?

Our findings

Although people could not tell us if they felt safe, we observed people to be comfortable and content in their surroundings. There was always a staff presence to provide reassurance and guidance where appropriate. A staff member told us that although people displayed behaviours that challenged, "They always felt safe and felt that staff were very good at making people feel secure and safe." For example, they said when one person's mobility needs were changing, "They did not feel safe moving about they didn't want to leave the house. Once they got the wheelchair they were more than happy to leave the house again."

Risks to individuals were well managed. This helped people to stay safe while their independence was promoted as much as possible. One person's furniture was secured to the walls to prevent them from knocking them over and injuring themselves when in a heightened state of anxiety. There were locks on their cupboards and we were told the person was able to ask for the doors to be opened but they always wanted them locked again when they got what they wanted. Staff told us that the person's use of the kitchen was dependent on their health which was assessed daily and more often if needed. Sometimes equipment like the kettle and toaster could be left on the counter and other times these needed to be locked away.

There had been no accidents. Records of incidents demonstrated each incident had been analysed for triggers and, in relation to how they had been managed, so that lessons were learned to minimise the risk of a reoccurrence. As part of this process people's communication, body language and facial expressions had been assessed to determine what made the behaviours start and stop. An example of this was when two staff were supporting one person. One was a core staff member and one agency. The core staff member left the room for a very short period but the person was immediately incontinent. This helped staff understand the person's need for security of having staff known to them around them at all times. The registered manager told us they were introducing new systems to monitor types of incidents using graphs and this would help them to monitor how and why incidents occurred.

Staff had an understanding of different types of abuse and told us what actions they would take if they believed people were at risk. Staff had received training in safeguarding and were able to tell us that if an incident occurred they reported it to the management team who were responsible for referring the matter to the local safeguarding authority.

Appropriate checks for the recruitment of staff were carried out and ensured as far as possible, only suitable staff were employed. There were enough staff to keep people safe and meet their needs. There were three full-time and one part-time vacancies in total across this and a second of the provider's homes. These hours were covered with staff working overtime or with regular agency staff. There were suitable systems to ensure checks had been carried out in relation to agency staff and to ensure agency staff had the skills to meet people's needs.

People's medicines were managed so they received them safely. Medicines administration records (MAR) showed people received their medicines as prescribed. Staff had received training in the management of medicines. Some people took medicines on an 'as and when required' basis (PRN) for example, for pain

relief. There were good procedures to make sure people received their medicines when they needed. Records showed that when medicines were given the reason why was recorded. A health professional told us staff, "Appear to manage medicines effectively and follow PRN guidelines correctly."

People were protected from the risk of infection. All areas of the house were clean. Staff had received training in food hygiene and infection control. There were cleaning schedules that ensured cleaning tasks were completed either on a daily, weekly or monthly basis. Audits were then carried out to ensure tasks had been completed effectively. Gloves and aprons were available for staff use.

People lived in a safe environment because the home continued to have good systems to carry out regular health and safety checks. These included, servicing of gas safety, electrical appliance safety and portable appliance testing. A legionella risk assessment had been carried out and water testing undertaken. There were robust procedures to make sure fire safety checks were carried out. A staff member told us they had not yet taken part in a fire drill but they were able to tell us what they would do in the event of a fire. The business contingency plan provided guidance to assist staff in a range of emergencies such as extreme weather, infectious disease, damage to the premises and loss of utilities.

Is the service effective?

Our findings

There were systems to ensure staff had the skills, knowledge and experience to deliver effective care and support. One person was away on holiday at the time of inspection. This had been specifically planned to address maintenance issues in their bedroom. The bedroom was completed refurbished in this time.

One person's mobility had recently deteriorated. A number of health tests had been carried out and further tests had been arranged. The person's changed needs meant they could no longer use the stairs to use the bathroom. A number of health professionals had been consulted for advice and support. Alternative arrangements were made as an interim measure. Whilst the approach used was not ideal, as a short-term measure it was considered appropriate by all concerned, until the cause of the deterioration was identified and an appropriate long-term solution could be found. There were several plans in discussion depending on the outcome of the assessment process.

The home had received a handling belt to support the person with their mobility. The registered manager had arranged for staff to receive training on how to use the belt appropriately. They had also received a new type bed in line with their assessed needs. The furniture in their room had recently been moved to enable the person to move about their room more independently. People's environment had been adapted to meet their needs. For example, some people displayed behaviours that challenged so it had been assessed that the television needed to be behind Perspex, there were no wires trailing and there were no curtains or blinds in the lounge area. Despite these, the room was homely and people appeared content. A social care professional told us, "The environment looks very much settled and feels like home to the service users." People used iPods and other electronic equipment for fun and to make their preferences known.

During our inspection staff demonstrated a thorough understanding of involving people in decisions and asking their consent before providing care and support. This was seen during interactions between staff and people and was also documented within care plans. The Mental Capacity Act 2005 (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. We found that best interests meetings had been held when complex health decisions had been made.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). 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 had the appropriate legal authority and were being met. We found applications had been submitted for standard authorisations and any conditions made were met.

New staff received training before they started in post. They then had a two-week shadowing period where they worked with experienced staff whilst getting to know people and the way they liked to be supported.

There was a three-month probationary period with two weekly supervision throughout. Staff told us the probationary periods could be extended if they didn't feel competent to work alone or if they needed to develop skills such as cooking or cleaning. We found this had been the case for some staff.

Staff continued to receive training in a variety of subjects including safeguarding, medicines, first aid, infection control and food hygiene. Specialist training had also been provided in relation to autism, dealing with behaviours that challenged, positive behavioural support and epilepsy. One staff member told us they had requested training on sensory needs of people with autism. They said this, "Helped them to understand people better." They learned the movements and sounds people made when they were happy and when they were distressed and this had made working with them easier. There were systems to ensure that when training was due arrangements were made for this to happen. All staff that had completed the Care Certificate had completed equality and diversity training and there was a plan to ensure this training was also rolled out to other staff.

Following the probationary period, staff attended three monthly supervision meetings and told us they felt well supported in their roles. A staff member told us, "If I need advice I can go to my manager who is always there for us. When I said I had difficulty with my working hours, these were changed. When I needed time off in the summer or a specific reason, the manager was there for me and very supportive." Another staff member said, senior staff will pick up if you do something wrong, but advice is constructive and supportive. I find this helpful."

There were very good arrangements to ensure people's health needs were met. People were supported to attend a range of healthcare appointments to meet their individual needs such as GPs and dentists. Specialist advice and support was sought from the local community learning disability team from occupational therapists, physiotherapists and the speech and language team. Staff were aware of the advice given and the actions they had to take to meet people's needs. A health professional told us staff, "Sought advice appropriately when needed and have been polite, courteous and professional in their interactions with me."

People had enough to eat and drink. There were seasonal four weekly menus based on people's known preferences. Pictures were used to aid choice and there were detailed recipes for each of the meals served. We were told all meals were home cooked. Online shopping was done, but in addition to this, people were supported to shop for parts of the daily menu and were then supported to be involved in preparation. One person was trialling a low wheat diet.

Is the service caring?

Our findings

Staff supported people as far as they possibly could to make informed choices. One person had two pictures on their bedroom walls. We asked how they had chosen these pictures. The registered manager said this this been done in a measured way. The person was initially drawn to the pictures. As they were rather unusual pictures, other pictures were offered but on each occasion the person stuck to their initial decision. They had no reason to believe the person was unhappy with their choice.

The importance of respecting one person's routine and personal preferences was clearly recorded in one person's care plan. We noted the registered manager asked the provider to change seats at the dining table when this person came back from the shops as it was their routine to sit and have a drink following their outing. The provider moved immediately and the person continued with their routine undisturbed.

Daily records demonstrated people were encouraged to do as much for themselves as possible to maintain their independence. People enjoyed helping around the house. We saw that one person was supported to make their lunch. We also saw staff supporting another person to lay the table for their evening meal.

Within the care plans people's needs in relation to sexuality had been assessed. The assessment looked at how people expressed their sexuality and what was considered appropriate and what was not, in terms of living in a shared house. There was guidance about how to support people to have their needs met.

People were treated with kindness and compassion. There was a very relaxed and calm atmosphere in the home and staff had a good rapport with people. People were supported by staff who knew them well as individuals and staff were able to tell us about people's needs, choices and interests. We observed staff talked and communicated with people in a way they could understand. A health professional told us they had no concerns and said, "Staff appear caring and seem to be able to manage clients and their complexities well and with compassion."

All staff received training on equality and diversity and we asked them how this was put into practice on a daily basis. A staff member said, "Everyone is equal. They make choices and we make sure we act on them." Another staff member told us about how they had to adapt the approach they used for one person due to their complex and changing needs. This involved continual assessment to make sure the level of support was right.

A staff member gave one person a foot massage in the lounge area. After ten minutes the person had fallen asleep and the staff member continued to provide the massage. The person looked very content and had obviously enjoyed having their feet massaged.

A staff member told us they spoke regularly with people's families to keep them up to date. People were also supported to keep in touch with their families whether this was through visits, via phone or staff writing a letter on their behalf.

Is the service responsive?

Our findings

Each person's needs had been assessed and from this information, detailed care plans had been introduced. There were two folders with repetition of documents in both. Folders were bulky with documentation from previous years that were no longer relevant. There was a wealth of information which included information about people's health and support needs their preferences, dislikes, daily routines, choices and what was important to them. However, mixed within these was information and risk assessments that were not up to date or accurate. One person's needs had changed significantly in recent months and there were no up to date risk management plans. This had been identified at a recent quality monitoring visit and plans were in progress to address this situation. The daily routines however were detailed and these clearly stated the role and expectations of staff to ensure people's needs were met appropriately. Daily records showed the activities people had been involved in, what they had done and how they had reacted to different situations. These records demonstrated the way staff worked in a very person-centred way to meet people's needs and wishes. The registered manager was aware that considerable work was needed to fully update the care plans. See the well led question.

People were enabled to make choices and were helped by staff to be as involved as much as they could or wanted to be. From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively.

People's communication needs had been thoroughly assessed. One person used Makaton (a form of sign language using symbols) to communicate. Records clearly showed some of the common signs they used and what they meant. We also noted on the staff handover sheet, that there was a Makaton sign of the week. This was a 'sign' or 'expression' the person had identified they would like staff to know. For example, the week of our inspection the sign was 'music'. During our inspection we saw the person regularly used Makaton and staff understood what they were saying and responded with signs. Records demonstrated that staff at the local shop now knew some of the signs used and that the person enjoyed interacting with them.

Along with a detailed complaint procedure there was also an easy read/pictorial version. We asked about complaints. The registered manager told us about two complaints received from neighbours and the actions taken to resolve them. These complaints had been recorded in the communication book and via emails but had not been written up as formal complaints. This had no impact for people as the concerns related to staff rather than people. Staff knew what to do if a concern was raised with them and would report it to the right person if needed, such as the senior person on duty or the registered manager. A health professional told us staff, "Contact us in a timely way with queries or concerns and are responsive in a crisis." A social care professional said, "Staff have always been responsive and they follow up on actions." Another social care professional told us, "The service are generally responsive in terms of lines of communication."

People had chosen not to attend day centres so activities had been organised based on their individual needs and preferences. One person had what was recorded as a 'sensory diet'. This included objects to

touch such as a plastic bottle, straw and vacuum-packed items. We noted this person liked to have a straw with them at all times. There were clear guidelines about how to support the person with communication using pictures or objects of reference. There was information from the local learning disability team on how to use objects of reference effectively. There was also a sensory assessment checklist and a very detailed behaviour support plan. People were supported with trips to shops, parks, theatre and restaurants.

People living at 17 Jerome Close were young. The registered manager said that if anyone needed end of life care in the future this would be fully assessed at the relevant time. However, there was a new care plan template and training was to be arranged so that if the situation arose staff would be able to respond appropriately. We were told the training would support staff to have discussions with people, if appropriate, and their relatives or representatives to hear their views and wishes.

Is the service well-led?

Our findings

The provider told us they had delegated the task of quality assurance at 17 Jerome Close to the nominated individual. The registered manager confirmed the nominated individual visited the home at minimum on a weekly basis. A monthly monitoring tool had been introduced to assess the running of the service but this did not demonstrate a full assessment of the service and did not identify the shortfalls in record keeping we found during our inspection. Following the inspection, the nominated individual told us they had adapted the quality monitoring tool they had used to ensure greater monitoring of the service and actions taken as a result of shortfalls identified. We asked for a copy of the adapted tool but this had not been received at the time of writing this report.

During our inspection we found numerous examples of shortfalls in record keeping. Whilst the care provided was person centred and people's needs were met, care plan documentation was not in date or accurate. We saw recent emails from the nominated individual that provided feedback on their review of two people's care plan documentation. Specific advice and guidance was given to ensure staff were clear about the type of information needed. Staff had updated some areas of the care plans but there was still a lot of information that required updating. For example, due to one person's changed needs the whole care plan needed a complete review. This was a task that could not have been completed in the time set. Staff were able to tell us and demonstrate how they supported the person when they displayed behaviours that challenged. However, the behavioural support plan was not within the care plan. We were told this had just been updated on the computer but had not yet been printed. We asked that this be sent to us but this had not been received at the time of writing this report. Whilst there were best interest meetings for complex health decisions, restrictions such as a privacy film on a bedroom window had not been documented. People's health action plans and care passports were also not up to date. The impact of up to date documentation not being in place was minimised as staff knew people well and if they were admitted to hospital they would always have to be supported by staff who knew them well.

There was no system to ensure the registered manager received regular supervision. Systems had not identified that most of the senior staff had not received regular supervision during 2018. Whilst the registered manager was able to tell us about complaints made to the service and the actions taken, the formal procedure for recording complaints had not been followed and would have meant monitoring in relation to complaints over time difficult. Although staff were able to tell us what they would do in the event of a fire there were no recent fire drills to assess staff performance.

Staff had been signed as competent in giving medicines but the second part of the medicines competency assessment had not been completed. The 'open dates' had not been written on bottles of liquid medicines. One of the bottles was no longer prescribed and should have been returned to the local pharmacy. Both bottles were immediately taken from the cupboard. The protocols for pain relief did not refer staff to the Disability Distress Assessment Tools (DisDAT) in care plans that offered detailed guidance on how to each person expressed pain. (DisDAT are used to document a wide range of signs and behaviours of distress and when a person is content.) However, as staff knew people well it was assessed that this had a low impact for people. This had not been identified in medicine's audits. Following the inspection, the registered manager

advised us they had clarified with their medicine's trainer that the second page of the competency assessment was recommended as 'best practice' but was not a requirement. They told us that they would be ensuring all staff completed the second page.

The systems to monitor the accuracy of record keeping and the quality of the care provided were not effective and are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

As a result of an inspection at another of the provider's services a plan to address all maintenance issues throughout the organisation's homes was drawn up and colour coded in terms of priority. However, there were no timescales. We discussed this with the provider who stated it was difficult to give timescales as due to people's needs there were often competing priorities. However, using this approach would mean that tasks in the lower bracket of priority would never be addressed. For example, the bath had several stains that could not be removed with cleaning. This task had been allocated as green (low) in terms of priority. The provider could not tell us when the bath would be replaced. The provider agreed to review their procedure.

Following the inspection, the registered manager sent us minutes of staff meetings held in August and October 2018. Minutes showed a wide range of matters had been discussed and actions agreed. Satisfaction surveys for people, relatives and staff were due to be completed. We were told the last surveys completed in 2017 were positive.

In addition to the daily tasks carried out by staff and people to ensure the cleanliness of the home a weekly walk around had been introduced. This was generally carried out by the team leader. Records demonstrated staff had different areas of responsibility. Where shortfalls had been found, there were details of the actions taken. An example was that an area was noted that needed to be cleaned. This had been passed on as a task for night staff and signed as completed that evening.

From our discussions with staff, the registered manager and our observations, we found the culture at the home was open, relaxed and inclusive. Care was person centred and staff enabled people to make choices and decisions. Staff said the registered manager was available and they could talk to them at any time.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have good governance procedures to ensure record keeping was up to date and accurate. (1)(2)(a)(b)(c)