PLUS (Providence Linc United Services)

Elwis House

Inspection report

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21 December 2017
16 January 2018

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

We carried out this unannounced inspection on 18, 21 December 2017 and 16 January 2018. At our last inspection on 28 October 2015 the service was rated Good overall but Requires Improvement in safe. This was because equipment was not properly maintained or sufficiently clean.

Elwis House provides accommodation for persons who require personal care. The home provides care and support for up to four people with learning disabilities, some of whom have additional physical disabilities. At the time of our inspection there were four people living at the home.

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.

The service had a registered manager who was available on the second day of the inspection. 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.

Information about the home was accessible and understood by people who used the service. People were listened to and their rights were respected by caring and considerate staff.

Recruitment checks were completed to assess the suitability of the staff employed. Staff received suitable training and good support from the registered manager to enable them to carry out their roles effectively. There was a suitable number of staff to meet the needs of the people who lived in the home.

The safe storage and auditing of medicines needed to be improved to ensure people were safely supported with their medicines. Staff had received medicines training and their competency was assessed.

Care plans were personalised and evidenced how people would like to receive their care, however some records required a review of people's needs.

Systems were in place to effectively improve the quality of care delivered. Surveys had been sent to obtain people's views and these were used to implement change within the service.

Suitable arrangements were in place to ensure people received good nutrition and hydration.

Staff understood their responsibilities with regard to reporting suspected abuse in order to safeguard people from harm. Guidelines were followed by staff to minimise the risk of harm to people and minimise re-

occurrences of any incidents.

People were supported by staff to attend medical appointments when there were changes to their health needs and/or associated risks to their health.

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 were encouraged to maintain good relationships with their relatives. People had access to activities that were important to them and were supported to be active in the community to help maintain their independence.

An easy read complaints policy was available to guide people how to make a complaint. The provider had received no complaints since the last inspection and one person told us they had no concerns.

We have made two recommendations about people's medicines and their care records.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not safe.

Medicines were not always stored safely or effectively monitored. Staff had received medicines training and their competency was assessed.

Areas of the home had been adapted to ensure equipment was safely maintained and suitable for people to use. Infection control protocols were followed by the staff team.

Risk to individuals were assessed and managed appropriately in order to keep people safe.

There were enough qualified and skilled staff at the service to meet people's needs. Staff were appointed following safe recruitment practices.

Is the service effective?

Good

The service was effective.

Staff received the appropriate training and support to deliver good standards of care to people.

People received good nutrition and hydration and people were involved in meal planning to ensure their preferences were met.

Staff supported people to visit health care professionals to ensure their medical needs were met.

The premises were suitable for people who lived in the home.

People's consent was sought in accordance with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were comfortable with staff and we saw caring interactions during our visit.

Relatives were welcomed in the home and involved in making decisions about people's care.

Staff treated people with dignity and respect.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

Care plans were written to demonstrate how people wanted to be cared for, however some records had not been reviewed for a significant period of time.

People had access to activities that were important to them. These met people's individual needs and interests and promoted people's wellbeing.

People and their relatives were given the opportunity to raise any concerns. They were confident if any concerns were raised, these would be resolved.

Is the service well-led?

Good

The service was well-led.

The provider completed a range of audits to identify any shortfalls with service provision.

Staff were kept informed about matters that affected the home and gave positive feedback about the support they received from the registered manager.

Systems were in place to monitor the quality of the service provided. Feedback was sought from people who lived in the home to improve the standards of care.

Elwis House

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.

Why we inspected – This was a routine inspection as we had rated the service "Good". We aim to return to services rated "Good" within two years of the publication of the inspection report.

This inspection took place on 18 and 21 December 2017 and on 16 January 2018 and was unannounced on the first day; we informed the provider we would be returning on the second and third day. The inspection was carried out by one adult social care inspector.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We checked information that the Care Quality Commission (CQC) held about the service including the last inspection report, the action plan they sent to us and notifications sent to the CQC by the provider. Notifications provide us with information about changes to the service and any significant concerns reported by the provider.

During our visit we spoke with one person. Some people in the home were unable to speak with us because of their communication needs. We also spoke with one relative who was visiting their family member during our visit. We checked four people's care records including their medicines records, staff rotas, health and safety checks, minutes of meetings and key procedures relating to the management of the home. We observed a staff handover and how people received care and support and held discussions with three support workers, the assistant manager and the registered manager. We also visited the head office and spoke with the human resources manager and training manager and reviewed eight staff recruitment files and training records.

Following the inspection, we contacted a representative of the local authority in the London borough of Lewisham to obtain further information about the home.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that some aspects of the premises were not safe. People were not always protected from risks associated with fire and the cleanliness of the kitchen was not sufficiently maintained. The provider sent us an action plan to tell us what changes they had put in place and we found this was followed.

During this inspection we found that all the fire doors were closed and not left wedged open. Fire door devices that closed doors to protect people from the risk of fire had been repaired. Refurbishments had been carried out to the kitchen and we saw that the kitchen was clean. Adaptations had been made to the kitchen worktop surfaces based on the recommendations of an occupational therapist. This included adjustments to the worktops in order for these to be raised and lowered for wheelchair users so they could prepare food at the safe and correct level.

People may not have always been protected from harm as medicines were not always managed safely. We looked at the way medicines were stored, administered and recorded. Medicines were stored in a locked cabinet and only the relevant staff held the keys. Cabinets held medicines such as ointments, liquids and tablets. However we found there were no thermometers or records for staff to check and record the ambient room temperature to ensure that medicines were being stored at the recommended temperature. Medicines should be stored at the correct temperature to maintain their effectiveness.

Tablets were held in the packets they were dispensed in. The registered manager told us they had liaised with the pharmacist to dispense people's medicines in blister packs rather than boxes to manage people's medicines more safely, but was told the pharmacist was unable to do this. We did a stock count on medicines but for one person we found that the stock count check list did not correspond and one tablet was missing. We checked the provider's audit but this was not identified. We recommend the provider review their current practice for monitoring and ensuring that medicines are stored safely at an appropriate temperature.

We observed people being given their medicines and the staff member gave us a detailed description of what each person's medicines were used for. For one person we observed they were given their medicines via a Percutaneous Endoscopic Gastrostomy (PEG) tube and this had to be flushed with water before their medicines were administered. However the tube came loose and would not reattach. The staff member contacted the appropriate practitioner to seek advice on how to rectify this. We saw records to demonstrate that all staff had received up to date medicines training and the staff member told us this was not a common occurrence.

People's medicines records held information such as a clear photograph of the person, a list of their medicines and what they were used for. Medicines records had been signed by staff to show these had been given and no gaps were found. There was a system in place for the disposal of medicines and this was safely managed.

Routine checks which helped to keep people safe were carried out. These checks included the general environment, fire detection equipment and drills, emergency lighting, adaptation and aids people used and legionella. This helped to ensure the premises were safe and emergency equipment would operate properly when required.

Infection control procedures were followed by staff. Before staff provided people with personal care and supported them with medicines, they washed their hands and wore personal protective equipment to prevent and minimise the spread of infection. The home was clean and free from malodour and cleaning and sanitising guidelines were available for staff.

One person and a relative told us they had no concerns about safety in the home. Information was available in the home about how to report abuse. The staff we spoke with told us the actions they would take if they suspected that people were at risk of harm. They had completed safeguarding training and the records we checked confirmed this. There had been two safeguarding concerns raised since the last inspection. Records showed the provider had liaised with the placing authority to ensure these allegations were investigated and resolved. Staff knew how to report workplace concerns if they suspected wrong doing and were able to explain what type of things they would report and to whom.

Risk assessments and the accompanying guidelines were in place to identify what could go wrong and to decide on the suitable control measures to prevent injury to people when being supported in and outside of the home. These contained instructions for staff to follow to ensure people's welfare and safety, for example, in relation to catheter care and behaviour support. Records showed that staff were required to support a person to wear protective clothing to prevent injuries from falls when being accompanied for walks outside the home. When this person went out for a walk with a member of the staff, we saw that these guidelines were followed.

Recruitment records for staff were held at the head office. We found that suitable arrangements were in place to ensure pre-employment checks were carried out by the provider. The human resources manager spoke about the recruitment process. They showed us information to evidence that right to work in the UK checks were up to date and these documents were regularly checked before they expired. Two references were on file for staff and there were written explanations for any gaps identified in their work history. Criminal record checks were undertaken so the provider could make informed and safe recruitment decisions. A record of checks along with an application form and interview questions were kept on staff personnel files.

There were enough staff deployed to support people in the home during the day and night and the rotas we checked evidenced this. The staff we spoke with told us there was enough staff to help support people in the home. When we arrived we were told that one staff member had taken unplanned leave. We observed that staff from another home arrived to cover the shift. Staff were available when people needed support with two to one care and when they needed to be supported in the community.

Good

Is the service effective?

Our findings

People received effective care as the provider worked with other services to achieve positive outcomes for them. Staff had access to specialist professional advice and guidance about people's nutritional and communication needs. We spoke with two speech and language therapists (SALTs) who came to assess two people's nutritional and communication needs. As part of the assessment one person was being supported by their relative to eat their meals while the SALT observed them. They gave guidance and advice to staff to follow on the person's food requirements to avoid the risk of choking. A second person was being supported with their speech and appeared visibly happy to see the SALT who told us they had worked with the person for a long time and knew them well.

Staff training was tailored to reflect the needs of people who used the service and the requirements of the role. The assistant manager explained they had been in post for two months and described the induction and mandatory training they had completed. We spoke with the training manager and a trainer from a college who worked in partnership with the provider to deliver face to face training to staff. They told us about the planned programme of training that staff had attended and the further training that would be available.

The training schedule showed that staff had received up to date training. This comprised of e-learning and classroom based training and showed when refresher training was due. Topics included risk assessing, first aid at work, moving and handling, health and well-being and Percutaneous Endoscopic Gastrostomy (PEG) feeding. The staff we spoke with told us they felt well supported by the management team and found them to be approachable. They further explained they had been supported with regular supervisions and appraisals and the records we reviewed confirmed this.

We checked to see if people had nutritious food and drink that is essential to good health outcomes. The home had a well equipped kitchen area, which people could use to prepare meals, drinks and snacks. We observed that people were supported by staff to prepare and eat their meals in accordance with their dietary plans. One person was being guided by staff on how to make their meals to help maintain their independent living skills. The person told us they enjoyed helping staff and liked to help staff "peel the potatoes". Adapted utensils such as plate guards and cutlery were used by some people during mealtimes. Drinks were readily available for people throughout the day and people ate where and when they chose.

People had access to healthcare services and received ongoing healthcare support. We saw evidence to show that people had been supported to attend a range of health related appointments and been given advice and treatment in relation to their medical needs. Appointment letters showed that people had been referred to have their needs assessed by health practitioners, such as the GP, psychologist and the optician. Oral healthcare plans were followed and we saw people were regularly supported to see the hygienist and dentist. Health Action Plans (HAPs) were held in people's files and contained information about their health needs, the professionals who supported them and an up to date record of their appointments.

We took a walk around the premises and found they were adapted and accessible for people who used

wheelchairs. The premises were laid out over one floor and adaptations were made to the building so people could access areas of the home with ease. Kitchen equipment had been installed and sensory aids were purchased for people with sensory impairments, such as those with limited vision and hearing. Equipment was installed to move and position people safely such as an electric hoist and bathrooms were adapted to be suitable for people's individual needs.

The provider followed the legal requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do 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 observed that staff sought people's consent before they offered them support and explained to them what they were going to do before they did this. For example, when giving support with their meals and medicines. Care records noted where people were able to make day to day decisions about care and support. Where people lacked the capacity to make specific decisions records showed that best interests meetings had been held in consultation with people's relatives and health professionals. We spent time talking with staff about how they obtained people's consent. They were able to tell us about the importance of obtaining people's consent and gave us examples of how they did this.

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 Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found that the necessary applications had been sent to the local supervisory body for DoLS but three applications were waiting to be authorised. We asked the provider to follow up on the applications that had been submitted to the supervisory body for three people.

After the inspection the provider sent us information to show that two applications for people were still awaiting approval. One person's application had been authorised by the supervisory body to deprive them of their liberty in their best interests. We emailed the registered manager to submit a notification to the CQC to inform us of the outcome of the DoLS authorisation for the person as required by law.

Good

Is the service caring?

Our findings

People were comfortable and relaxed with staff and the atmosphere in the home was pleasant and cheerful. One person told us they were "very happy" living in the home. Conversations between people and staff were respectful and explanations were provided to people when they asked staff questions. We heard people being offered choices and encouraged to express their decisions about what they wanted. Staff understood the requests of people who found it difficult to verbally communicate. When asked, staff members knew how people communicated different feelings such as being unhappy or in pain so that they were able to respond to these.

Staff we spoke with had a good level of knowledge about people and their life histories. This included people's pastimes and hobbies, how they communicated, and the people who were important to them. We saw an assessment of these needs was gathered and written in people's care plans when they first moved into the home. This information assisted staff to get to know the person and foster good relationships with the people they cared for.

The provider actively encouraged people to maintain contact with family and friends through arranged visits and telephone calls. One person had recently moved into the home and their relative told us their family member was taking time to adjust to their new surroundings but overall had settled in well. During our visit, relatives arrived to support their family members with their day to day routines and take them out on activities in the community.

People's care records made reference to their individual preferences. Their cultural and spiritual needs were recorded in their care plans in relation to their food choices, the events they attended and their preferred place of worship. They were given Information about their rights and responsibilities when they came to live in the home. Tenancy agreements were user friendly and informed people about their privacy in the home, valuing others and the right to live free from harassment and discrimination. This was to ensure they understood the expectations of living in the home and how they would be supported during their stay.

Advocacy services were available for people to access to enable them to express their views. An advocate is an independent person who acts on behalf of another person to put forward their views.

Staff sought the permission of a person before they showed us around their room. The person told us this was personalised to their liking. Staff knocked on people's doors and called their names before being granted permission to enter their rooms. Private matters about people were discussed discreetly and when staff helped people with their personal care this was carried out in privacy behind closed doors.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives had been involved in the assessment and care planning process. This helped to ensure people's needs were accurately assessed and their preferred options explored so they received personalised care. The areas covered in people's records included information about their mobility, communication, positive behaviour support, nutrition and their health care needs. We observed that staff anticipated people's needs and responded promptly to any requests for assistance.

However, one person's care records had not been reviewed for a significant period of time. Reviews of people's needs were to be undertaken with the relevant health and social care professionals and their relatives. Aspects of the person's care needs had not been reviewed to ensure they reflected their current circumstances. Their care plan showed their needs had not been reviewed since October 2016. The registered manager told us that this person had been in hospital and a review of their needs was to be undertaken with healthcare professionals. They agreed to follow this up.

After the inspection, the registered manager sent us information to show that there were up to date PEG feeding guidelines in place. In addition to this they sent us records to show that a review of the person's needs had been arranged on 4 January 2018. However there was no care plan to evidence the person's records had been updated.

Staff were required to complete daily notes to show the care people received and how they were supported with their daily routines. This information could be used to demonstrate that people had received care when this was needed and reviewed to support care planning. We checked these records over a period of one month and found some records were completed daily but some daily entries were incomplete. We pointed this out to the registered manager who agreed more thorough written records were required and agreed to address this with the staff team.

We recommend that people's daily care records and support plans are consistently reviewed to evidence that people receive safe care that is responsive to their needs.

The provider sought guidance from external professionals and followed up on any referrals in a timely manner. Guidance and advice was used to inform care planning with the aim of providing the best possible outcomes for people.

People were involved in a range activities and events to help prevention social isolation. The provider had good links with the local community and organised people's participation in, for example social clubs. Time had been spent to find out what meaningful activities were important to people and these were used to provide social stimulation for people and maintain their interests. Records showed that a person attended a work placement and had been involved in forums to express their views. A second person's record demonstrated that they regularly attended a day centre that met their specific cultural needs. We observed that people were taken out to enable people to participate in their interests, such as the day centre and the cinema as they wished.

One person told us they were happy in the home and had no concerns. Easy read information was available for people to ensure they understood how to make a complaint and this was available for people and their relatives. This included contact details of other organisations which people could escalate their complaint to, if they did not receive a satisfactory resolution. The provider had not received any complaints since the last inspection.

We found there were plans in place for two people about their end of life care. These plans took into account people's wishes and preferences, and how they wanted the people that were most important to them involved.

Good

Is the service well-led?

Our findings

There were a variety of systems to assess and monitor the quality of the service provided. These included team meetings, surveys, safety checks and audits on medicines, care planning and incidents. Records showed that audits had identified that some care records required updating, a requirement to reinforce guidelines with staff about people's support and the designated duties of waking night staff. However we found that audits had not identified gaps in safe medicines management.

Staff told us the home was 'lovely' to work in and spoke respectfully about the people they cared for. They said that guidance and instructions were written down for them to follow and that the registered manager was always available if they needed further support and advice. There was an on call system staff could use to contact the management team in the event they needed an immediate response to any concerns that arose out of hours. A member of staff explained it would be helpful if people's medicines were dispensed in blister packs to reduce any anomalies or errors but overall told us the service was well managed.

Team meetings were held with staff to discuss updates about changes to people's circumstances, their finances and the requirement for records to be legible records and kept up to date. In keeping with the legal requirements of the Mental Capacity Act, the registered manager had facilitated MCA training for staff during a team meeting. This was to help ensure any decisions made about the care people received were in their best interests.

A survey had been undertaken in 2016 on some of the provider's services to capture people's experiences about their care and support. The results were mainly positive, however there were some areas of improvement required. An action plan was written up to show that people with no next of kin would be supported with befrienders or volunteers to reduce social isolation and a decision was made that the survey for 2017 would be undertaken by an external organisation. This was being done to increase survey participation and ensure the provider was given honest and open feedback. The results for the 2017 survey were not available at the time of the inspection as the survey was in the process of being undertaken.

The provider worked in partnership with multi-disciplinary teams from the local authority and could access their training and seek guidance and support when this was needed. This helped staff keep up to date with key information and relevant changing legislation within health and social care.

It is a requirement that provider's display the rating we have given in a conspicuous place. The last Care Quality Commission (CQC) report was displayed in the home and on the provider's website. The provider is required by law to notify the CQC of important events which occur in the home to protect the safety of people who use the service and this was being done.