Ordinary Life Project Association(The)

Ordinary Life Project Association - 67a St George's Road

Inspection report

67a St George's Road
Semington
Wiltshire
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Tel: 01380870168

Date of inspection visit:
19 October 2018

Date of publication:
07 December 2018

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

At the last inspection on 27 September 2017, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance. We asked the provider to take action to make improvements in their auditing procedures.

Following the inspection, the provider wrote to us, to tell us the action they would take to meet legal requirements. At this inspection we found improvements had been made.

67a St Georges Road is a 'care home' registered to provide accommodation and personal care for up to three people with learning disabilities. 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. At the time of the inspection three people were living at the service.

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. Registering the Right Support CQC policy

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

People were safe. Staff understood their responsibilities to safeguard people and to report any concerns. Staff had received training to ensure they remained up to date with recognising the signs of abuse and what to do about it.

People were protected from risks. Where risks had been identified, risk assessments were in place with guidance for staff on action to take to manage the risks. Medicines were administered, stored and managed safely. Protocols were in place to manage 'as required' PRN medicines.

Staff had a good understanding of the Mental Capacity Act (2005) and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions.

People were treated as individuals by staff who respected people's diverse needs and individual preferences. Care plans were personalised and reviewed or updated when people's needs changed.

The home requested and gained feedback, all of which was positive. There was a complaints procedure in place and no complaints had been received in the 12 months prior to the inspection.

The staff spoke positively about the provider and the management team. The home manager felt supported by senior managers and the values of the service were evident throughout the staff team.

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.

We found that improvements had been made in the recording protocols for 'as required' medicines'. Medicines were administered and managed safely.

People were protected from risks.

There were sufficient, safely recruited staff deployed to meet people's needs.

Is the service effective?

Good

The service was effective.

People's needs were assessed and care planned to ensure their needs were met.

People were supported by trained staff who had the knowledge to support then effectively.

Staff were trained in the Mental Capacity Act (2005) and understood and applied its principles.

Is the service caring?

Good

The service was caring.

Staff were kind compassionate and respectful and treated people and their relatives with dignity and respect.

Staff encouraged and supported people to maintain skills and independence.

Recordings in care plans and daily records were written using respectful language.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and gave clear guidance for staff on how to support people.

People received care and support which was individual to their diverse needs.

People had their end of life wishes recorded.

Is the service well-led?

Good

The service was well-led.

The home had systems in place to monitor the quality of the service and care of people.

The staff and home manager felt well supported and values were shared across the whole staff group.

The home requested and gained positive feedback from relatives, visitors and professionals.

Ordinary Life Project Association - 67a St George's Road

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 was a comprehensive inspection and was announced. We gave the service two days' notice of the inspection visit because the people living in the home can become unsettled by the presence of an unannounced visitor. This gave the provider an opportunity to plan our visit with the people using the service. The inspection was carried out by one inspector.

Before the inspection we reviewed the information, we held about the service and the service provider. This included statutory notifications sent to us by the registered manager and their most recent provider information return form (PIR). Notifications are information about specific important events the service is legally required to send to us. A PIR is a document which provides information about the service such as what they do well and what improvements they plan to make.

We spoke with one relative, three care staff, the home manager, the residential services coordinator and the personnel officer. During the inspection we reviewed three people's care plans, daily records and carried out general observations of the care being provided. We reviewed records relating to the management of the service, including policies, procedures and staff personnel files. We looked at accident and incident reporting and quality assurance audits. Following the inspection one professional responded to our request for feedback about the service.

Good

Is the service safe?

Our findings

At the last inspection we found a breach of Regulation 17 good governance. Protocols for 'as required' (PRN) medicines were not in place. At this inspection we found the required improvements had been made. People's medicines records included PRN protocols for oral medicines and prescribed creams for topical application. The protocols included body maps, person centred instructions and guidance for staff on how and when to administer the medicine. All medicine administration records were completed fully. Medicines were stored safely with a separate area for medicines to be returned to the pharmacy. Stock checks were completed weekly and at every pharmacy delivery.

People were supported by staff who were knowledgeable about their responsibilities to report any concerns. One staff member told us, "Safeguarding is put in place to protect people, from sexual, financial physical or mental abuse. I would report it to the manager." Staff received annual safeguarding training and we observed the local authority safeguarding flowchart available for staff guidance. Staff were also aware of their responsibility to whistle blow but had not needed to make a report. Whistleblowing procedures ensure that they are protected from reprisals when they raise concerns of misconduct they have witnessed at work.

People were protected from risks. Care plans were personalised and contained clear actions and outcomes to guide staff on how to keep the person safe. We saw for one person, a comprehensive risk assessment to manage their epilepsy. This included a rating for the level of risk, detailing the severity and likelihood of a seizure. The assessment had recorded existing controls and measures in place to reduce the risks associated with a seizure and actions for staff to follow.

A choking risk assessment was in place which gave clear visual instructions on how to appropriately and safely thicken fluids and puree foods. The guidance to staff included ensuring the person was seated in an upright position whilst drinking and eating and to remain sitting for a recommended time once finished. Moving and handling risk assessments were also in place to ensure people were safe when using bathing equipment and when staff were using hoists and slings. The service had a record of environmental safety checks including testing of electrical and fire equipment.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. Pre-employment checks were completed. These included references, identity checks and DBS. A DBS check allows employers to make safer recruitment decisions and helps to prevent unsuitable people from working with vulnerable groups of people.

The staff we spoke with told us there were enough of them on duty to meet people's needs. The permanent staff group had been with the service for many years. The service relied on the use of agency staff to cover some shifts. However, many of them had worked in the home regularly, which meant the people they were supporting knew them well. The registered manager told us that they were continuously recruiting but there was continuity of agency and core staff.

People were protected from the risks of infection. Staff had training in infection control practices which

included the chain of infection, the management of linen and laundry and hand washing technique. We observed hand gels, paper towels and personal protective equipment (PPE) in place. The home was clean, tidy and smelt fresh. Staff guidance on safe hygiene practices were visible in the kitchen.

The service monitored accidents and incidents and reflected on them as a means of improving safety for people. At the time of our inspection there were no current episodes of accidents or incidents. Previous learning included a medicines error made by an agency member of staff. They had signed that the medicine had been administered however, following audit checks, it was found it hadn't been given to the person. The staff sought guidance from the GP. There was no urgency or safety issue but additional processes were put in place to prevent it re-occurring home manager contacted the agency and requested that the staff were re-trained and they checked the training of each new agency member of staff.

New guidance has been put in place to complete accident and incident forms. This included recording concise, factual and objective details and using additional evidence such as observation charts and body maps. All accident and incident forms were reviewed by the home manager and sent to OLPA head office to monitor and identify any themes or trends.

Good

Is the service effective?

Our findings

People's care records contained detailed information about their health and social care needs and had been assessed professionals involved in their care. Care and support plans reflected how each person wished to receive their care and gave guidance to staff on how best to support people. We saw evidence of people's choices, what was important to them and their preferred daily routines.

For example, one person liked to have a piece of cake offered at around 09.30 as they liked to eat their breakfast early at 06.30. Another person was given a choice of colours for clothes to be worn every day and they were encouraged to participate in dressing by making small movements to assist staff.

Community medical and nursing assessments had been completed detailing specific needs and guidance for staff on how to support the person appropriately. Positive behaviour support plans had been developed by specialists in the community team for learning disabilities. Guidance for managing epilepsy including an emergency plan and person-centred profile.

People's communication needs were recorded in their care plans. Staff were guided to use communication methods appropriate to meeting the 'accessible information standard.' This is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. For example, for one person the guidance for staff stated, '[person's] post will be opened in front of [them] and read out at a level appropriate to [their] understanding. Staff will ensure that as far as possible [person] understands and has retained any necessary information.'
Other methods used were pictures, gestures and guidance on ensuring a quiet area to minimise distractions.

People were supported by staff who had the skills to meet their needs. Staff training consisted of computer based e-learning and some face to face practical training. Provider mandatory topics included safeguarding, medicines administration, manual handling and first aid. In addition, staff also received more specialist training in areas such as sensory processing and meaningful engagement. Staff told us they had the opportunity to acquire their national vocational qualifications and diplomas in health and social care. These were work based occupational qualifications aimed at care staff, which involved written assessments and observation of practice. All staff completed a reflective learning log to embed their knowledge and test their awareness. Staff told us they were looking forward to new training in behavioural support and holistic planning which was being rolled out. Where they recognised a shortfall in their knowledge, staff told us they requested training and the registered manager ensured they were booked onto the relevant courses.

Staff received regular monthly one to one supervision with their line manager. Each member of staff had a supervision contract which detailed responsibilities and expectations to be gained from sessions. The staff we spoke with told us they could access one to one informal guidance and supervision at any time. Staff were also supported with an annual appraisal to discuss their progress and future plans for development.

People were offered a choice of meals and staff knew people's preferences. We observed people being offered and supported to have regular drinks and snacks. One person was being assisted to eat their breakfast and was patiently supported to finish a full bowl of porridge and a whole cup of tea. The person was encouraged to use the spoon themselves and once tired the staff member checked if they wanted some help. The staff member told us that this person's appetite had reduced recently and they were encouraging them to maintain their intake. We saw that where appropriate people had fluid intake charts to ensure they were well hydrated.

The home had been adapted to meet the needs of the people living in it. There were ramps into and out of the property for the use of wheelchairs. A new wet room had been built and the kitchen was to be re-furbished as part of the housing associations improvement plans. Internal improvements to the flooring and decoration were planned. There was a large open access garden with a flat paved area for people to sit and enjoy the outdoors safely and in privacy. People's private spaces were decorated and furnished with their own belongings and to their preferences.

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.

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.

Staff had a sound knowledge of the Mental Capacity Act (2005) and how to apply its principles in their work. We saw appropriate mental capacity assessments and associated best interest's decisions were in place. The residential services co-ordinator told us one person had a Lasting Power or Attorney (LPoA) for finance and property and two people had appointeeships for financial management. One person had been supported by an Independent Mental Capacity Advocate (IMCA) in line with the legislation. This person had an authorised DoLS in place and others were in the application process. Reviews were carried out regularly to monitor the appropriateness of restrictions in place, such as bed rails and bumpers.

Good

Is the service caring?

Our findings

People were supported by staff who had developed a knowledgeable and caring relationship with them. We observed very gentle and kind interactions. One person was being supported to prepare for breakfast. The staff member continually spoke with the person, explaining what was happening throughout. For example, "could you just lift your head for me please? That's better. I'm just going to put your apron on now [person's name]."

This person was encouraged to use the spoon themselves to eat breakfast and we observed the staff member intervening at times when they needed assistance. The staff member used gentle strokes on the person's cheek (as well as talking) to assist with chewing and swallowing and to encourage them to open their mouth. When the person became tired the staff member took over and very patiently waited for the person to chew and swallow, saying "well done, that's a far better effort [person's name]."

The staff member told us that the person could understand what was being said but chose mostly not to speak. They explained to the person what the speech and language therapist had recommended and encourage the person to follow their own guidelines. For example, "'if you can drink that much on your own. I will help you with the rest, do you think you can manage that [person's name]? Remember, head back and lift it up, well done [person's name]." Each interaction was patient and un-rushed, giving the person time to manage parts of the tasks independently.

Another person was given lots of positive and up-beat encouragement to drink their tea independently, "look at this, brilliant." There was lots of eye contact, gentle and friendly chat and involvement in conversation. There was regular engagement with another person, doing exercises and making gestures and faces, having fun with laughter.

The staff we spoke with told us that one person had begun to communicate more noticeably, holding their eye contact and being more aware and involved in their surroundings. They felt this was because they were more content and calm and that it was as a result of the stability of the home and the staff team. This was reported to us in a very compassionate way, the staff felt a sense of fulfilment recognising this positive change in the person's behaviour.

Some of the people living at the home were not able to fully participate in their care planning, however, where they were able to make choices these had been recorded. For example, people had been involved in choosing colours for the rooms when they were re-decorated. People were regularly offered choices of food, where to go and what to do as an activity. People were able to respond in different ways, using vocal sounds and gestures, which the staff were able to interpret.

For people who were unable to fully communicate, we observed their behaviour and demeanour. People appeared to be relaxed and calm in the presence of the staff and where able, freely moved around their home. The home had a calm and homely atmosphere.

Care and support plans were written using respectful language and description. Daily notes were also written in a kind and dignified way, stating choices offered and preferences recorded. For example, "awoke singing…chose to watch TV, having a laugh and a joke", "person was in a very good spirit, and her mood was lots of laughs and smiles. Of her choice, wanted to listen to her favourite music" and "[person] was very tired today, evening personal care carried out, left quiet and comfortable with TV on and lights out." Daily notes also detailed dignified language to describe personal care tasks and continence care.

People's privacy and dignity were respected. For example, in one person's care and support plan there was privacy guidance stating, 'please remember to respect [person's] privacy and dignity by closing [their] bedroom door and the bathroom door when assisting with personal care'. People also had a hospital passport with guidance for hospital staff on how to understand, treat and care for the person in a dignified way which met their specific needs. We heard staff speaking about the people they supported in a respectful and affectionate way.

A relative we spoke with was positive about the care their family member received stating, "[person] has always looked good with the way they dressed, and given the pampering she liked, and always looks clean." A visiting professional wrote, "They get a lot of one to one time here, they are looked after well and well cared for." The staff we spoke with had worked for OLPA for many years, one staff member had taken a break and had returned as they "enjoyed it so much."

Good

Is the service responsive?

Our findings

Each person had an individual weekly planner displayed on the notice board and in a daily file, colour coded for indoor, planned outings and outdoor everyday activities. A daily record of various activities and the person's involvement or enjoyment was noted. One person enjoyed a game of connect 4 and their involvement was described as 'full and willing'. Another entry of drawing described 'reluctant, but when encouraged took hold of the pencil'.

We saw occupational therapy recommendations and guidance on 'the importance of meaningful activities'. This included leisure activities such as reminiscence using photographs, reading or being read to, as well as everyday personal self-care tasks. The aim was to maintain skills, build satisfaction and a sense of achievement thereby improving their quality of life. We observed guidance in action when a person was given verbal praise and prompts and continued encouragement.

We saw that one person was supported to maintain family relationships. Their weekly routine included outings in the car, visits to important places for the family, holidays and spending time together at Christmas. People were using a local hydrotherapy pool weekly and records showed how much they benefited and enjoyed the experience.

Daily records show where people needed assistance or how much they were able to do for themselves, for example loading a spoon independently or being fully assisted. Some people had regularly recorded skin care and position charts to highlight any changes to their condition. Care plans were reviewed regularly and updated when any changes occurred.

One person had a comprehensive positive behaviour support plan which had been regularly reviewed and had shown no changes since 2015. It was agreed with professionals at a multi-disciplinary meeting that this was no longer required. Epilepsy profiles and management plans had recently been devised by the specialist nurse from the community team for people with learning disabilities for two people at the service. There had been changes to one person's experience of seizures and required treatment. The updated plans alerted staff to the new actions required.

The staff worked with professionals such as speech and language therapists, occupational therapists and specialist nurses to ensure people received ongoing health and social care support. The home had a regular visiting GP and people had access to community healthcare services such as podiatry, community nurses and opticians. People had up to date health screening assessments such as for bowel cancer and an annual flu jab. There was evidence in one person's care and support plan that staff had contacted their GP as they had been losing weight. A referral to the dietician resulted in weight increase following the use of prescribed build up drinks and when the person's weight had stabilised they changed, as directed, to fortified meals.

We saw that people had received their Cardiff health checks annually. This is a comprehensive physical and mental health check specifically developed for people with learning disabilities. Each person had a diary of health appointments attended and forthcoming.

The service had a complaints policy and procedure in place. There was guidance to staff on how to manage any complaint or concern in the first instance from a person using the service and any other person visiting the service. If the complainant was dissatisfied with the levels of staff the complaint has been passed through, the complaint would be passed to the Chief Executive who would respond in writing within five days. The registered manager told us they had not had any complaints within the past 12 months. One relative told us, "[my relative] has been here for a few years and I have never had to complain about anything."

Each person had a 'living well' care plan to record their thoughts and plans for end of life care. The plans contained recorded details of the person's life history, important memories and important relationships. Specific questions were asked, for example, 'what would you like to do towards the end of your life? And 'who would you like to say goodbye to?' People had recorded detailed preferences and personalised information. At the time of our inspection no-one was receiving end of life care.

Good

Is the service well-led?

Our findings

At the last inspection we found a breach of Regulation 17 good governance relating to auditing procedures. At this inspection we found that the relevant improvements had been made. There were auditing and quality checks in place which were conducted monthly. There were several layers of checks ranging from staff up to senior management and OLPA's own quality team. This meant there were checks and balances in place to monitor the provision of service.

People's keyworkers carried out a quarterly audit of the care plan for the person they support. We saw a comprehensive checklist of areas to audit and a template which guided the keyworker to identify any changes, develop actions and communicate them. For example, the updating of sections to reflect the person's changing needs would be communicated to all staff via team meetings, handover and the communication book. The home manager had a robust 'self-assessment audit' in place with guidelines from OLPA's central management team to complete and forward this monthly. The audits were then returned with any actions for the home manager to undertake.

The service had a clear vision and set of values to promote person centred care which was evident throughout the staff group. The statement of purpose highlighted the mission and objectives of the service which included, recognising the diversity, values and human rights of people and provision of enabling support in their own home within the community.

The home manager told us they had been employed by OLPA for over 20 years and they had worked their way up from being a support worker to a registered manager in a different service. The home manager had submitted an application for registration which was being assessed for this service. As they will have a dual registration, a senior support worker post was being advertised to act as a second level of leadership within the home.

The home manager told us that they "loved the team, we are like one big family and get on well together". The staff were described by the home manager as being a "tight team" and "gaining in confidence of how things could improve for people." Part of her improvement plans were to be more flexible in using staff resources from neighbouring homes in order to enable people to go out more. A staff member told us that they were very happy that after a long time, the whole home were able to go out for an afternoon together due to the flexibility of staff. They told us that the home manager had made this possible. They said, "I think they really did enjoy it. All out together the plan is that next summer we can do it again, share a van from another home."

The home manager told us about her experience of OLPA. "Anything was possible for people, if we were willing to do it, then managers were, most people did over and above." These values had stayed with her and influenced her management style. "Leading by example, be open up front and encourage the team and breakdown barriers."

The home manager also felt very supported by their senior team. They said "[senior manager] is the best, I

can go to her with anything. Supervision is twice monthly, going down to once per month formally and also informal, I can text her, ring her, even when [senior manager] is off duty [they] check their phone." The home manager told us that there was 'transparency' in OLPA and they could talk openly in managers meetings.

The service requested and gained feedback from staff and visitors to the service. Family members were invited to take part in people's reviews and visitors fill out questionnaires. The feedback we saw was positive and stated how well people were looked after. Feedback from visitors included, "very welcoming helpful staff, residents appear relaxed and content" and "Very homely. Very well-run care home with a nice ambient atmosphere, very happy with [relative] staying here. Efficient and competent staff." One relative we spoke with said, "I have never found fault with 67A or the staff."

The home manager was in the process of developing a new business plan for 67a St George's Road with improvements to all areas. Some of these included a personalised activity planner for people, accessing the community more, staffing and training. The service works in partnership with other agencies including health services, Wiltshire Council and the Housing Association who provide the premises. The home manager told us that they have good relationships with them all.