Ashcroft Care Services Limited

Flint Cottage

Inspection report

Kingsmill Lane
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Surrey
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection and took place on 1 November 2016.

Flint Cottage is registered to accommodate a maximum of four people with learning disabilities. The home is situated in a rural location close to South Nutfield in Surrey. At the time of inspection the home was fully occupied.

At the time of our inspection the home 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 and associated Regulations about how the service is run.

In October 2013, our inspection found that the service met the regulations we inspected against. At this inspection the home met the regulations.

Flint Cottage had a warm, welcoming atmosphere with people freely coming and going as they pleased. People's body language showed that they enjoyed the way that staff provided care and support for them and living at the home. People engaged in a variety of activities. They chose their activities themselves, when they wanted to do them and with whom. They were safe in the home and the local community. There was positive interaction between people using the service and also with staff.

People were provided with information about any activities taking place so they could decide if they wanted to join in. Staff provided care and support in a friendly, professional and supportive way that was focussed on people as individuals. Staff told us they knew people who use the service and their likes and dislikes well. Staff were well trained, had appropriate skills and were accessible to people. They said they enjoyed working at the home and had received good training and support from the manager.

The home records were accessible, kept up to date and covered all relevant aspects of the care and support that people received. This included the choices people made, activities they attended and the way their safety was protected. People's care plans were completed and the information contained was regularly reviewed. This enabled staff to perform their duties competently and efficiently. People were encouraged and supported by staff to address their health needs and had access to GP's and other community based health professionals. People were supported to be healthy by choosing nutritious, balanced meals that promoted a healthy diet whilst taking into account their likes, dislikes and preferences. This meant people were protected from nutrition and hydration associated risks. We saw that people enjoyed the meals provided and that they were of good quality with plenty of choice.

Relatives told us the manager and staff were approachable, responsive and listened to them. The quality of the service provided was consistently monitored and assessed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safe and treated with respect and dignity. There were effective safeguarding procedures that staff understood, used, and assessments of risks to people were in place.

There was evidence the home had improved its practice by learning from incidents that had previously occurred and there were enough staff to meet people's needs.

Staff had been recruited in a robust way with appropriate checks carried out.

People's medicine was safely administered and records were completed and up to date. Medicine was regularly audited, safely stored and disposed of.

Is the service effective?

Good

The service was effective.

People's support needs were assessed and agreed with them. Staff were well trained.

People's food and fluid intake and diets were monitored within their care plans and people had access to community based health services.

The service had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures. Staff who were suitably trained carried out mental capacity assessments for people. Staff arranged 'best interests' meetings for people as required.

Is the service caring?

Good

The service was caring.

People were valued, respected and involved in planning and decision making about their care. People's preferences for the way in which they wished to be supported were clearly recorded.

Staff provided good support, care and encouragement to people. They listened to, acknowledged and acted upon people's opinions, preferences and choices.

People's privacy and dignity was respected and promoted by staff. Care was centred on people's individual needs. Staff knew people's background, interests and personal preferences well and understood their cultural needs.

Is the service responsive?

Good

The service was responsive.

People decided if they wished to join in with a range of recreational and activities at home and within the local community during our visit. Their care plans identified the support they needed to be involved in their chosen activities and daily notes confirmed they had taken part.

The home had a complaints procedure and system and relatives said that any concerns raised were discussed and addressed as a matter of urgency.

Is the service well-led?

Good

The service was well-led.

The service had a positive and enabling staff culture. The manager encouraged people to make decisions and staff to take lead responsibility for specific areas of the running of the service.

Staff said they were well supported by the manager.

The quality assurance, feedback and recording systems covered all aspects of the service constantly monitoring standards and driving improvement.

Flint Cottage

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 checked 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 an unannounced inspection and took place on 1November 2016.

The inspection was carried out by one inspector.

During the visit, we spoke with three people who use the service; although as three people were none verbal and the other person part verbal we focussed our findings on observation. We spoke to three relatives, two care staff and the registered manager. We also spoke to three health care professionals. There were four people living at the service.

Before the inspection, the provider completed a Provider Information Return (PIR). 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. We also considered notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed care and support, was shown around the home and checked records, policies and procedures and maintenance and quality assurance systems. We also looked at two personal care and support plans for people using the service. We also checked two staff files.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People were safe living at the home and we saw that there was no pressure on them to do things they did not want to. This was reflected in the way people using the service were encouraged to choose what they wanted to do and when. One relative said, "He (Person using the service is very safe."

Staff were aware of how to raise a safeguarding alert and had been trained to do so. There was no current safeguarding activity. Previous safeguarding alerts had been appropriately reported, investigated and recorded. People were advised and supported by staff about how to keep safe. Staff had access to information and guidance about how to do so. Staff had received training in assessing people to take acceptable risks, at home and in the community.

Staff knew what constituted abuse and the action to take if it was encountered. Staff had access to policies and procedures regarding abuse and they had received induction training that helped them identify if abuse was taking place. This meant people were safely protected from abuse and harm.

The staff recruitment procedure was thorough and all stages of the process were recorded. The process included advertising the post and providing a job description and person specification. Prospective staff were short-listed for interview. The interview contained scenario based questions to identify people's skills and knowledge of learning disabilities. References were taken up and Disclosure and Barring Services (DBS) security checks carried out. This was before staff started work. There was also a six month probationary period. If there were gaps in people's knowledge the organisation decided if they could be filled and the person employed. Staff received a handbook that contained disciplinary policies and procedures. The staff rota showed and staff confirmed that staffing levels were flexible to meet people's needs. The staffing levels during our visit enabled people's needs to be met and the activities they had chosen to be pursued safely.

Each person had a care and support plan that contained risk assessments enabling them to take reasonable risks and enjoy their lives in a safe way. The assessments included home and community based activities. The assessments were regularly reviewed and adjusted if people's needs and interests changed. Staff had access to information contained in people's care plans that enabled them to accurately risk assess people's chosen activities. They were able to evaluate and compare risks with and for people against the benefits they would gain. This was demonstrated by the way people were enabled to access community based facilities. There was also general risk assessments for the home and equipment used that were reviewed and updated. Equipment was also regularly serviced and maintained.

The staff team shared information regarding individual risks to people. This included discussing any incidents or planned activities during shift handovers and at staff meetings. Accident and incident records were kept up to date. Staff said they were familiar with people living at the home, their routines and were able to identify the situations which might put people at unacceptable risk or make them feel distressed. This meant they could take action to minimise risks and not put people in situations they may not be comfortable with.

Medicine was safely administered and the records were completed and up to date. Records were regularly audited and medicine properly stored and disposed of. Staff were trained to administer medicine and this training was regularly updated.

Good

Is the service effective?

Our findings

Staff supported people to make their own decisions regarding how and when care and support was delivered. Their relatives told us the care and support people received from staff was provided in the way that they liked and needed. One relative said, "My son is very happy." Another relative told us, "He gets lots of attention."

Staff were provided with induction and scheduled annual mandatory training. This was identified in the training matrix. Training encompassed the 'Care Certificate Common Standards' and included manual handling, infection control, health and safety, first aid, food hygiene, equality and diversity and the person centred care approach. New staff also spent a minimum of two weeks shadowing more experienced staff. Staff meetings included situations that may identify further training needs. Supervision sessions and annual appraisals were also used to identify any gaps in required training. There were staff training and development plans in place.

The care plans contained areas for health; nutrition and diet that included nutritional assessments that were completed and regularly updated. The home kept weight and fluid charts of people if required and staff monitored the type of meals and how much people had to eat to encourage a healthy way of living and diet. The care plans also contained information regarding the type of support people required at meal times. Staff told us that if they had concerns about people's health, they were raised and discussed with the person and their GP. Staff had access to meal guidelines for each person and provided nutritional guidance and advice. There was access to community based nutritional specialists who reviewed nutrition and hydration needs as required. The records showed that referrals were made to relevant community based health services and they were regularly liaised with. People also had annual health checks.

People chose the meals they wanted, participated in food shopping and could change their minds at any time with alternatives provided. Meals were timed to coincide with people's activities and their wishes. Staff monitored peoples meals to make sure they were served at the correct temperature.

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 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).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted and the provider was complying with the conditions applied to the authorisation. Best interests meetings were

arranged as required. Best interests meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The capacity assessments were carried out by staff that had received appropriate training and recorded in people's care plans. Staff received mandatory training in The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood their responsibilities regarding the Mental Capacity Act 2005 and Deprivation of liberty safeguarding. Staff continually checked that people were happy with what they were doing and activities they had chosen throughout our visit. People's consent to treatment was regularly monitored by the home and recorded in their care plans.

The organisation had a de-escalation policy and procedure should people demonstrate behaviour that may challenge, that staff had received training in. Any behavioural issues regarding people who use the service were discussed during shift handovers and staff meetings.

The service had contact with organisations that provided service specific guidance regarding providing care and support for people with learning disabilities so that best practice could be followed.

Health care professionals we spoke with said that the home provided an effective service that met people's needs.

Good

Is the service caring?

Our findings

Relatives told us that people liked the staff. This was confirmed by their relaxed body language towards staff during our visit. People's body language also indicated that they were happy in the environment in which they lived and with the way staff supported them and provided care.

Relatives said that staff treated everyone with dignity and respect, were friendly and kind and provided the support that was required. The staff care practices reflected this and there were many instances of positive care practices when we visited. People were encouraged and enabled by staff in a friendly and positive way that made people comfortable when communicating with staff. Staff treated people as their equals, did not speak condescendingly to people and treated everyone in an equal way, giving them the same care, support and as much time as they wished to have their needs met. Staff listened to what people were telling them, valued their opinions and acted on them in a patient and friendly way. The support they provided was caring and helpful. A relative told us, "The service is very good and we are very pleased."

Staff had been trained to acknowledge people's rights to dignity and being treated with respect. This was reflected in the caring, compassionate and respectful support staff provided. There was a relaxed, inclusive and pleasant atmosphere for people due to the approach of the staff.

The home had a confidentiality policy and procedure that staff said they understood, were made aware of and followed. Confidentiality was included in induction and on going training and contained in the staff handbook.

People were encouraged to make decisions about their lives and staff met their needs in a relaxing and supportive way. Staff demonstrated skill, patience and knew people, their needs and preferences well. People were communicated with by staff at a pace and in a way that made it easy for them to understand and enabled them to make themselves understood. Where people had difficulty expressing themselves staff listened carefully and made sure they understood what the person was telling them. Staff gave people choices by asking people what they wanted to do, when and who with.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of the person they were visiting and other people using the service.

Good

Is the service responsive?

Our findings

Relatives and health care professionals confirmed that people's needs were met in a supportive and friendly way that they enjoyed and were comfortable with. Staff encouraged people to give their views, opinions and to decide things for themselves. They listened to people and made themselves available to discuss any wishes or concerns people might have. During our visit people contributed to decisions made about their care and activities. Their needs were met and support provided promptly. The appropriateness of the support was reflected in people's positive responses to verbal and physical contact with staff. One relative said, "I'm bedbound and they bring him to see me." Another relative told us, "He is always happy to go home after visiting, which is a good sign."

If people had a problem, it was discussed with them and if appropriate their relatives, resolved quickly and in an appropriate way. Records also showed that people and their relatives were asked for their views and opinions. People were supported to put their views forward, including any complaints or concerns.

There was a policy and procedure that stated people and their relatives would be consulted and involved in the decision-making process before moving in and staff understood and explained the procedure. Service commissioners forwarded assessment information to the home, which also carried out pre-admission assessments with a behavioural specialist. People were invited to visit the home as many times as they wished before deciding if they wanted to move in. Information from any previous placements was requested if available. Staff said they also sought the views of people already living at the home, regarding a new placement. During the course of people visiting the manager and staff would add to the assessment information.

People and their relatives were provided with written information about the home and organisation and regular reviews took place to check that the placement was working for them. Staff told us about the importance of recognising people's views as well as those of relatives so that care and support could be focussed on the individual. Placement agreements were based upon the home's ability to meet the needs of the individual, safety of other people staying at the home and the support that could be provided. Placements were reviewed after six months and if not working, alternatives were discussed and information provided to prospective services where needs might be better met.

People's care plans were developed with them and their relatives and people were encouraged to contribute to them. If practicable they were signed by them or their representatives as appropriate. The care plans were part pictorial to make them easier to understand. They recorded people's interests, hobbies, health and life skill needs and the support required for them to be fulfilled. They were focussed on the individual and contained people's 'social and life histories'. The care plans were live documents and added to when new information became available. The information gave the home, staff and people using the service the opportunity to identify activities they may wish to do. People's needs were regularly reviewed, re-assessed with them and their relatives and care plans re-structured to meet their changing needs. The care plans were individualised, person focused and developed by identified lead staff. People were encouraged to take ownership of the plans if practicable and contribute to them as much or as little as they wished. They

agreed goals with staff that were reviewed, underpinned by risk assessments and daily notes confirmed that identified activities had taken place.

Activities were a combination of home and community based. Each person had their own activity planner. One relative said, "The home keeps us informed of what is going on." The home made use of local community based activities wherever possible and people chose if they wanted to do them individually or as a group. Activities included trampolining, cycling, carriage horse riding, garden centre visits, sensory therapy and reflexology. One person returned from playing bowls during our visit. They also had lunch out. Other activities included, visits to the cinema, walks, a disco for people with learning disabilities and the pub. People were also going to attend a fireworks display later on in the week. Outings had taken place to Brighton, Chessington, Worthing and parks in Crawley. One relative told us, "Always plenty to do." People were also encouraged to do tasks in the house to develop their life skills such as laundry, hoovering, tidying their rooms and helping prepare meals. People's positive body language demonstrated that they were enjoying the activities they were taking part in during our visit.

Relatives had been made aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly. They were also aware of their duty to enable people using the service to make complaints or raise concerns.

Good

Is the service well-led?

Our findings

People's body language showed they were comfortable with the manager and staff. This was also confirmed by relatives. Relatives were confident that any concerns they may have would be addressed. One relative told us, "They keep us informed about what is going on." The home had an open culture with the manager and staff paying attention to people, what they wanted and acting accordingly.

The organisation's vision and values were clearly set out. Staff we spoke with understood them and said they were explained during induction training and revisited during staff meetings. The staff practices we saw reflected the organisation's stated vision and values as staff went about their duties.

There were clear lines of communication within the organisation and specific areas of responsibility that staff were aware of. Staff told us they received good support from the manager and their suggestions to improve the service were listened to and given serious consideration. Staff said they enjoyed supporting people using the service and working at the home. One staff member told us, "There is a very good staff team who communicate and work together."

There was a whistle-blowing procedure that staff knew how to access. There was a career development programme that enabled staff to progress towards promotion in a way that was tailored to meet their individual needs.

Regular monthly staff meetings enabled staff to voice their opinions. Records demonstrated that staff supervision took place every six to eight weeks and annual appraisals were carried out. This was confirmed by staff.

There was a policy and procedure in place to inform other services, such as district nurses, GPs and physiotherapists of relevant information should services within the community or elsewhere be required. Our records showed that notifications were made to the Care Quality Commission as required and in a timely way. Accidents and incidents were fully investigated, documented and procedures followed correctly including hospital admissions.

There was a robust quality assurance system that contained performance indicators which identified how the home was performing, any areas that required improvement and areas where the home was performing well. This enabled required improvements to be made. Areas of particular good practice were also recognised by the provider. Relatives and staff satisfaction questionnaires were also sent out, although the results were not available.

The home used a range of methods to identify service quality. These included monthly provider visits that focussed on a particular area such as, files maintenance, care plans, night reports, risk assessments, infection control, the building, equipment and medicine. An annual review took place of all aspects of the service provided. There were also manager and staff checks that included weekly health and safety and vehicle checks, people's personal money records, water temperatures and people's support records. Shift

handovers also included information about each person.