Enable Care & Home Support Limited

Larch Road

Inspection report

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Date of inspection visit:
25 July 2016

Date of publication:
22 September 2016

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 inspection took place on 25 July 2016 and was unannounced.

Larch Road cares for people with a learning disability and is registered for 8 people. On the day of our inspection there were 7 people living there. The registered manager had retired in February 2016 and had not yet been replaced. However, the provider had put interim management arrangements in place and the service was being managed by an interim manager with support from a registered manager from the wider organisation, until a new registered manager was appointed. 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 cared for by qualified staff who understood their responsibilities to keep people safe from harm. There were risk assessments in place which were reviewed regularly and helped ensure people were protected from identified risks. There were sufficient numbers of trained staff on duty to meet the needs of people using the service. Staff who administered medicines were suitably trained and their competency checked, to ensure they had the knowledge and skills to manage medicines safely.

Staff received appropriate training for their job role and had frequent supervisions and appraisals with the managers. Training was arranged in response to the particular needs of people using the service and ensured that staff had the knowledge and skills to fulfil their responsibilities to people. Staff gained consent from people before starting care and explained what they were doing in ways that people understood. People were involved in planning their meals, which included shopping and preparing meals or setting tables. People were supported to access community healthcare services to manage their overall health.

People were cared for by caring and compassionate staff who enjoyed their work. Staff spent time getting to know people and their personal characteristics. They developed positive and supportive relationships with people, whilst promoting independence and dignity. People contributed to their care plans and made decisions about their daily activities and meals.

There was an open and inclusive culture within the organisation where staff and people felt supported and heard. The provider and wider organisation were going through a period of transition and there was an element of uncertainty for some staff regarding their future roles. However, staff continued to provide good quality care and support for people using the service.

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 received care from suitably trained staff who understood their responsibilities to keep people safe from harm. There was sufficient staff to meet the needs of people using the service. People received their medicines from trained and competent staff and medicines were stored and managed safely.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and support to enable them to care for people effectively. Staff gained consent before caring for people. People were involved in menu planning and in the preparation of meals.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and compassionate and enjoyed their work. Staff developed positive, supportive relationships with people based on mutual respect. People's dignity and independence was promoted by caring staff.

Is the service responsive?

Good

The service was responsive.

People contributed to their care plans and made decisions about their daily lives. Staff spent time getting to know individuals and their preferences and developed personalised activities that people enjoyed.

Is the service well-led?

Good

The service was well led.

There was an inclusive and empowering culture within the organisation, where people and staff were able to comment and make suggestions. There was good visible leadership and staff felt supported and motivated. There were effective quality assurance systems in place that were used to improve the service and care of people.

Larch 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 inspection took place on 25 July 2016 and was unannounced.

The inspection team consisted of an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the person had experience of caring for someone with a learning disability.

Before the inspection, we asked the provider to complete 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. As the provider returned this form we used this when planning our inspection. We also contacted commissioners for feedback before the inspection and viewed notifications sent to us by the provider. Notifications are events or incidents that the provider must tell us about under the terms of their registration.

In order to gather information during the inspection we spoke to six people who used the service, five staff including the manager and a visiting nurse. We observed interaction between staff and people using the service. We also viewed three staff files, three care plans, person centred records and various management records; including rotas, training records, meeting minutes and medicine audits.

Good

Is the service safe?

Our findings

People told us they felt safe living at Larch Road. One person told us, "Staff look after me, they help me", another person said, "I'm happy here". Staff told us they had annual safeguarding training and knew how to report any concerns they had to keep people safe from abuse. Staff told us they felt confident the senior managers would respond to any concerns they raised. They also said they would report it to the local authority or the Care Quality Commission, if they felt their concerns were not being acted on and a person was at risk of harm or abuse. We viewed training records that demonstrated that staff had regular training in safeguarding and our conversations with staff demonstrated that staff knew how to respond to any concerns. This meant people were protected from the risk of abuse and avoidable harm.

People told us they were involved in reviewing their care plans and risk assessments and we saw evidence in care records of discussions with people about their care needs and how to manage any known risks. For example, in one record there was evidence of a discussion regarding safety when bathing and using bathroom aids, which clearly involved the person. Staff told us that two staff were available to support with bathing when mechanical aids were used, and one person told us, "We only have a bath when staff are with us". In another care plan we saw evidence of a discussion between staff and a person who required assistance when walking long distances. The records confirmed that a wheelchair would be taken if they go on a trip in the mini-bus, where the person may have to walk longer distances than they do at home. This meant that risks to people were identified, reviewed and managed in order to keep people safe from harm, whilst respecting and supporting their freedom as much as possible.

Staff told us they felt there were enough staff on duty to care for people safely. Where required people had two staff assisting them with moving and staff also provided 'sleep-in cover' or 'waking night' cover to meet individual need at night and keep people safe. One staff member said it would be nice to have more staff available so they could provide more trips or outings for people, because it sometimes required 3 or more staff when taking a larger group of people. However, we noted from speaking to people, from daily records and person centred plans that people did attend activities and events with the support of staff, but in smaller groups or individually. We heard a conversation between the manager and a person who was going out on a trip the next day. The manager was heard to say, "We're going to the market tomorrow, would you like me to take your wheelchair in case you get tired". The person replied, "Yes please, I might need a rest, I don't think I'll be able to stand too long". This meant that staff had considered how they could continue to offer a varied programme of activities with a small team of staff, whilst still managing known risks to people.

We saw records that demonstrated that staff were recruited safely. Before caring for people, staff completed an application and interview where their skills and experience were assessed. This was followed by pre-employment checks which included providing references and agreement to a disclosure and barring service check. In addition, new staff completed a supported induction when they started work to learn about their role and the people they would be caring for. Staff confirmed they had completed an induction period which they said helped them understand their role and the organisation. This meant that staff were assessed to be suitable to care for people and were introduced to the safe working practices of the organisation before they cared for people.

Medicines were managed safely. We were shown the medicines storage arrangements, medicine records and audits carried out by the manager. We saw that errors had been identified by the manager and saw evidence that this had been followed up with discussion with the pharmacist and with staff in team meetings and supervisions. The manager explained how they had reviewed the auditing process for medicines and showed us the old and new process which had recently been introduced. We saw that the new process was more robust and gave a clearer account of stock control, medicine administration and management. This demonstrated that people received medicines safely and as prescribed.

Good

Is the service effective?

Our findings

People were cared for by staff who had the knowledge, skills and experience to carry out their role. We saw evidence in staff records of training completed and in team meetings of discussions regarding good practice. Staff told us that training was useful and helped them improve their skills and knowledge, especially when it was related to the specific needs of people using the service. For example, staff had completed training on dementia which they said helped them understand the condition better and enabled them to provide more personalised care to people living with dementia. A staff member told us, "The dementia training helps us understand and care for people better". This meant that staff had the knowledge and skills to meet people's needs.

Staff told us they had supervision regularly and we saw records that demonstrated that supervision took place every six weeks in line with their policy. A staff member told us, "I have supervision every six weeks with the manager, I can bring anything to this meeting, it helps me understand my role". Another staff member confirmed they had regular training to keep them updated on latest guidelines and good practice, they said, "This company has their training sorted". Training records demonstrated that staff had regular training which included safeguarding people and person centred care. We saw staff put this into practice with their interactions with people and was central to the care people received. This meant staff were supported to develop and improve their knowledge and skills, in order to care for people effectively.

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 observed staff asking for consent from people before offering care. Staff were heard to say to people, "Would you like me to help you with that", rather than just taking over. We also saw staff asked for consent from people before entering their room to take laundry back. Where people lacked capacity to make some decisions we saw 'best interest meetings' had been carried out. For example, when one person who lacked capacity to make financial decisions told us, "I bought my own chair"; we checked the records to find that a 'best interest meeting' had taken place before the chair was purchased. This meeting included the person, staff and relevant professionals who considered all available options and supported the person to make a decision which was in their 'best interest'. This demonstrated that staff took account of the Mental Capacity Act when they supported people to make decisions.

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. We found copies of DoLS applications in people's care records that had been submitted to the authorising body in September 2015, but had not yet been authorised. This was due to acknowledged

delays in processing the applications. However, there was evidence that 'best interest' meetings had taken place within the service, whilst the decisions were being processed. These meetings had ensured that the least restrictive methods had been used, when it was necessary to deprive a person of their liberty or expose them to constant supervision and control in order to keep them safe.

The manager told us they did not use restraint or medication to manage challenging behaviour. They said they preferred to use recognised techniques to keep people calm and prevent escalation of behaviour that my challenge themselves and others. This demonstrated that staff were aware of their responsibilities in respect of complying with the MCA and sought appropriate authorisations to safely and effectively care for people.

People were supported to have sufficient food and drink to maintain a nutritious diet. People were involved in planning menus, shopping for food and preparing meals. One person told us, "We go shopping in the van on Saturdays" and another person said, "We like to push the trolley and choose our own food". We saw people in the kitchen washing and drying dishes, they told us they liked, "helping in the kitchen" another person said, "I set the table". There was a picture menu in the kitchen of one bungalow and people told us what they liked for their meals. In the second bungalow there were no menus or posters in the kitchen or communal areas. The manager said this was to keep it looking more homely and less like a service. Menus were available in a folder in the dining room, but the manager said that as people generally chose what they wanted each meal, the menu was used only as a guide for people. We saw records that demonstrated that special diets were catered for, people were involved in menu planning and staff confirmed that they knew who needed specially prepared food or assistance to eat. A person with diabetes was encouraged to choose low sugar options and supported to make healthy choices. People told us they liked the food and they could choose what they wanted. This showed that people were involved in the planning of meals and menus in an inclusive and respectful way.

People were supported to maintain good health by staff supporting access to community health services. We saw individual health action plans that recorded dates of dentist and GP visits. We saw evidence of people being supported with their diets and nutrition by referrals to Speech and Language Therapists (SALT), and dieticians and we saw that staff had acted on advice from specialists in their food preparations. We saw referrals for eye checks, special shoe fittings and a dementia assessment for one person who was unwell. One person expressed concern for the person who was unwell and told us the doctor had been out, another person told us they had an optician's appointment due soon. A visiting nurse told us everyone had annual health checks, and longer appointments were available at the GP surgery, or the GP would visit people at home, if required. The manager explained that they had a good relationship with the pharmacy and could ring for advice if they had any concerns or needed medicines quickly. This demonstrated that people were supporting to access community health services in a way that met their individual needs, in order to maintain their health.

Good

Is the service caring?

Our findings

Staff developed positive caring relationships with people, based on kindness and compassion. One person told us, "I love it here, this is my home". We saw lots of positive and caring interactions between staff and people. We observed staff lowered their voices and were discreet when checking to see if people needed support with personal care. They sat and spoke to people individually, made eye contact and used reflective listening during conversation. This was particularly effective with people who had verbal communication difficulties, where staff took time to listen to people and understand what they were saying. We observed staff patiently trying to understand a person who had little verbal communication. They studied their facial expressions and movements and told us, "[Person] says they want a drink". We then observed staff trying different types of cups so this person could drink independently. This demonstrates that staff were compassionate and cared about people and treated people as individuals and with dignity.

People were supported to express their views about their daily living activities and their care. Each person had a book which recorded their person centred meetings with staff. These books included comments, pictures and their thoughts about activities they had taken part in, or about their goals and aspirations. These records covered events from previous years and provided a personal history for people to look back on and remember events and people. One person talked to us about events in their person centred meeting book and told us how they enjoyed the activities and what they would like to do in the future.

People attended meetings where they discussed menus and future activities and events, we saw minutes of these meetings and records of where activities suggested by people had taken place. For instance, one person likes butterflies so they had a trip to a local butterfly house in the minibus. We saw in records that people were supported to maintain relationships with their family and friends by staff providing transport for visits. There were trips and activities for individuals as well as for groups of people, depending on individual interests and abilities. This meant people felt listened to and their individual needs were met, at the same time as being balanced against the needs and preferences of the wider group of people.

Staff encouraged people to be independent. We were given a tour of the bungalow by a person who lived there; they said to us, "I'll show you everything. This is where we live. This is my room. This is the bathroom". We saw people using walking aids to support them walking around, staff gave people freedom to move around inside and outside the two bungalows. There was a safe enclosed garden and 'french windows' were open to allow freedom of movement and access to the patio and various seating areas. There was a garden shed that one person stored their fishing tackle in and we were told by staff that they accompanied this person fishing so they could maintain one of their personal interests and their own identity.

Each person had their own room with a wash hand basin for privacy and we saw that staff knocked before entering. People also had their own, locked (by staff) medicine cabinet in their rooms, where their own supplies were stored. This meant people's rights to privacy were respected. People told us they chose their own colours and furnishings for their bedrooms and we saw rooms were all decorated to take account of individual personalities and preferences. One person told us, "We're helping choose new curtains for the

lounge". Another person told us, "This is my home, I like it here". This showed that people were involved and made decisions about their living environment that took account of their individual personalities and preferences.

The manager told us how people had chosen to spend fundraising money on new table mats and were attending another fundraising event the next day. They said this helped people understand the process of saving money to buy things themselves. People told us, "We've been to work today", when they had been to an activities club. The manager explained how they supported people to access regular meaningful activities that matched their individual interests and abilities. They told us how this gave people a sense of purpose and structure to their daily lives, which in turn promoted their dignity and independence.

We saw people being offered discreet support to meet their personal needs and staff told us how they gave people privacy whilst supporting them to bathe, by using curtains and standing outside the room. This ensured people had privacy and retained their dignity and independence, whilst staff continued to manage risks and meet people's needs.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. We saw that each person had a needs and risk assessment completed on admission which was used to develop a care plan and programme of support. People contributed to their assessments and care plan and were involved in the decisions about how their care would be delivered and managed. We saw comments made by people in care records and people's thoughts and preferences were recorded. Our review of daily records demonstrated that these preferences were respected by staff and people were cared for how they had requested or described. For instance, one person preferred female care staff for personal care and this was respected and provided.

We saw that people were supported to follow their interests and this was incorporated into their daily lives. For instance, one person liked to knit and they had made scarves for the garden gnomes to wear. A second person liked fishing and they had a special shed to store their equipment. We saw records that demonstrated this person was supported to maintain their interest, as staff accompanied them on fishing trips. A third person was a fan of Elvis Presley and took pleasure in showing us their 'Elvis' outfit and impersonation. They told us how they enjoyed "Everything about Elvis" and "Went to a tribute show".

Staff encouraged and enabled people to pursue their interests by ensuring resources were available to accompany people on trips or provide materials for them to use in their activities. For people unable to physically participate in their preferred activities, we saw records of how staff took time to talk to them about their interests, read or watch videos related to their interest. This provided meaningful stimulus and opportunities for discussion or reminiscence. This showed a respect for people and their preferences, which was supported by the way staff engaged with people.

People were supported to access activities outside of home and on the day of our inspection five people had attended a day centre, where they participated in a variety of activities to suit their interests. One person told us, "I've been to work today, I did bowling". Another person took pleasure in showing us the card they were making, "I'm making a card for staff" and they told us, "I like being busy". Staff told us another person liked the outdoors and was involved in painting a fence at the moment. Some people also participated in activities in the evenings with people outside of their home and one person said, ""I like going out - see my friends"; another person told they liked to go to church. Staff told us, "Each day is different, it depends on what people want to do; we are very flexible". This showed that care and support was personalised and took account of personal interests.

We saw records and staff told us, of various trips and outings that people had been on; these included a pantomime, garden centres and other local attractions. Staff told us some of these were the favourites activities for some people and others were suggested by staff who knew people's personal likes and interests and sourced activities and events that people liked. This demonstrated that staff knew the personal preferences and interests of people and developed an activity programme that responded to these.

We saw there was a complaints policy in place and was shared with people on admission. We observed that care and support was offered with respect and compassion, from staff who were also the friends of people and were 'tuned-in' to their individual needs. Due to these close and supportive relationships, staff were able to quickly identify if people were unhappy or unwell. With this knowledge and understanding staff responded quickly and ensured that people were happy and comfortable. With such personalised and responsive care there were no formal complaints from people or their families regarding the care they received. However, we saw records of individual and group meetings with people, where feedback was sought by staff and recorded in minutes. This showed that the provider was creative in its collation of feedback and used different opportunities that suited the abilities of the people using the service.

We saw that the provider conducted surveys with referring agencies and these were collated and shared with staff, as well as used to improve services and care. A visiting nurse told us that staff were very responsive to changing need and how rotas and staffing arrangements were changed in response to the changing health needs of people. For instance staff provided 'waking night' cover the previous week when a person was unwell, had provided staff to sit with a person in hospital and additional equipment had been put in place to support a person whose health had deteriorated. This meant this person stayed at home where they were happy and comfortable rather than having to return to hospital with its unfamiliar environment and routines. This demonstrated that staff responded positively to changing needs and feedback from people was used to improve the service.

Good

Is the service well-led?

Our findings

There was an open and inclusive culture within the organisation where staff and people felt supported and heard. The service promoted a positive person centred culture where people were at the heart of all decisions and actions. People told us they knew the name of the manager. Staff told us the manager was available, supportive and hands-on. The manager told us they received support from the wider organisation and senior management team who they said, "Were always available to support".

The organisation was going through a period of transition regarding staff contracts and had recently conducted a staff survey which was available for us to see. Some staff told us, they felt 'in the dark' about what was happening whilst others acknowledged that it was a long and difficult process and felt the decisions had been shared in a timely manner. In spite of some staff concerns regarding their future contracts we observed an open and person centred staffing culture within the organisation and staff told us of times when managers had been flexible to accommodate personal situations. The manager of the service said they were responsible for ensuring that, even if staff were unhappy with the wider organisation, this did not affect the quality of care they provided and people remained at the focus of their daily activities.

We saw that team meetings took place regularly and staff had opportunity to contribute ideas and discuss best practice. Staff told us they understood their roles and responsibilities and were motivated to provide good quality care for people. This was echoed by the manager who said it was a strong team who worked well together. Staff records confirmed that most staff had worked there for a number of years which demonstrated that it was a stable staff team. There were clear lines of authority and decision making within the organisation and staff received support and supervision from senior staff. Although not yet a registered manager, the manager had complied with the registration requirements of the service and provided information as requested to the care quality commission. This included the provider information return (PIR). The regional manager told us that as soon as the outcome of the staff review was concluded, they would be making arrangements to appoint a registered manager for the service. This demonstrated good management and leadership of the service.

We also saw examples of changes to auditing and data collection by the manager which enabled better analysis of data and quicker identification of areas requiring improvement. For instance, medicine management and storage processes had been improved since the manager had been in post and were now more effective at identifying medicine errors. This enabled quicker identification and response to medicine errors in order to keep people safe from harm. Care plans had also been reviewed and now provided easier access to information. The wider management team conducted quality assurance audits of the service and checked progress against targets and outcomes for people. The local authority and clinical commissioning group also conducted their own audits and contract management reports, which were available for us to see. This demonstrated an integral approach to quality assurance which included feedback from others involved in the referral process. It also demonstrated inclusive and accountable management of quality within the organisation at all levels.

We saw incidents were reported and acted upon, with records of decisions and any changes to practice. For

example, we were told how peoples changing needs were monitored and assessed to ensure that the service continued to meet these needs; and how alternative arrangements were made for people where their needs became too complex for the staff team to manage safely. This demonstrated that the service strived to provide good quality care to people, that met their individual needs and where this was not possible staff sought more suitable and effective care.