Forge House Care Ltd

Forge House Care

Inspection report

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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 inspection took place on 22 August and 01 September 2017 and was announced.

Forge House Care provides care services to adults with mild, moderate or complex learning disabilities, some of whom had additional behaviours that challenged services. The care provided is known as supported living and is delivered to people in their own homes mainly in Medway and Kent and is managed from an office in Chatham. Some people needed intensive 24-hour support packages and others were more independent and needed less staff support. People needed help with day-to-day tasks like cooking, shopping, washing and dressing and help to maintain their health and wellbeing. There were 20 people using the service at the time of our inspection.

This service was rated as Good in all of the domains and had an overall Good rating when we last inspected on 17 September 2015.

There continued to be a registered manager employed at the service. 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. The registered manager was also the provider.

People continued to experience care that was caring and compassionate. People spoke about the staff in a positive light regarding their feelings of being safe and well cared for.

Staff were trusted and well thought of by the people using the service.

People continued to have their needs assessed and their care was planned to maintain their safety, health and wellbeing.

Risks were assessed and recorded by staff to protect people. There were systems in place to monitor incidents and accidents.

Staff had received training about protecting people from abuse and showed a good understanding of what their responsibilities were in preventing abuse.

The provider had updated their policies since we last inspected in line with published guidance and practice in social care.

Procedures for reporting safeguarding concerns were in place. The registered manager knew how and when they should escalate concerns following the local authorities safeguarding protocols.

The provider had processes in place to monitor the delivery of the service. People's views were obtained through one-to-one meetings, meetings with people's families and meetings with social workers. The provider also carried out an annual staff survey. However, the provider had not collated all of the data to analyse their performance and quality. We have made a recommendation about this.

Staff training covered both core training like first aid and more specialised training. They also understood the Mental Capacity Act 2005 and how to support people's best interest if they lacked capacity.

Staff continued to have good levels of support and supervision to enable them to carry out their roles.

Staff continued to be recruited safely and had been through a selection process so that they were fit to work with people who needed safeguarding.

Staff had been trained to administer medicines safely and staff spoke confidently about their skills and abilities to do this well.

People were pleased that staff encouraged them to keep healthy through eating a balanced diet and drinking enough fluids. Care plans were kept reviewed and updated.

There were policies in place so that people would be listened to and treated fairly if they complained.

The management team and staff were committed to the values of the organisation and they took these into account when delivering care and support.

People were happy with the leadership and approachability of the service's registered manager, the provider and the management 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? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Forge House Care

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 22 August 2017 and 01 September 2017 and was announced. 48 hours' notice of the inspection was given because the service was small and the registered manager was often out of the office supporting staff. We needed them to be available during the inspection. The inspection team consisted of two inspectors and an assistant inspector.

We looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law. The provider completed a Provider Information Return (PIR). The PIR 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 used all this information to plan our inspection.

We visited five people in their homes to ask their views about the service. We spoke with six staff including the provider who was also the registered manager, the operations manager and four care staff.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at four people's care files, ten staff record files, the staff training programme, the staff rota and medicine records. We asked the provider to send us more information about the staff supervisions, staff team meetings and audits. The provider sent the information to CQC in a timely manner.

Good

Is the service safe?

Our findings

People told us they had confidence in the service and felt safe when staff were in their homes delivering care. One person said, "The staff prompts me with my medicine and this works okay". Another person said, "I am looking at being able to take care of my own medicines in the future."

The provider took a balanced approach to risk and developing people's independence. People who went out on their own told us that staff talked with them about their personal safety. One person said, "I am always looking at road safety, I take my mobile out with me and I check in with staff so that they know I am okay."

People continued to be protected from the risk of receiving care from unsuitable staff. Staff had been through an interview and selection process. The registered manager followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Staff told us the policy was followed when they had been recruited and their records confirmed this. Applicants for jobs had completed applications and been interviewed for roles within the service. New staff were not offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications. All new staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

Staff continued to support people in the right numbers to be able to deliver care safely. People had been assessed for the numbers of staff they would need. People's individual hours varied depending on the activities they may be doing or if there were any risks identified. For example, some people had two staff supporting them for set hours and one staff supporting them for other set hours. Some people had staff with them who stayed awake overnight and others had staff called sleeping staff. Some people did not need staff with them all of the time. We checked the assessments against the staff rota and saw that staff were allocated based on people's needs.

People had consistent care from regular staff who knew their so they were protected from risk. For the people we visited, staff were available to them 24 hours. In situations where agency staff were used, people told us they normally knew the agency staff as they had worked with them before. The registered manager told us that if there was a change in the staff calling, for example due to sickness, they informed people so that they would know. Staff we spoke with confirmed that they were rostered with the same people whenever possible. This meant that they got to know people well.

Staff continued to follow the provider's medicines policies. People were encouraged to develop their independence around medicines. Medicines were audited monthly through visits to each person's home by a designated manager from head office. The audits were recorded and returned to the office and were checked by the registered manager. Issues arising from the audits were corrected with staff who provided support at the time. For example, over stocked or unused medicines were removed by the auditor and returned to the local pharmacy. Medicines audits were discussed at senior staff meetings looking for trends

and looking at ways of making improvements to practice. People who received support from staff with their medicines were given their medicines as required by their GP. Staff we talked with told us in detail how they supported people safely when dealing with medicines.

The medicine administration record (MAR) sheets showed that people received their medicines at the right times. The system of MAR records allowed for the checking and recording of medicines, which showed that the medicine had been administered and signed for by the staff visiting the person's home. Staff were made aware if there had been any changes to people's medicines or they were unsure about anything to do with medicines they would seek advice from a manager or field supervisor. This protected people from potential medicine errors.

People continued to be kept safe by staff who understood and received training about the risks relating to their work. Safe working practices and the risks of delivering the care were assessed and recorded to keep people safe. For example, people had been assessed to see if they were at any risks whilst they were in the community or not eating and drinking enough. If they were at risk, the steps staff needed to follow to keep people safe were well documented in people's care plan files. Environmental risks were assessed. For example, identified hazards in people's homes or lone working risk. Staff received food hygiene and infection control training. Staff had access to personal protective equipment [PPE] when appropriate, such as disposable gloves and aprons. Infection control was an agenda item on the quarterly staff meeting minutes. This meant that the risk of cross infection was minimised.

Incidents and accidents were fully investigated by the registered manager to ensure steps were taken to prevent them from happening again. The incidents recorded so far in 2017 had all been fully recorded and investigated with actions taken to reduce the risk recorded. For example, the registered manager had recently introduced lessons learnt debriefings following incidents. Incident records had also been shared with people's care managers where appropriate. Guidance was given to staff about reporting incidents and accidents and this was backed up by a policy. The policy gave details of how the registered manager would monitor incidents and accidents.

The registered manager continued to understand how to protect people by reporting concerns they had to the local authority and protecting people from harm. Staff followed the provider's policy about safeguarding people and this was up to date with current practice. Staff were trained and had access to information so they understood how abuse could occur. Staff understood how they reported concerns in line with the providers safeguarding policy if they suspected or saw abuse taking place. Staff gave us examples of the tell-tale signs they would look out for that would cause them concern. For example, bruising. Staff understood that they could blow-the-whistle to care managers or others about their concerns if they needed to. Blowing the whistle enables employees to contact people with their concerns outside of the organisation they work for, like social services.

People's care could continue if there was disruption to the service. The registered manager had an up to date business continuity plan. This included details of how staff should manage different kinds of foreseeable events. For example, during periods of extreme weather conditions or if someone had to move out of their home due to fire or flood. This meant that the service could focus its resources into getting staff to the people most in need and protected people's continuity of care.

Good

Is the service effective?

Our findings

Staff understood people's needs, followed people's care plan and were trained for their roles. People said, "I am supported with my medicines by staff and this works okay for me, they always record things they have helped me with."

Staff understood the care they should be providing to individual people as they followed detailed care plans. Staff said, "The care plans have enough information in them for us to provide care to people." Care plans were left in people's home for staff to follow and staff confirmed to us that these were in place and kept up to date. Services were managed locally by team leaders. The team leaders checked staff performance at a local level, this was checked by the registered manager through audits. People told us that staff followed their care plans.

The care people received continued to be fully recorded by staff. We could see that their notes reflected the care required in people's assessment of need. Staff told us they read people's care notes before they started delivering care so that they were up to date with people's needs. People told us that staff read and followed their care files.

People's health and welfare continued to be protected by staff. Staff were not always cooking for people, but supported people's development by assisting people to plan, shop and cook meals. Staff told us how they did this in line with people's assessed needs. Staff described to us how they helped people maintain a healthy diet and avoid foods that could affect their health. One person said, "We plan our menu and then go shopping with staff or we look to see what's in the kitchen cupboard." Some people learnt cooking skills at local learning centres and often brought home meals they had cooked to share with their house mates. They also make sandwiches. If people had food allergies or needed a particular diet, staff supported people to access the right food. Food hygiene training was provided to staff. People told us that when staff helped them with their meals, staff did this with them rather than for them. This encouraged people to learn about staying healthy and independent.

When people needed referring to other health care professionals such as GP's or district nurses, staff continued to understand their responsibility to encourage people to seek help or ensure they passed the information onto relatives or care managers so that this was organised to protect people's health and wellbeing. People continued to have health action plans in place and care plans were cross referenced to information about visits people made to their GP, dentist or if they had appointments with community nurses. This meant that people's on going health was effectively recorded and monitored.

People had recorded their consent to receive the care in their care plan or through a best interest approach. Gaining consent from people before care was delivered happened routinely. Staff continued to gain verbal consent at each care visit. People were free to do as they wished in their own homes. The registered manager had a good understanding of the Mental Capacity Act (MCA) 2005. There was an up to date policy in place covering mental capacity. Staff had received training in relation to protecting people's rights. This prepared them for any situation where they may think the MCA needed to be considered as part of

someone's care. The registered manager worked jointly with social workers and other health and social care professional to carry out assessments under the MCA 2005. After the inspection, the registered manager sent us further evidence of decision specific MCA 2005 assessments they had carried out. For example, to protect one person's health who may be at risk from obesity. Their assessment included a best interest meeting.

The registered manager trained staff to have the skills and support they needed to do their jobs well. Staff received a comprehensive induction when they started working for the service. Records showed that when new staff started they would begin training using the Care Certificate Standards. These are nationally recognised training and competency standards for adult social care services. Staff told us they had completed shadow shifts and an induction when they started working at the service. Staff had a training manager who oversaw the completion of their competency standards. During the staff induction shadow shifts were completed. This meant that new staff could be introduced to people before they took up their role fully. New staff needed to be signed off as competent by the registered manager at the end of their induction to ensure they had reached an appropriate standard. Where required, staff working with people who had behaviours that may cause harm to themselves or others received specialised behavioural management training. This meant that people received the correct levels of intervention to manage their behaviours safely.

The registered manager continued to use a range of methods to enable staff to develop the right skills for their role. They provided competency checks for staff which challenged them to say how they would maintain standards in relation to dignity and privacy, administering medicines and keeping people safe. Team meeting were held for staff on a quarterly basis. The minutes of the last meeting included useful information for staff. Hands on training was provided for things like safe moving and handling. We saw documented evidence that staff attended training in autism and learning disabilities awareness, caring for people with epilepsy or diabetes. Staff spoke about the training they received and how it equipped them with the skills to deliver care effectively. This meant that staff had training relevant to the people they delivered care for.

Staff continued to be observed and supervised whilst at work and provided with guidance about their practice if needed. Staff met with their management supervisor to discuss their training needs and kept a training plan for staff to follow so that they could keep up to date with developments in social care. One member of staff said, "Since starting work, I have had an induction and I get supervisions." When managers met with staff they asked them questions about their performance. Staff had been asked how they deal with health and safety concerns. Staff supervisions were recorded and registered manager gave guidance to improve staff knowledge.

At the time of this inspection, the staff supervision and training matrix had not been kept up to date. We discussed this with the registered manager and they explained that this had happened because the training manager had recently left and the operations manager who had taken this job on had been on jury service for six weeks.

The staff we spoke with told us they had supervision meetings with a team leader and also confirmed they had been receiving training. For example, one member of staff had recently updated their first aid training. Following the inspection the registered manager sent us up to date information about how they planned staff training, supervision and appraisal so that staff understood their roles and could gain more skills. Regular supervision and training led to the promotion of good working practices within the service.

The registered manager had a plan in place so that staff received an annual appraisal. This gave staff the opportunity to discuss what had gone well for them over the previous year, where they had weaknesses in

their skills and enabled them to plan their training and development for the coming year.

Good

Is the service caring?

Our findings

People described the care that they received positively. One person said, "I like going out into my garden, I know my key worker really well." Another person said, "I do my care plan [with staff] and say how I like to be supported." Another person said, "I go through my care plan with staff, if it's changed they have to sign it." And, "The staff are always here for me, I choose when I get up or when I go to bed." Another person said, "The staff are nice and friendly, I get my privacy." And, "My house is nice and peaceful."

People told us that they continued to experience care from staff with the right attitude and caring nature. The service had a person centred culture focused on the promotion of people's rights to make choices and live a fulfilled life. Staff said, "We really try and involve people in daily activities and household tasks to promote people's independence." People told us that staff communicated well and told us about staff chatting and talking to them. People told us about staff respecting their independence. One person said, "I like to go out on my own, but staff hover around to make sure I am okay." We observed staff speaking to people respectfully.

Staff demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care for a person. We found the staff team continued to be committed to delivering a service that showed compassion and respect for people. When they spoke to us they displayed the right attitude. Staff knew the people they were supporting well. They had good insight into people's interests and preferences and supported them to pursue these. The registered manager and staff that we spoke with showed genuine concern for people's wellbeing. It was evident from discussion that all staff knew people well, including their personal history, preferences, likes and dislikes.

People let us know how important it was for them to be as independent as possible and how staff supported this. People indicated that, where appropriate, staff continued to encouraged them to do things for themselves and also respected people's privacy and dignity. Staff told us that they offered people choices about how they wanted their care delivered. People talked to us about how they had built friendships with the people they shared their home with. One person said, "My house mate moved in just after me, sharing works okay for us." Another person said, "Now I have a place to stay I want to get back into work. I like working with horses." Building good positive relationships with staff meant that people had the support to develop fulfilled lives.

Staff continued to support people to undertake tasks and activities aimed at encouraging and promoting their independence. For example, staff encouraged people to prepare their own meals or form friendships with others. People had time built into their weekly activities for laundry, cleaning, personal shopping tasks and travel in the community, aimed at promoting their independence.

Information was given to people about how their care would be provided. People signed their care plan. Each person had received a statement setting out what care the service would provide for them, what times staff would arrive and information about staff skills and experience. People were knowledgeable about the service and told us that there were care plans they could look at in their homes. The care plans enabled

people to check they were receiving the agreed care.

Archived information about people was kept securely in the Chatham office and the access was restricted to senior staff. Staff understood their responsibility to maintain people's confidentiality.

Good

Is the service responsive?

Our findings

People were encouraged to discuss issues they may have about their care and to live lifestyles they chose. One person said, "I can complain if I want to." Another person said, "I like clothes shopping, bowling and swimming." Others told us about their chosen routines. One person said, "We share the cooking and the washing up, we can always get hold of somebody if we need staff support."

There continued to be systems in place to make sure that people's concerns were dealt with promptly. There was regular contact between people using the service and the management team. All people spoken with said they were happy to raise any concerns. There was a policy for dealing with complaints that the staff and registered manager followed. A complaint written by a person who used the service was recorded in the complaints file. This showed that the complaint had been responded to appropriately and a meeting had been arranged to discuss and resolve the issue raised. We spoke to the person who made the complaint and they said, "I complained about the attitude of a member of staff, I mentioned this and my key worker helped me complain, I was sent a letter and I had a meeting; after that it got better". The registered manager had responded to and resolved complaints within the provider's guidance. People told us that they got good responses from the office staff if they contacted them to raise an issue.

Since our last inspection more people were now being supported with personal care. Before people received care and support an assessment of their needs had been completed to confirm that the service was suited to the person's needs. After people moved into their home they and their families where appropriate, were involved in discussing and planning the care and support they received. Assessments and care plans reflected people's needs and were well written.

People gave feedback about their experiences of the service they received during meetings at their home. Records of this were kept and staff responded by discussing changes people would like. Care reviews captured the views of relatives and care managers. However, the provider had not collated the feedback formally so that they could look at what people's overall experience was about the quality of the provider's services.

We have recommended that the provider researches guidance about collating and analysing people's and other stakeholders views about the quality of the service.

People continued to receive care that was person centred and met their most up to date needs. People's life histories and likes and dislikes had been recorded in their care plans. Information about how people preferred to communicate was recorded. For example, 'please make eye contact with me and do not use complex sentences so that I can understand you'. Another person preferred to have things written down so they could read them as this made them less anxious. Staff encouraged people to advocate for themselves when possible. This assisted staff with the planning of activities for people. Each person had a named key worker. This was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their dreams and aspirations. We saw from care plans that when people had met and chosen activities these had been organised by their key worker and they recorded when

they had taken place.

People's needs had been fully assessed and care plans had been developed on an individual basis. The care plans covered every area of people's lives to assist their development. For example, the things people were good at, their dreams and aspirations and the things they needed help and support to achieve.

When needed behavioural support care plans detailed early interventions based on people's individual needs. This enabled staff to intervene early if they saw people becoming upset or agitated. Staff understood the recorded behavioural triggers for each person. If people's needs could no longer be met at the service, the manager worked with the local care management team to enable people to move to more appropriate services. This had happened when people's behaviours had become distressing to others living in the service.

Assessments and care plans were completed and reviewed with people, their care manager from the learning disability team or their relatives whenever possible. Sections in the care plan called 'How I like to be supported detailed people's individualised support needs. The provider used appropriate personalised care planning formats for people with a learning disability. For example, one person had covered their care plan with pictures of characters from their favourite television program. People also used lots of photographic and pictorial information in their care plans to assist their understanding. For example, keeping safe from abuse or places they liked to visit. This gave people some interest and ownership of the information about them.

People told us they had been fully involved in the care planning process and in the reviews of those plans. Reviews of the care plans were scheduled in advance, but could also be completed at any time if the person's needs changed. Care plan reviews had taken place as planned and that these had been recorded. Records showed that care plan reviews were comprehensive and inclusive. Staff told us care plans were kept up to date and that they checked people's daily records for any changes that had been recorded. The registered manger reviewed people's care notes to check that people's needs were being met.

Staff were responsive and flexible to people's choices and needs. People and their staff showed us how people in the service chose the activities they wanted to do. People talked to us about the things they liked doing. Two people were involved in walking retired greyhounds. One person said, "I like the dog walking." Others told us about using their computers to search the internet, one person said, "I have just used the internet to search out a new television for my room, and my key worker supported me to buy it." Other people spoke to us about how much they enjoyed going to a local learning centre five days a week. Here they enjoyed learning cookery skills, basic food hygiene and food preparation, met friends and learnt other skills they needed to live more independent lives.

People continued to have a routine for one-to-one staff support in the community. This included participating in leisure activities, going to the pub for lunch and personal shopping. People also went on holiday. Staff were allocated to people's activities based on their skills and experience. This meant staff could understand and meet this person's individual needs.

Good

Is the service well-led?

Our findings

People we spoke with experienced a service that was well run. They had no complaints about the way the service was managed.

The registered manager was also the provider. They had been registered as the manager since May 2015. They were supported to develop and manage the service by an experienced team of operations managers. The management team at the service provided a good balance of skills experience and knowledge. Operations managers had designated roles and responsibilities, for example overseeing medicines and people's health care, staff deployment, complaints handling and staffing issues. All of the people we visited at home had met the operations manager responsible for their medicines and the operations manager with overall day-to-day responsibility for the effective operations of the service. This meant that people knew who people were from head office and they could experience meeting them on a regular basis.

Staff said, "The senior managers at Forge House Care are very approachable, always open to discussion."

The senior management team at Forge House Care met every Monday. The meetings were minuted and discussed the operational effectiveness of the service and any issues that may need addressing within the service. The registered manager or other senior staff provided leadership in overseeing the care given and provided support and guidance where needed. For example, the provider visited the service regularly, they attended tenants meetings and they met with staff. People spoke positively about the service. Feedback about the service was indicative of a well led service. For example, people told us they were often visited managers from the office who kept in touch with them.

The aims and objectives of the service were set out and the registered manager of the service was able to follow these. Staff received training and development to enable this to be achieved. The registered manager continued to have a clear understanding of what the service could provide to people in the way of care.

We spoke with staff who were well supported and who had regular and effective communications with their managers. The provider carried out annual staff surveys to gather information about staff satisfactions and highlight any areas that needed improvement.

Staff told us they enjoyed their jobs. One member of staff said, "I absolutely enjoy my work, there is always something different going on." Staff believed they were listened to as part of a team, they were positive about the management team of the service. Staff spoke about the importance of the support they got from senior staff, especially when they needed to respond to incidents or needed to speak to the registered manager for advice. They told us that the registered manager and operations managers were approachable.

The registered manager had carried out quality audits of the service. These audits assisted the registered manager to maintain a good standard of service for people and consistently meet the legal requirements and regulations associated with the Health and Social Care Act 2008, and Care Act 2014. Care plans, risk assessments and staff files were kept up to date and reviewed with regularity. Records showed that the

registered manager responded to any safety concerns and they checked that risks affecting staff were assessed. For example, lone working risks were minimised by assessment. We saw that the audits were effective in picking up potential medicines errors where staff had not always signed the medicines administration records.

Our discussion with the registered manager confirmed there continued to be systems in place to monitor and review any concerns about abuse, accidents, incidents and complaints. Accident audit reports provided an analysis of accidents and identified any themes. Audits included responsive actions and lessons learnt.

There continued to be a range of policies and procedures governing how the service needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the service, known as 'Whistle Blowing.'

The registered manager continued to be proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The registered manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This meant that that people could raise issues about their safety and the right actions would be taken.