

Residential Community Care Limited

Glebe Garden

Inspection report

Reading Road
Burghfield Common
Reading
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Tel: 01189835476

Date of inspection visit:
12 April 2016

Date of publication:
01 June 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 12 April 2016, and was unannounced.

Glebe Garden is a care home that offers accommodation for people who require personal care. The service is registered to provide a service for up to four people, with bedrooms located on the first floor. People who live at the service have a primary diagnosis of learning disabilities. The home specialises in working with people to reintegrate them into the community promoting independence and choice.

The home is required to have a registered manager. The registered manager has been in post since March 2015. 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.

Staff knew how to keep people safe. They were aware of how to report concerns promptly and confidentially. They were familiar with procedures that were clearly outlined in training as well as the service's own policies and procedures. Comprehensive processes for recruitment of staff were in place to ensure suitable employment and the protection of people against the risk of abuse. Sufficient staffing numbers of trained and experienced staff were provided by the service to ensure the needs of people were met. A rolling training programme was in place, which focused on providing the company's mandatory training as a minimum standard, with additional supporting training offered in line with best practice meeting the Skills for Care guidelines.

Good caring practice was observed during the inspection. People reported they were content with the support and care provided by the staff. People, and where appropriate their relatives, were involved in the development and reviewing of care plans. These were well documented, detailing individual preferences well and reflective of the person's needs. Risk assessments specific to the person were contained in files, with guidance on how to manage these risks should they occur.

Responsive practice was observed during the course of the inspection. The service responded to the needs of people, offering them both verbal and emotional support. This lowered anxiety and enabled retention of independence.

Staff and people reconfirmed observations of good communication. The service offered an open door policy, giving people, staff and visitors the opportunity to speak with the registered manager at any time. People told us that they were treated with respect, at all times. Staff always ensured they preserved people's dignity when working with them.

People were supported by a team of staff who were competency checked prior to being given responsibility for care. Medicines were kept and managed securely. Comprehensive records were kept of guidelines for as

required medicines. Audits were completed regularly and showed no medicine errors.

Staff had training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This meant that they understood the importance of informed choice being situation and time specific. All people living at the service had capacity to make decisions for themselves, with the support and guidance of staff.

The quality of the service was monitored by the registered manager. Feedback was obtained from people, visitors, families and stakeholders and used to improve and make any relevant changes to the service. Comprehensive audits were completed that produced reflective action plans that identified timescales for improvement. Evidence illustrated this was actioned promptly.

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 kept safe from abuse by a staff team who understood how to report any concerns that they had. Staff were able to describe what whistle blowing was and were confident to use this.

Risk assessments and emergency plans had been completed for all people living at the service.

People were kept safe by a highly trained and competency checked staff team.

Medicines were managed and administered safely.

Is the service effective?

Good ●

The service was effective.

People, and where appropriate their relatives, were involved in making decisions about their care.

Choice was offered to people during the delivery of care. Meals and drinks were offered throughout the day and reflected the person's choice.

Staff received regular supervision, and were appraised annually.

Staff underwent a comprehensive induction and training programme that allowed effective care.

Is the service caring?

Good ●

The service was caring.

Staff worked respectfully and in a caring manner with people.

People's dignity was maintained and choice was respected at all times.

Individual needs and preferences were well understood and

recorded appropriately in people's care documents.

Is the service responsive?

Good ●

The service was responsive.

A comprehensive pre-assessment of needs was completed prior to people's admission.

People were offered both group and individual activities that were responsive to their needs.

The service had a well-documented complaints procedure. People knew how to make a complaint, and were confident to raise concerns.

Care plans were reviewed and responsive to people's changing needs.

Is the service well-led?

Good ●

The service was well-led.

The service was open to suggestions, complaints and compliments, clearly illustrating correct management of these.

Processes were in place to monitor the quality of service.

Quality assurance surveys identified that people were happy with the service and that opinions were used to formulate an action plan to improve the service.

The registered manager completed regular audits of the service to ensure that the service provided appropriate support to people.

Glebe Garden

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 comprehensive inspection took place on 12 April 2016 and was unannounced. This inspection was completed by one inspector as the service was a small residential home.

Prior to the inspection the local authority care commissioners were contacted to obtain feedback from them in relation to the service. We referred to previous inspection reports, local authority reports and notifications. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to 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. This was further used to inform the inspection process.

During the inspection we spoke with three members of staff, including the registered manager and two care staff. We spoke with three of the four people who live at the service.

Care plans, health records, medication records and additional documentation relevant to support were seen for all four people. In addition a sample of records relating to the management of the service, for example staff records, complaints, quality assurance assessments and audits were viewed. Staff recruitment and supervision records for all six staff employed at the service were reviewed.

Is the service safe?

Our findings

People were kept safe by a comprehensive well documented recruitment process. This included obtaining references for all staff in relation to their conduct in previous employment, specifically in health and social care jobs. A Disclosure and Barring Service check was completed for all potential staff. This is a check that allows the provider to see whether an applicant has any criminal convictions that may make them unsuitable to work with vulnerable people. All gaps in employment were explained, photographic identification was verified with recent photos for staff files. All checks were completed prior to commencement of employment, to ensure staff were appropriate to work with people.

People told us that they felt safe at the service. One person said "I'm very safe here. The staff always look out for me." Another person reported, "It is a wonderful place to live. Staff keep us safe here, oh definitely, yes we're all safe". This was reinforced by staff who had a comprehensive understanding of safeguarding and whistleblowing procedures, and were able to describe the various types and signs of potential abuse.

Training records showed all staff had undertaken training in safeguarding people against abuse, and that this was refreshed on a regular basis. Staff we spoke with were aware of external agencies that should be contacted in circumstances where they thought that either the manager or the organisation were involved in the abuse. For example, the police, local authority, safeguarding team or the Care Quality Commission. One member of staff when asked about reporting abuse stated "Of course. Immediately." Staff stated they believed the registered manager would effectively deal with any concerns should these arise, with her priority being to keep people safe at all times.

People were kept safe by the use of appropriate risk assessments within which strategies were used to enable them to do things they enjoyed. This meant that people were not restricted. For example, when a person wanted to go to the community for employment opportunities, a comprehensive assessment was carried out highlighting potential risks and how these should be minimised. Where it was identified people were unsafe to go out alone, rather than prevent the community outing people went out accompanied so as to manage the risks better. For example, we saw that one person was not ready in time to independently use public transport to get them to their place of work. This led to an increase in anxiety. This was managed safely by suggesting that a member of staff accompany them to their place of work. This reduced any possible risk linked to increased anxiety as a result of being late.

Sufficient staff were employed to work on shift with people to keep them safe. Rotas illustrated that any staff shortfalls were covered by regular staff. If shifts could not be covered internally by the service, staff from sister homes were asked to cover shifts. This meant that consistency in approach was maintained, through company ethos being practiced.

Generic evacuation plans had been created for people in the case of an emergency, and were easy to read and accessible for staff. People were encouraged to participate in routine evacuations so that they would know what procedure to follow in the event of a fire.

People were kept safe by the monitoring of incident and accidents to prevent the likelihood of similar incidents occurring. The registered manager would develop strategies to implement and use these across comparable instances. This was an effective way of keeping people safe whilst monitoring useful strategies.

Medicines were supplied by a community based pharmacist. They were stored safely in a locked medicines cabinet. Medicines were ordered and managed to prevent over-ordering and wastage using a Monitored Dosage System (MDS). Each person's MDS held a copy of their photo, to reduce the risk of potential error. Medication Administration Record (MAR) sheets were signed and dated correctly, with no medicines errors noted. Audits of the MAR sheets were carried out by the registered manager monthly to identify any errors. None were noted. Where people were being encouraged to self-medicate, risk assessments had been developed to assess the possibility of incorrect medicine management. Staff remained present during self-administration until the person felt confident to independently medicate.

Records of 'as required' (PRN) medicines provided details on when these should be administered. The document gave guidance to staff on what action to take prior to offering a person PRN medicines, as well as illustrating signs that PRN medicine needs to be given. This is to ensure that medicines are only given when necessary. MAR sheets showed that these were only being given when needed, therefore minimising over usage.

All maintenance safety checks were up to date, for example fire systems, emergency lighting and fire extinguishers. The provider had made alterations to the external premises to make these safer for people as they moved around. Hand rails were fitted to areas, where appropriate, to offer additional support when stepping into the garden.

The home was clean and tidy. The kitchen had received a food hygiene rating of five which meant that all food prepared was done so in a clean environment. Personal protective equipment such as gloves and aprons were available for staff to use as required. Colour coded systems for cleaning products and kitchen equipment were visible. This reduced the potential risk of cross contamination. All cleaning products were correctly stored in a locked cupboard and documents related to the chemicals they contained with risk assessments were regularly reviewed.

Is the service effective?

Our findings

Effective support was provided by a highly trained staff team who had undertaken a comprehensive induction process. This included completion of mandatory training and additional training that would be supportive to their role. Before commencing unsupervised work new staff shadowed experienced staff until they felt confident to work independently and were assessed competent to do so. The training matrix showed that whilst not all mandatory training had been completed for staff, this was booked for staff. The service ensured that all staff were trained in the Skills for Care national minimum training standards and the new Care Certificate. The Care Certificate is a specialist induction programme that sets out the regulations and how these need to be worked towards. The registered manager told us that the competency of the staff team was checked following training, for example for medicines.

The registered manager told us that she operated an open door policy and made certain all were aware when she was in the home. Staff reported her presence reinforced the delivery of effective care. Staff told us that the registered manager would immediately converse with staff if she observed practice that needed reflecting on. This ensured that they always focused on delivering care that was effective, safe and responsive to the person's needs.

People were supported by a staff team that received effective staff supervision and annual appraisals by the registered manager. This meant that staff had the opportunity to discuss issues with their supervisor that may further enhance and strengthen their practice. In addition to the scheduled supervisions, staff told us that if they needed to speak with their relevant supervisor, they were confident to do so. We were told, "She [the registered manager] is there for us, if we need her."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Staff had received training in the MCA. People residing at the service had full capacity to make decisions related to their wellbeing. Staff would explain any concerns and discuss how to overcome these, through risk assessing. However, people had been assessed to have full capacity.

People's health care needs were met by the service. Records evidenced visits by external professionals and recorded the advice offered. This included GPs, speech and language therapist and the local mental health team. The advice made by the visiting professional on how to further support people was appropriately updated in the care plans. For example, one person had a specific plan in place in relation to drinks. Visual imagery was used to enable the person to work on this effectively. The service had developed hospital passports for people. This provided essential information in one document for staff to take to the hospital should a person require hospitalisation.

Drinks and snacks were regularly offered to people, to keep them hydrated. In addition the open kitchen encouraged people to independently make themselves drinks and snacks. One person required additional support with this, and had a specific plan to help manage over eating. People were reminded of the meal options, and encouraged to assist staff in preparing meals, this helped to promote independence. If a person did not want to eat the food on the menu, they were offered an alternative. People told us that the "food is good here. I enjoy the choice and variety."

Is the service caring?

Our findings

The service was caring towards the people that were provided with support. Staff were observed speaking with respect and approaching people politely. People stated they were comfortable with staff, and that they were caring towards them. One person said, "The staff are very caring, oh yes, they look after me well." Another person stated, "I like living here, they are good to me." The service was observed to be calm and peaceful. People could be heard interacting and laughing with staff and the visiting people from the sister home, who had attended for a group activity. Positive interactions between staff and people were observed throughout the inspection. The visiting people also reported that staff were hospitable and caring towards their needs and the people who live at the service.

People had been told that an inspection was underway to enable them to be involved in the process should they choose to be, and to allow them to ask any questions. This was found to lower anxiety, as people were reassured of the reason for the inspector's presence. Some of the people asked to spend time with the inspector to share information on their experience of living at the service. The feedback received was all positive.

People told us that staff always maintained their privacy and dignity. Before entering their room, staff would knock to check it was okay for them to enter. If people did not wish to be disturbed, staff would come back later, at a time that was convenient for the person. We observed that people were independently getting up at the time they wanted to in the morning, as opposed to the time that suited the service. If people had to attend a work placement, or college they were encouraged to get up, however if they didn't wish to get up, they were left alone. People were offered and assisted with breakfast of their choice when they came down in the morning.

When being supported with personal care, people reported that staff would always offer assistance as they required, preserving their dignity. People were encouraged to complete tasks for themselves, however where staff support was needed this was offered immediately. Staff reinforced that the service aimed to work with people to help them maintain their independence where possible. They would support the person how they wished to be supported whilst motivating them to complete tasks independently.

People's likes and dislikes were known by the staff. During the interviews, staff were able to describe how people liked to be supported. This information was cross referenced against care plans and found to be accurate. For example people were supported to buy and wear clothes of their choice. People stated that staff knew them well and always tried to offer assistance in the way they liked, and preferred, as opposed to what would be easy for them. Care plans were found to be accurate and updated frequently to ensure they were reflective of people's changing care needs and preferences. One person told us how the staff cared for them and encouraged them to do things for themselves.

Records were maintained safely and securely. This ensured that confidentiality was maintained. Daily records were updated as required after each shift. We observed that when staff needed to speak about a person, they would either go to another room or lower their voice and stand to a corner, discreetly

discussing any issues. People's human rights were protected at all times. They were treated with respect and dignity and enabled to do things for themselves.

Is the service responsive?

Our findings

All people who use the service had a comprehensive assessment of their needs prior to their admission to the service to ensure that their needs could be appropriately met. The assessment also served to establish relationships by enabling people to come and visit the service prior to an admission. The home had been operating at full occupancy for several years. This reinforced how successful the pre-admission assessment had been in terms of compatibility. The registered manager emphasised the importance of ensuring the home was able to respond to people's needs appropriately. Where appropriate care was continually delivered in response to changing social and health care needs. However, should this not be appropriate, the registered manager advised this would be discussed with the family and the local authority.

The home had a structured communal activities programme as well as an individualised activity plan. This enabled people to engage either collectively or complete activities that were created around their choices or needs. For example, two people told us that they enjoyed community based activities together, and would often go out with one another. They were due to go out later in the week for a birthday meal to a local pub. "We like going together, we're friends", one person told us. In addition where possible people were offered the opportunity to engage in individual community activities. For example two of the people who lived at the service were employed, and would go to work independently.

Care plans were developed with people and where appropriate their representatives. Information such as their significant history, people important to them, their hobbies, how they like things done, and how they communicate their everyday needs were included. Care plans were reviewed frequently or when there was a change in the person's needs. This ensured staff were able to respond to needs appropriately. Care plans were reviewed in conjunction with people where possible as well as family members and professionals as required. This meant that care was responsive to the needs of the people.

Complaints procedures were displayed in communal settings within the home. People were further given information on how to complain upon their admission, with copies retained in their files for reference. The procedure outlined who people could complain to if they were unhappy with any element of the service. People were confident that their complaint would be dealt with if they had one. The service also offered house meetings where people could discuss any issues that they had, as well as provide positive feedback. The outcome of the last meeting was discussed at each new meeting so to ensure people were kept up to date.

The service responded to people's needs with the implementation of a key worker system. This allowed one staff to take a lead in how people were supported and how this was documented. People were encouraged to speak to their key worker about any issues that they may have, or anything that they felt was going well. One person told us that they spoke with their key worker about holidays that they would like to go on. When asked if these were arranged, we were told yes. Another person told us how they had wanted to have chickens, after seeing one of their neighbour's chickens. The service discussed this collectively with all people, and people agreed they would like to see how a chicken develops. Eggs were brought in from a local farm with appropriate lighting. People were encouraged to care for the developing chicks, with the view that

they would provide a source of fresh eggs to the home.

One person said, "I'm very happy. If I wasn't I would speak with [name of staff], I know [name] would help." This was replicated by staff comments, "I'd go straight to [registered manager], I'd talk through any issues, like I have." The complaints log illustrated that the complaints had been dealt with appropriately. Investigations had been completed and transparency was evident in the responses given to the complainants.

Is the service well-led?

Our findings

People benefitted from the honest, calm and open culture of the service. Staff showed an awareness of the values of the service. They spoke about providing "best practice". This was reflected in the training they received during the induction, as well as evidenced as being discussed in team meetings. People and staff told us that the registered manager was "hands on". She was happy to role model showing staff how to work with people. People stated that the personal touch and willingness of the registered manager and the provider to become involved in care made it "so much more special". The provider would frequently visit the service and offer assistance as required. The management were described by staff and the people as "friendly." Staff described them as "always here... totally professional".

An open door policy to staff, visitors, people and their relatives was provided by the registered manager. She would walk around the service, engaging with staff, people, visiting professionals and relatives alike. This allowed all the opportunity to raise any concerns, complaints or compliments with the registered manager at any time. We observed staff and people enter the office to have a general chat with the registered manager as well as discuss any issues. Staff reported that the registered manager and the provider were "pleasant, and very approachable." One member of staff stated, "You can approach [registered manager] at any time. She provides guidance... It doesn't matter what the issue is, we can ask for help."

The service had comprehensive auditing processes in place. These included audits completed by the managers from sister homes on one another's services. Audits were further completed by the registered manager. These included checking the service in line with the domains of the Care Quality Commission inspections. Action plans were generated in relation to this with a timeframe for when these needed to be completed by.

Feedback was sought from people, professionals and relatives to help improve the service. Surveys were sent out to collect information on what was being done well, and areas that needed to be further improved. Key workers worked through these with people, whilst relatives and professionals were asked to return these. An action plan was generated from the information collected. We were shown evidence of changes that had been made as a result of the surveys. This included alterations to the garden, as per recent feedback by people.

The registered manager had a comprehensive record that documented all the concerns or issues raised by staff, people, or visitors. Within this we found sufficient evidence of investigations being completed following on from concerns. Details of the feedback provided to the complainant was included in this. This illustrated that the registered manager were transparent in her handling of complaints. We discussed the new regulation on "Duty of Candour" and found that the registered manager was able to clearly describe the importance of this as well as reflectively illustrate through the documented concerns how this had been achieved.

There was strong evidence of working in partnership with internal and external professionals. For example if upon completing a trends analysis on behavioural incidents a pattern was found, the service would liaise

with the in-house psychologist. Guidance provided would then be incorporated into the person's care plan to ensure they were supported appropriately with their behaviour. In a similar way guidance and advice from other professionals was incorporated into the care of people living at the service – for example the speech and language therapist.

The communication within the service was good. Handovers were documented to ensure they could be referred to as required and to detail what had happened on shift. A communication book was used to transfer information that was not included in these. In addition a diary was used to retain information regarding appointments or any training specifically booked for staff.