

ABI Developments 3 Limited

1 Sewardstone Close

Inspection report

1 Sewardstone Close
Sewardstone Road
London
E4 7RG

Tel: 02084985620

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29 February 2016

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

The inspection was completed on 19 February 2016 and 29 February 2016 and there were 20 people living at the service when we inspected.

1 Sewardstone Close offers residential, nursing and intermediate care for up to 20 people with complex needs, as well as acquired brain injury and neurological conditions following an accident or other life threatening trauma.

A registered manager was in post. 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.

Although staff were supported improvements were required to ensure that they received regular formal supervision and where actions were highlighted, these were followed up and addressed.

People told us the service was a safe place to live and that there were sufficient staff available to meet their needs. Appropriate arrangements were in place to recruit staff safely so as to ensure they were the right people. Staff were able to demonstrate a good understanding and knowledge of people's specific support needs, so as to ensure their and others' safety.

Medicines were safely stored, recorded and administered in line with current guidance to ensure people received their prescribed medicines to meet their needs. This meant that people received their prescribed medicines as they should and in a safe way.

Staff understood the risks and signs of potential abuse and the relevant safeguarding processes to follow. Risks to people's health and wellbeing were appropriately assessed, managed and reviewed.

Staff received opportunities for training and this ensured that staff employed at the service had the right skills to meet people's needs. Staff demonstrated a good understanding and awareness of how to treat people with respect and dignity.

The dining experience for people was positive and people were complimentary about the quality of meals provided.

Where people lacked capacity to make day-to-day decisions about their care and support, we saw that decisions had been made in their best interests. The manager was up-to-date with recent changes to the law regarding the Deprivation of Liberty Safeguards (DoLS) and at the time of the inspection they were working with the local authority to make sure people's legal rights were being protected. People who used the service and their relatives were involved in making decisions about their care and support.

Care plans accurately reflected people's care and support needs. People received appropriate support to have their social care needs met. People told us that their healthcare needs were well managed and they received suitable therapies.

Staff were friendly, kind and caring towards the people they supported and care provided met people's individual care and support needs.

People and their relatives told us that if they had any concern they would discuss these with the management team or staff on duty. People were confident that their complaints or concerns were listened to, taken seriously and acted upon.

There was an effective system in place to regularly assess and monitor the quality of the service provided. The manager was able to demonstrate how they measured and analysed the care provided to people, and how this ensured that the service was operating safely and was continually improving to meet people's needs.

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.

The provider had appropriate systems in place to ensure that people living at the service were safeguarded from potential abuse.

Suitable arrangements were evident for managing and reviewing risks to people's safety and wellbeing.

There were sufficient numbers of staff available to meet people's care and support needs.

The provider's arrangements to manage people's medicines were suitable and safe.

Is the service effective?

Requires Improvement ●

The service was effective.

Improvements were needed to ensure that staff employed at the service received regular formal supervision. Where actions were highlighted; information was not available to show that these had been addressed and followed up.

Staff were appropriately trained to meet people's needs.

The dining experience for people was positive and people were supported to have adequate food and drinks.

People's healthcare needs were met and people were supported to have access to a variety of healthcare professionals and services.

Is the service caring?

Good ●

The service was caring.

People and their relatives were positive about the care and support provided at the service by staff. Our observations demonstrated that staff were friendly, kind and caring towards the people they supported.

People and their relatives told us they were involved in making decisions about their care and these were respected.

Staff demonstrated a good understanding and awareness of how to treat people with respect and dignity.

Is the service responsive?

Good ●

The service was responsive.

Staff were responsive to people's care and support needs.

People were supported to enjoy and participate in social activities of their choice or abilities.

People's care plans were detailed to enable staff to deliver care and therapies that met people's individual needs.

Is the service well-led?

Good ●

The service was well-led.

The management team of the service were clear about their roles, responsibility and accountability and we found that staff were supported by the registered manager and other members of the management team.

Appropriate arrangements were in place to ensure that the service was well-run. Suitable quality assurance measures were in place to enable the provider and management team to monitor the service provided and to act where improvements were required.

1 Sewardstone Close

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 19 February 2016 and 29 February 2016 and was unannounced. The inspection team consisted of one inspector on both days and on 19 February 2016 the inspector was accompanied by two specialist advisors. Their specialism related to speech and language therapy and physiotherapy.

Before our inspection we reviewed the Provider's Information Report (PIR). This is information we have asked the provider to send us to evidence how they are meeting our regulatory requirements. We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

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

We spoke with six people who used the service, one relative, three members of rehabilitation staff, the registered manager, the deputy manager, the clinical lead, speech and language therapist, physiotherapist, chef and the service's business manager.

We reviewed nine people's care plans and care records. We looked at the service's staff support records for six members of staff. We also looked at the service's arrangements for the management of medicines, complaints, compliments and safeguarding information and quality monitoring and audit information.

Is the service safe?

Our findings

Staff told us that they felt people living at the service were kept safe at all times. People confirmed to us that staff looked after them well, that their safety was maintained and they had no concerns. People told us that they felt safe and secure. One person told us, "I feel really safe. The staff are nice and kind." Another person told us, "I am safe living here. The staff support me fine." One relative told us, "I have total piece of mind that my relative is kept safe at all times."

People were protected from the risk of abuse. Staff had received safeguarding training. Staff were able to demonstrate a good understanding and awareness of the different types of abuse, how to respond appropriately where abuse was suspected and how to escalate any concerns about a person's safety to a senior member of staff or a member of the management team. One member of staff told us, "If I have any concerns about any of the people who live here I would tell the nurse on duty or the manager." Staff were confident that the manager or deputy manager would act appropriately on people's behalf. Staff also confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission if they felt that the management team were not responsive.

Staff knew the people they supported. Where risks were identified to people's health and wellbeing, staff were aware of people's individual risks. For example, staff were able to tell us who was at risk of poor mobility, who had poor swallowing reflex and who had a Percutaneous Endoscopic Gastrostomy [PEG] tube in place and the arrangements in place to help them to manage this safely. The latter is used to provide a means of feeding when normal oral intake is not possible. In addition, risk assessments were in place to guide staff on the measures in place to reduce and monitor these during the delivery of people's care. Staff's practice reflected that risks to people were managed well so as to ensure their wellbeing and to help keep people safe. Environmental risks, for example, those relating to the service's fire arrangements and Legionella were in place.

People told us that there was always enough staff available to support them during the week and at weekends. One person told us, "There are enough staff available. If I need help, staff are there for you." Another person told us, "I think there are enough staff." Staff told us that staffing levels were appropriate for the numbers and needs of the people currently being supported. Suitable arrangements were in place to determine the basis for the service's staffing levels so as to ensure that these remained suitable and flexible to meet people's individual care and support needs. Our observations during the inspection indicated that the deployment of staff was suitable to meet people's needs. For example, where people were seen to ask staff for assistance with personal care, to be supported to have a cigarette or to request a drink, staff responded in a timely manner.

Suitable arrangements were in place to ensure that the right staff were employed at the service. Staff recruitment records for three members of staff appointed within the last six months showed that the provider had operated a thorough recruitment procedure in line with their policy and procedure. This showed that staff employed had the appropriate checks to ensure that they were suitable to work with the people they supported.

We found that the arrangements for the management of medicines were safe. People received their medication as they should and at the times they needed them. Medicines were stored safely for the protection of people who used the service. There were arrangements in place to record when medicines were received into the service and given to people. We looked at the records for eight of the 20 people who used the service. These were in good order, provided an account of medicines used and demonstrated that people were given their medicines as prescribed. Specific information relating to how the person preferred to take their medication was recorded and our observations showed that this was followed by staff.

Staff involved in the administration of medication had received appropriate training. Regular audits had been completed and where these highlighted areas for corrective action, a record was maintained of the actions taken.

Is the service effective?

Our findings

Although staff told us that they felt supported by the management team, staff had not received regular supervision in line with the provider's own policy and procedures. The registered manager confirmed that it was the provider's expectation that staff should receive formal supervision at bi-monthly intervals and a record of supervision detailing the topics discussed should be maintained. We found that staff had not received formal supervision as frequently as they should and where records were in place; these provided little or no evidence of the topics discussed. Additionally, where issues that required further action had been highlighted, there was no proof to indicate that these had been followed up, addressed or the timescale for action. For example, one member of staff in 2015 had raised concerns relating to feeling intimidated and fearful for their safety as some people using the service could be anxious and distressed. No information was recorded as to how this was to be addressed by the management team.

Staff were trained and supported effectively, which enabled them to deliver appropriate care to the people they supported. Staff confirmed that they received regular training opportunities in a range of subjects and this provided them with the skills and knowledge to undertake their role and responsibilities and to meet people's needs to an appropriate standard. Staff told us that this ensured that their knowledge was current and up-to-date. Records confirmed what staff had told us and showed that their mandatory training was up-to-date. In addition, staff received specialist training, for example, the speech and language therapist confirmed that all staff received dysphagia training on an annual basis. They confirmed that this was due for renewal in March 2016 or April 2016.

The registered manager and deputy manager confirmed that all newly employed staff received a comprehensive induction. On the first day of inspection we found that an 'induction checklist' in the form of a tick chart was completed detailing what was accomplished as part of this process. However, there was no other evidence available to show that this was robust or in line with the 'Care Certificate.' We discussed this with the registered manager and deputy manager and on the second day of inspection, a new induction process had been devised. This was detailed and in line with the 'Care Certificate.' This showed that the registered manager and deputy manager had reviewed their practice to ensure that all newly employed members of staff received a comprehensive induction which was relevant to their workplace, their role and experience. Staff told us that in addition to the above they were given the opportunity to 'shadow' and work alongside more experienced members of staff. The deputy manager confirmed that this could be flexible according to previous experience and level of competence.

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 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.

Staff were able to demonstrate that they had a good knowledge and understanding of MCA and DoLS and

when these should be applied. Records showed that each person who used the service had had their capacity to make decisions assessed. This meant that people's ability to make some decisions, or the decisions that they may need help with and the reason as to why it was in the person's best interests had been clearly recorded. Where people were deprived of their liberty, the registered manager had made appropriate applications to the local authority for DoLS assessments to be considered for approval. For example, where people had lap belts in use for their safety, sensory mats to notify staff of a person's movements and where people's cigarettes and lighters were kept for safe keeping. This meant that the provider had acted in accordance with legal requirements.

People were observed being offered choices throughout the day and these included decisions about their day-to-day care needs. People told us that they could choose what time they got up in the morning and the time they retired to bed each day, what items of clothing they wished to wear, where they ate their meals and whether or not they participated in social activities.

Observation of the dining experience for people over both days of the inspection was noted to be relaxed, friendly and unhurried; with staff conversing with colleagues and people using the service. People were supported to make daily choices from the menu provided, received food in sufficient quantities and were encouraged to have additional servings of food if they so wished. Where people required assistance and support to eat and drink this was provided in a sensitive and dignified manner, for example, people were not rushed to eat their meal. During the lunchtime meal on the first day of inspection one person had a substantial coughing spell that caused their eyes to water, their facial skin colour to change and was distressed by the incident. However, we were anxious that they were not prompted or reminded to not cram their food into their mouth by staff whilst eating as highlighted within their individual plan of care. This information was discussed with the registered manager and business manager and an assurance was provided that this would be addressed for the future.

The chef informed us that some people using the service who had swallowing difficulties or dysphagia, required their meals to be pureed and/or required the thickening of thin liquids with a specially prepared formula so as to make them easier to swallow. A list was displayed in the main kitchen detailing the recommendations for those people who required a modified textured meal and there was good communication between the chef, the speech and language therapist and vice versa. This ensured that there was a correct handover of information and recommendations so as to support the person using the service effectively and safely. The chef confirmed that they had received appropriate training relating to acquired brain injury and dysphagia in 2015. On the first day of inspection initial concerns were raised with the management team relating to inappropriate equipment [hand blender] being used by the chef to amalgamate high risk foods. This referred to food items such as, baked beans, sausages and hash browns to the right consistency so as to prevent coughing, choking and the risk of aspiration to people using the service. On the second day of inspection, we were advised by the registered manager and business manager that a more suitable blender had been available but was not being used by the chef. An assurance was provided that this would be used from now on.

Where appropriate people told us that they were encouraged and supported with meal and snack preparation so as to maintain their independence. People were able to use the 'satellite' kitchens on both the ground and first floors and had access to a kettle, fridge and microwave in their room.

People told us that their healthcare needs were well managed. People's care records showed that their healthcare needs were clearly recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital

appointments and to see their GP. Relatives confirmed that they were kept informed of their member of family's healthcare needs and the outcome of healthcare appointments.

Is the service caring?

Our findings

People were satisfied and happy with the care and support they received. One person told us, "It's much better now since the new manager has been here. The staff see you as a human being." Another person told us, "I didn't like it before but now it is much better. The staff are very nice and they support me when I need assistance or advice."

We observed that staff interactions with people were positive and the atmosphere within the service was seen to be welcoming, calm and friendly. Staff were noted to have a good rapport with the people they supported and there was much good humoured banter during both days of the inspection which people enjoyed. Staff were attentive to people's needs, whether it was supporting a person with their personal care needs, supporting someone to have a snack or to make a drink or enabling them with household chores.

We saw that staff communicated well with people living at the service by listening to them and talking with them appropriately. One person told us, "There is much better communication. Staff takes time to really listen to you. I feel that there is a real connection with the staff." This showed that staff knew peoples' individual communication needs and their abilities. For example, which people were able to verbally communicate, who was encouraged to use a communication diary, who used Makaton and who were only able to communicate using non-verbal cues, such as, eye contact and body language. The Provider Information Return [PIR] detailed that two people used British Sign Language to communicate and several people had mobile phones, laptops and electronic tablets to aid their communication. Our observations showed that the latter was accurate.

Staff understood people's care needs and the things that were important to them in their lives, for example, members of their family, key events, hobbies and personal interests. People were also encouraged to make day-to-day choices and their independence was promoted and encouraged where appropriate and according to their abilities. For example, one person advised us that they looked after their medication and were able to self-medicate. Additionally, they confirmed that they were able to access the local community for personal shopping, to go to the bank, to attend college twice a week and to undertake all aspects of day-to-day living at the service, such as, cooking and attending to their personal laundry.

Staff were able to verbally give good examples of what dignity meant to them, for example, knocking on doors, keeping the door and curtains closed during personal care and providing explanations to people about the care and support to be provided. Our observations showed that staff respected people's privacy and dignity. We saw that staff knocked on people's doors before entering and staff were observed to use the term of address favoured by the individual. In addition, we saw that people were supported to maintain their personal appearance so as to ensure their self-esteem and sense of self-worth. People were supported to wear clothes they liked, that suited their individual needs and were colour co-ordinated. Staff were noted to speak to people respectfully and to listen to what they had to say. The latter ensured that people were offered 'time to talk', and a chance to voice any concerns or simply have a chat.

People were supported to maintain relationships with others. People's relatives and those acting on their

behalf visited at any time. Staff told us that people's friends and family were welcome at all times. Relatives confirmed that there were no restrictions when they visited and that they were always made to feel welcome. One visitor told us that they always felt welcomed when they visited the service and could stay as long as they wanted.

Is the service responsive?

Our findings

People received personalised care that was responsive to their individual needs. Our observations showed that staff were aware of how each person wished their care to be provided. Each person was treated as an individual and received care and support relevant to their specific needs and in line with information recorded within their care plan.

Appropriate arrangements were in place to assess the needs of people prior to admission. This ensured that the service were able to meet the person's needs. The provider used 'CareDocs' a computer based care planning system. People's care plans included information relating to their specific care needs and how they were to be supported by staff. Care plans were regularly reviewed and where a person's needs had changed these had been updated to reflect the new information. For example, one person had recently made a conscious decision to have a vegetarian diet. Their care plan had been updated to reflect this. Staff had access to an electronic tablet so as to upload clinical and daily care records to the 'CareDoc' system. This ensured that information recorded was up-to-date and accessible to all staff.

The service provides slow stream rehabilitation to people whose physical, communicative, behavioural and cognitive needs require on-going support. This is to ensure that people have the opportunity to achieve their goals, increase their independence and do not lose any skills they may have already accomplished. The service offers a programme of on-going rehabilitation provided by a range of clinical professionals, such as, occupational therapy, physiotherapy, psychiatry, speech and language therapy and psychology. The length of stay is dependent on the achievement of individual's rehabilitation goals. There was evidence to show that each person received specific hours for rehabilitation and appropriate therapies according to their needs. Information relating to the therapies provided and undertaken was recorded within each person's care plan. Information included goal setting, therapy sessions and evidence of joint multidisciplinary team meetings. The PIR detailed that within the last 12 months four people had returned to living in the community. At the time of the inspection one person was waiting to move to independent living.

Staff told us that some people could become anxious or distressed. Clear guidance and instructions for staff on the best ways to support the person were recorded and these were noted to be thorough and comprehensive. Staff were able to demonstrate a good understanding and awareness of the support to be provided so as to ensure the individual's, staffs and others safety and wellbeing at these times.

Staff told us that they were made aware of changes in people's needs through handover meetings and discussions with senior members of staff. This meant that staff had the information required so as to ensure that people who used the service would receive the care and support they needed.

People told us that they were supported to follow their interests and take part in social activities of their choice and preference. It was evident from our observations and discussions with staff that they encouraged and enabled people using the service the opportunity to take part in social activities of their choice and interest, both 'in house' and within the local community. One member of staff confirmed that they were able to attend college twice a week. Each person had a weekly activity planner detailing activities to be

undertaken in line with their personal preferences. We noted that staff took part in engaging and supporting people in interactions and activities as opportunities arose throughout both days of inspection. For example, enjoying a game of bowling on the home video games console, arts and crafts, watching television, cooking club, accessing the local community and attending fitness classes. The registered manager confirmed that a fitness coordinator worked with three people using the service.

People spoken with knew how to make a complaint and who to complain to. People and their relatives told us that if they had any concern they would discuss these with the management team or staff on duty. The service had an effective complaints procedure in place for people to use if they had a concern or were not happy with the service. The complaints log showed that over the past 12 months there had been five complaints from people using the service and/or those acting on their behalf. A record was kept of all issues raised, action taken and the outcome. A record of compliments was also maintained so as to capture the service's achievements. A visiting professional recorded, 'It was a pleasure to review with you and I was impressed with all that I saw.'

Is the service well-led?

Our findings

The registered manager was able to demonstrate to us the arrangements in place to regularly assess and monitor the quality of the service provided. This included the use of questionnaires for people who used the service and those acting on their behalf. In addition to this the registered manager monitored the quality of the service through the completion of a number of audits. This included a monthly 'Home Audit' by the registered manager, a monthly report by the service's business manager and an internal review of the service by an external auditor requested by the provider. The latter linked in with our new approach to inspecting adult social care services introduced in October 2014. This was completed in January 2016 and showed that an overall rating score of 'good' was attained. The audit highlighted where the service was compliant and the areas for improvement. This demonstrated how the provider and registered manager identified where improvements were needed and the actions to be taken to improve the service.

People using the service, people acting on their behalf and staff had many positive comments about the overall management of the service. One person told us, "I have seen manager's and staff come and go. Before [name of current manager], I did not feel safe, things were not done properly and my needs were not being met. I was upset most days and spent a lot of time in my bedroom. The new manager has made a big big difference and things are much better." Another person told us, "It is much better since the arrival of the new manager. They have made a lot of difference." Staff demonstrated that they were clear about the registered manager's and provider's expectations of them. Staff told us that they were well supported and for the first time in a long while, staff told us that their views were respected and they felt able to express their opinions freely. Staff felt that the overall culture across the service was open and inclusive and that communication and morale was good. This meant that the provider and management team of the service promoted a positive culture that was person centred, open and inclusive.

Staff told us that regular staff meetings, clinical meetings for the registered nurses, heads of department meetings and multidisciplinary team meetings were held at the service to enable the management team and staff to discuss topics relating to the service or to discuss care related matters. Records were available to confirm this and demonstrated where actions were required and how this was to be achieved. Additionally, the registered manager told us that meetings were held for people using the service and those acting on their behalf. This showed that people using the service and those acting on their behalf were encouraged to have a 'voice' and to express their views about the service. For example, in December 2015 the provider gave money for the communal areas of the home environment to be re-decorated and furnished. People told us that catalogues had been made available and they were involved in picking out colour schemes and choosing new furniture.

The manager had an understanding and awareness of our new approach to inspecting adult social care services, which was introduced in October 2014. Information was readily available for staff in relation to the fundamental standards and included was a copy of 'The State of Health Care and Adult Social Care in England' for the period 2014/2015.

The management team advised that to reward staff's efforts the provider held an annual 'Heart of Gold'

award ceremony. This is held to recognise employees for their dedication and commitment to providing good quality care. People are nominated by people using the service, those acting on their behalf, co-workers and professionals.