Home from Home Care Limited

Kirk House

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

The inspection took place on 10 November 2016 and was announced.

Kirk House is registered to provide accommodation and personal care for up to 11 people who have a learning disability or autistic spectrum disorder.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment. Some people living at the service had their freedom lawfully restricted under a DoLS authorisation.

Relatives told us that their loved ones were cared for by kind, caring and compassionate staff. Staff undertook appropriate risk assessments for all aspects of a person's care to keep them safe from harm inside and outside of the service. Care plans were developed to support people's individual needs. Staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care. People received their prescribed medicines safely from staff that were competent to do so. The registered provider ensured that there were always sufficient numbers of staff on duty to keep people safe.

People were supported to have a nutritious and balanced diet and hot and cold drinks and snacks were available throughout the day. People had their healthcare needs identified and were able to access healthcare professionals such as their GP and dentist. Staff knew how to access specialist professional help when needed.

People were at the centre of the caring process and staff acknowledged them as unique individuals. Relatives told us that staff were kind and caring and we saw examples of good care practice. People were always treated with dignity and respect. People were cared for by staff that were supported to undertake training to improve their knowledge and skills to perform their roles and responsibilities.

People lived busy and active lives and were encouraged to take part in hobbies and interests of their choice. Some people were supported in education, voluntary work and all enjoyed being part of a strong social network. Relatives commented that their loved ones were well looked after and their wellbeing had improved since moving into the service.

People were supported to make decisions about their care and treatment and maintain their independence. People had access to information in an easy read format about how to make a complaint.

The registered provider had robust systems in place to monitor the quality of the service and make improvements. Staff had access to professional development, supervision and feedback on their performance. People, their relatives and staff found the registered manager approachable.

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 had their risk of harm assessed to keep them safe.

Staff were aware of safeguarding issues and knew how to raise concerns.

Medicines were stored, administered and unwanted medicines were disposed of safely.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities.

People were supported to have a healthy lifestyle and received support from healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

Staff formed a strong relationship with people and people felt that they mattered.

Staff communicated with people in a way that helped them to understand their care.

People were treated with dignity and staff respected their choices, needs and preferences

Is the service responsive?

Good

The service is responsive.

People were at the heart of the service. They were enabled to take part in a range of innovative activities of their choosing that met their social needs and enhanced their wellbeing.

A complaints policy and procedure was in place in a format that was accessible to people.

Is the service well-led?

Good

The service was well-led.

There were systems and processes in place to check the quality of care and improve the service.

Staff felt able to raise concerns.

The registered manager created an open culture and supported staff.

Kirk House

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.

The inspection took place on 10 November 2016 and was announced. The inspection team was made up of one inspector.

We gave 24 hours notice of our inspection because people who live at the service are often out of the service taking part in recreational activities. We needed to be sure that they would be in so as we could speak with them.

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 what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about.

During our inspection we spoke with the registered manager, the compliance director for the provider organisation, an assistant manager, one member of care staff, and five people who lived at the service. Following our inspection we spoke with four relatives by telephone. We also observed staff interacting with people in communal areas, providing care and support.

We looked at a range of records related to the running of and the quality of the service. These included staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for three people, daily diaries for three people and medicine administration records for five people.

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 were unable talk with us.

Good

Is the service safe?

Our findings

Several people who lived in the service had communication difficulties and were unable to tell us if they felt safe living there. However, we watched people interact with staff and saw that they were at ease with staff. We observed that people had put their trust in the staff to keep them safe.

We spoke with relatives of three people who lived at the service who told us that the provider had processes in place to ensure people were as safe as they could be. One relative said, "All the standards and safeguards are there as you would wish." Another relative said, "We are very pleased. Delighted to be there. [Name of loved one] is safe and secure.

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. Staff told us that they had received training on how to keep people safe and how to recognise signs of harm and abuse and who to report any concerns to.

There were systems in place to support staff when the registered manager was not on duty, such as access to on-call senior staff out of hours for support and guidance. There was a business continuity plan to guide and support staff in an emergency situation such as a power failure. If the service needed to be evacuated in an emergency, procedures were in place to relocate people to a neighbouring service.

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care such as travelling in the mini bus or the risk from boiling water when cooking. Detailed care plans were in place to enable staff to reduce risks and maintain a person's safety. A senior member of staff undertook a daily walkabout of the service and the registered manager undertook a walkabout once a week. A senior member of staff told us that the purpose of the walkabouts was to do visual checks on the internal and external environment to ensure that there were no hazards that compromised people's safety.

There were robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post. A senior member of the staff team was a mentor to new staff and supported them through their induction.

We found that the provider employed sufficient numbers of staff to keep people safe and each person had a support worker allocated to them to assist with assessing, planning and delivering their care and social needs. The registered manager explained that the service used a layering system of staffing to ensure people had the right support to undertake hobbies and interests and keep them safe inside and outside of the service. Having a layering system meant that staffing levels were increased to cover periods of high activity. For example, we saw that two people went out for the day in the mini bus and they were accompanied by three members of staff. However, the people who remained in the service had one to one support from a member of staff. Relatives told us that their loved one had the right level of support to meet all of their needs. One person's relative told us that staff went beyond the call of duty and said, "Two members of staff were prepared to put in a long day to support [name of loved one] at her sister's wedding. They made it

possible for her to be there."

People received their medicine from staff who had received training in medicines management and had been assessed as competent to administer them. We were unable to observe medicines being administered as most people were only prescribed medicine at breakfast time and bed time. We looked at medicine administration records (MAR) for five people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a recent photograph of the person for identification purposes and any allergies and special instructions for the storage and how to administer the medicines were recorded. Where a person did not receive their medicine a standard code was used to identify the reason. For example, one person was on regular medicine to relieve hay fever, but the seasons had changed and they were no longer suffering with hay fever. We saw evidence that the person's GP had been contacted to change the regular hay fever medicine to be taken as required.

All medicines were stored accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines and the medicines policy.

Good

Is the service effective?

Our findings

Relatives told us that staff had the knowledge and skills to provide appropriate care for their loved one. One relative said, "It's a marvellous place. [Name of loved one] has thrived since living there." People were unable to tell us if staff had the knowledge and skills to look after them. Therefore we observed staff deliver care to people and saw that understood people's individual needs and they acted in a responsible and confident manner. All staff undertook mandatory training in key areas such as safeguarding, deprivation of liberty safeguards and health and safety. In addition, staff were provided with training in areas relevant to the care needs of people who lived in the service such the care of a person living with epilepsy and autistic spectrum disorder and safe hold and breakaway techniques. The provider had their own training facility that staff attended for most of their training needs. We looked at the staff training matrix and saw that training was planned until 2019. Staff spoke positively about the training they received. One staff member told us that training helped their professional development and said, "Fantastic training. Our strengths are identified. I have trained as a staff mentor."

Staff received an annual appraisal and regular supervision sessions and were expected to attend 10 a year. The registered manager received regular supervision and an annual appraisal from their line manager. The responsibility for undertaking staff appraisals was shared by registered manager and assistant managers. A member of staff shared with us the benefits of supervision and said, "I do my prep before we meet. I can be honest and share my concerns. It's a good opportunity to reflect on my work. We look at development strategies to complete delegated tasks."

Most people who lived in the service were not always able to give consent to their care and treatment and we saw that staff followed the guidance in the Mental Capacity Act 2005 (MCA). The 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. For example, we saw that people had their mental capacity assessed and best interest decision were made so as they could receive their medicines safely.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS and ten applications had been submitted to the relevant local authority; six were authorised and four were waiting on assessments. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and staff knew who was subject to a DoLS authorisation and how to support them.

The service was on two floors, both with their own open plan kitchen and dining room, a spacious lounge, laundry and clinical room. People who had their bedroom on the ground floor were more dependent on

staff for their care needs, whereas the people who had their bedrooms on the first floor where enabled to undertake every day domestic tasks with support and supervision. During the morning we found three people engaged with staff in the upstairs kitchen baking sausage rolls for their lunch, and a selection of cakes for snacks. We saw that people were proud of their achievements and that food was important to them. When we asked if they were looking forward to having homemade sausage rolls for their lunch, one person replied, "Yes and we can have beans and sandwiches as well."

The service did not employ cooks. People who lived at the service met with staff on Sunday to plan the menus for the following week. We saw photographs of their menu choices for the week ahead on display in the kitchens. We found that where able, people were supported to order the weekly food order on-line and access food shops in the local community. On the day of our inspection two people had gone food shopping accompanied by members of staff; one to the local butchers and the other to a supermarket in a nearby town. Mealtimes were flexible and were planned around the times that people were coming and going from their different activities and trips out.

Four people who lived at the service did not eat a "normal" diet. Staff were aware of their special dietary needs and their care plans reflected this. One person had been assessed as needing dietary supplements and another person who was at risk of weight gain was supported to follow a healthy eating programme. Food and drink was stored in locked cupboards and fridges in the downstairs kitchen for people's own safety, as some people would react badly if they ate the wrong foods. However, people could have a drink or snack at any time. Apart from knives which were locked, people who used the upstairs kitchen had open access to all the food and drink storage cupboards and crockery and utensils. We saw that to help people find what they needed that the cupboards and drawers were labelled with a picture and name of their contents.

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, dentist and dietician. One person's relative told us how staff in the service had worked in partnership with other healthcare professionals to help their loved one and said, "[name of loved one] is prone to chest infections and at risk of choking when eating and drinking. We had expert advice and help from the speech and language therapist (SALT) and occupational therapist. It was dealt with carefully and communicated well to others." Staff told us about another person who had been unable to take oral diet and fluids for the last four years. One staff member said, "They've had no oral food for three or four years, has a PEG. We are now working with the SALT to have taster fluids, to introduce different tastes to [name of person]." A PEG is a tube inserted directly into the stomach to provide a person who is unable to swallow with adequate nutrition and hydration.

Staff supported people to take regular exercise to maintain their physical fitness. We saw that a wide range of activities were enjoyed, such as countryside walking, swimming and horse riding. In addition, we saw staff had worked in partnership with health professionals and relatives so that different relaxation approaches were taken with people to help them stay calm and reduce their anxieties. For example, on the day of our inspection one person accessed the sensory room in the adjoining day care centre. Another person enjoyed a regular foot spa and another enjoyed a head massage when having their shower.

Good

Is the service caring?

Our findings

We observed staff interacting with people who lived at the service. People and staff had a good relationship and there was evidence of mutual respect and trust. We heard a lot of laughter and friendly banter. People who had difficulty verbally communicating there excitement and enthusiasm for whatever they were doing at the time were demonstrating their pleasure with loud squeals and hand waving.

We spoke with relatives who were positive about the care their loved one received. One relative said, "We searched long and hard to find an appropriate place. We are delighted with the placement. She is happy, well cared for and comfortable. It shows in her mood, when we are visiting we can hear her laughing before she sees us. That is a sure indication." Another person's relative told us, "Marvellous place. She has thrived since there. They do an awful lot with her."

We found that a person centred approach was taken with people who had difficulty communicating their needs verbally. For example, one person used picture cards to inform staff of their needs. People had a communication passport that they took with them on visits to their GP or to attend an outpatient appointment. We noted that one person's passport translated what different sounds meant to them. In addition, people had an "accident and emergency" grab sheet that went with them if they were admitted to hospital as an emergency. The grab sheet provided hospital staff with information that the person would be unable to provide them. For example, we read in one person's grab sheet; "Has no concept of risks, likes soft toys and loud music" and suggested that the person would be best cared for in a single room.

People were enabled to maintain contact with family and friends and could receive visitors at any time. We saw that most people had regular visits to the family home and some went on family holidays. Relatives spoke about the contact they had with their loved ones. One person's relative told us, "They come home every two weeks and stays over at Christmas. The family feel very welcome. We went to a barbeque in the summer; all the family went." Another person's relatives told us, "She comes home once a fortnight and doesn't mind going back. They put on four activities a year for all the family to join; we've been to a barbeque and summer fair."

We observed how staff enabled people to develop and maintain their skills to be as independent as possible. As we mentioned earlier, the service did not employ ancillary staff such as a cook or housekeeper. People who lived at the service were supported to undertake a range of general housekeeping duties where physically able. For example, some people assisted with on-line food shopping twice a week, others helped with meal preparation and most were prompted to keep their bedrooms clean and tidy and help with their laundry. We observed people and staff working together in the kitchen preparing their evening meal.

We saw that people's right to their privacy and personal space was respected. For example, all ground floor windows are tinted, so as people who lived in the service could look out, but passers-by could not look in. Staff told us what actions they took to respect a person's privacy and dignity. One staff member said, "There privacy and dignity is respect, staff always shut the bedroom curtains when we are giving personal care." One staff member shared with us that most members of the public respected people when were in the

community, but added, that there were occasions when swimming that members of the public showed no tolerance towards people who lived at the service.

We found that all confidential records were generated and stored electronically. Staff had access to hand held computers that were locked when not in use and were password protected to protect personal information.

People and their relatives were made aware of the lay advocacy service. Lay advocacy services are independent of the service and local authority and can support people to make and communicate their wishes. There was no one at the time of our inspection using the lay advocacy service.

Good

Is the service responsive?

Our findings

We found that before a person moved into the service there was a period where a key member of staff got to know the person and their relatives and supported the transition from one care environment to another. A relative told us, "[name of key worker] came to our house several times and did things with her [their loved one] and got to know her." Another person's relative spoke of how staff supported them through the transition into the service and said, "Letting go was difficult, but I'm confident she is well looked after." We saw that some people had the same curtains, bedding and wall paper as they had at their family home. Relatives and staff told us this helped the person settle as their surroundings looked familiar to them.

We saw that areas of the service had been adapted to meet individual needs. For example there was a lift to the first floor that could accommodate a person who was dependent on their wheelchair for all their mobility needs. Another person had a ceiling mounted tracking system that allowed them to transfer safely from their wheelchair to their bed with minimal handling. We saw that the track ran into their bathroom and they had a specially designed shower trolley that they used twice a day. Each person had their own bedroom and en-suite bathroom or shower room. People were happy for us to see their rooms. We saw that their decoration, furniture and personal items were relevant to their needs, preferences and personality and people had chosen them with the help from their relatives. For example, one person had posters of their favourite pop stars that they had seen in concert, another person had their bedroom decorated in the colours of their favourite football team and another person kept tropical fish.

We saw that several people were engaged with staff in one to one activities. Music played a significant part in helping people express their mood. Several people had electric keyboards, one person had a drum kit and all had access to music players. We saw that some people enjoyed books and being told stories. One person was supported to go to the local library to select talking books to listen to in bed at night.

The provider had a discussion group called "our voices" for people who lived in their services. One person who lived at the service represented their peers at the monthly meetings. We saw that the meeting minutes were accessible to all and were recorded in word and picture format. Furthermore, there was a photograph of all the people who attended the meetings. The vice chairperson of "our voices" discussion group had been involved in creating a "resident" satisfaction survey. The survey used pictures and words to help people understand the questions asked and people gave their response through "yes, no and don't know" smiling faces. The purpose of "our voices" was to empower people who lived in the provider's services to have a say in the running of their service and give their feedback on areas for improvement. We spoke with the relatives of the person who represented Kirk House and they said, "Our voice is good for her. She now has a friend."

The registered manager told us that each day was different and structured around the people who lived in the service and was influenced by their planned activities and individual moods and behaviours. We observed and care records recorded that people lived busy and active lives and were encouraged to take part in hobbies and interests of their choice. Some people were supported in education, others in voluntary work placements, sporting activities and all enjoyed being part of a strong social network. We found that

people's sporting, life skills and academic achievements were recognised. For example, we saw some people had a nationally recognised certificate of achievement for "skills for independence" and others had received an award for gardening.

We found that staff exchanged information about a person's care needs and wellbeing at shift handover to maintain continuity of care throughout the day. The handover was face to face and also an electronic record was maintained and staff could consult this at any time during their shift. We looked at copies of the handover sheets for the previous 48 hours and saw that an update was provided on each person who lived in the service. In addition staff had access and maintained a daily diary that recorded all aspects of the person's day. For example, any accidents or incidents, any contact made with their family and in-depth details of any activities undertaken and their outcome.

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. One person's relative told us, "We went to the September review. It was good. We have the chance to discuss little niggles. Just minor things." Another person's relative told us, "We go to the reviews. We go through things. We had trouble with her wheelchair. It took a long time to get it right". We saw that this person's wheelchair was custom made to meet all their support needs including a moulded headrest to help their comfort and posture. We looked at the care plans for three people. We saw that individual care plans focussed on supporting a person to live well, maintain their independence and develop new skills. A new care plan system had been introduced across the provider organisation following feedback from CQC inspections undertaken in the last year. We found that the new care plans were straightforward and we readily found the information we needed.

People and their relatives had access to information on how to make a complaint and we saw it clearly displayed in word and pictorial format. One person's relative who was full of praise for the care their loved one received said, "If I wasn't happy I would be just as quick to criticise. But there is never a big issue. Praise where praise is due." Another relative told us that they had no need to make a complaint and added, "It's nice to say it's very good." The registered manager had received one complaint about the service in the last 12 months. We found that this had been investigated and resolved within 24 hours."

Good

Is the service well-led?

Our findings

Staff told us that they found the registered manager approachable, supportive and knowledgeable and said they could go to them at any time. One staff member told us, "[Manager's name] is a good leader. Has given me support and shared their knowledge. I wouldn't be where I am without her." The registered manager was supported by two assistant managers and the compliance director. We found that the registered manager was a visible leader and knew their staff and the people in their care. Relatives told us that they could speak with the registered manager or a member of senior staff at any time.

Although relatives could speak with the register manager or any staff member at any time, the provider has introduced a system called "Parent call". Relatives had the option to receive a regular monthly phone call from a member of their loved one's core team. One person's relative told us that they had been approached to take part, but declined and said, "We were offered a monthly chat and opportunity to air our thoughts. However, we have such a good relationship with staff. We feel familiar and comfortable."

Monthly staff team meetings were held with the registered manager and a member of the human resources department. Human resources attended so as any employment issues could be addressed straightaway. Staff were expected to attend a minimum of ten meetings a year. To enable all staff to attend, staff meetings were held three times a month. We saw the minutes of the last team meeting held on 18 October 2016. Topics discussed included quality assurance, training and development and health and safety. A member of staff said, "We get to speak out at the staff meetings. It's a time to share. However, we don't have to wait for a team meeting or our one to ones, we can approach [registered manager] at any time."

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and infection control and guidance on supporting people when they became distressed. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager.

A programme of regular audit was in place that covered key areas such as health and safety, medicines and infection control. Action plans with realistic time scales were produced to address any areas in need of improvement. The audit outcomes and required actions were shared with staff. In addition, some areas were subject to external audit such as the safe management of medicines by the dispensing pharmacist and fire safety. In addition, the service has an unannounced quality audit once a month that was structured on the Health and Social Care Act 2008 regulations. The registered manager also undertook regular health and safety walkabouts of the service. The outcomes of the audits are shared with staff, lessons are learnt and changes to practice are introduced.

We found that the culture of the service was focussed on continuous learning; making improvements to the quality of care people received. Management and staff were involved in local authority forums, specialist publications and had registered to receive national updates on clinical excellence and medical alerts.

The provider had a system were the registered manager reported their staffing levels and skill mix, and

accident and incidents to their head office once a week. In addition, the provider had informed us of notifications as required by law. Notifications are events which have happened in the service that the provider is required to tell us about.