# Community Homes of Intensive Care and Education Limited

# Appleton House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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 and 13 July 2018. It was unannounced. This was the first inspection at Appleton House since it re-registered with a new provider.

Appleton House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Appleton House is registered to provide residential and personal care for up to seven people with mental health needs. The home is situated in a residential district of Southampton with nearby public transport links. Facilities include an enclosed garden for people to enjoy at the rear of the home, a dining room and shared lounge, and a quiet sitting area. At the time of the inspection there were six people living at the home, with one person in hospital.

There was a registered manager in post. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are "registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had arrangements in place to protect people from risks to their safety and welfare, including the risks of avoidable harm and abuse. Staffing levels were sufficient to support people safely. Recruitment processes were in place to make sure the provider only employed workers who were suitable to work in a care setting. There were arrangements in place to protect people from risks associated with the management of medication and the spread of infection.

Care and support were based on thorough assessments and care plans, which reflected professional standards and were reviewed regularly. Staff received appropriate training and supervision to maintain and develop their skills and knowledge to support people according to their needs. Staff advised people to eat a healthy diet while respecting their individual food choices. People were supported to access healthcare services, such as GPs and specialist mental health teams. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Care workers had developed positive relationships with people they supported. People were supported to take part in decisions about their care and treatment, and their views were listened to. Staff respected and promoted people's independence, privacy, and dignity.

People's care and support took into account their abilities, needs, preferences and choices, and reflected their physical, emotional and social needs. People were able to take part in a range of leisure activities and entertainment. People were aware of the provider's complaints procedure, and complaints were managed

professionally.

The provider had a clear vision and strategy, which was shared with staff and people using the service. Systems were in place to make sure the service was managed efficiently and to monitor, assess, sustain and improve the quality of service provided.

## 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 protected against risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

The provider employed sufficient staff and carried out recruitment checks to make sure workers were suitable for work in a care setting.

Processes were in place to make sure medicines were administered and stored safely and to protect people from the risk of infection.

### Is the service effective?

Good

The service was effective.

People's care plans and assessments were comprehensive and reflected professional standards.

Staff were supported by training and supervision to care for people according to their needs.

Staff were guided by the Mental Capacity Act 2005 where people lacked capacity to make decisions or were at risk of being deprived of their liberty.

People had access to other mental and physical healthcare services when required.

### Is the service caring?

Good

The service was caring.

People had developed caring and supportive relationships with their care workers.

People were supported to participate in decisions affecting their care and support.

People's independence, privacy and dignity were respected and

promoted.

## Is the service responsive?

Good

The service was responsive.

People's care and support met their physical, mental, emotional and social needs and took account of their preferences and wishes.

There was a complaints procedure in place, and complaints were dealt with professionally.

## Is the service well-led?

Good

The service was well led.

The provider had a management system and processes to monitor and assess the quality of service provided. There was a development plan to sustain and improve the quality of service.

There was a supportive, empowering culture in which people were treated as individuals and could speak up about their care and support.

# Appleton 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 was 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 12 and 13 July 2018 and was unannounced.

A single inspector carried out the inspection.

We reviewed information we had about the service before the inspection. This included previous inspection reports, notifications and information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. Notifications are information about certain events providers are required to tell us about by law.

We spoke with three people living at the home. We observed people's care and support in the shared areas of the home. We spoke with the registered manager, the assistant regional director and three members of staff.

We looked at the care plans and associated records of three people, including their medication administration records. We reviewed other records, including the provider's policies and procedures, meeting minutes, internal checks and audits, the provider's development plan, quality assurance survey returns and reports, training and supervision records, mental capacity assessments, and recruitment records for two staff members. We also looked at safeguarding records, records of reflective practice and complaints.

After the inspection the registered manager sent us a summary of their governance and quality assurance systems.

Good

# Is the service safe?

## Our findings

The provider had in place appropriate systems and processes to protect people from harm and the risk of abuse or unsafe care. Staff received training in the types of abuse, the signs they should look out for and how to report concerns. This was followed up by a questionnaire and assessment to show learning had been retained. Staff were aware of the provider's whistle blowing policy which protected their rights if they had to raise concerns. This was summarised on a card issued to all staff which included contact numbers for senior managers where staff could report concerns in confidence. Information about safeguarding and contact numbers were readily available to staff.

Where concerns were raised about people's safety, the provider had systems and checklists to make sure the correct processes were followed including notifying us and the local safeguarding authority. People's care plans contained information about their changing risk of abuse during periods when their mental health might be in decline. This might make them more vulnerable to financial abuse by others, or more conscious of verbal abuse by others in the community. One person's risk review stated, "[Name] feels safe in the home. He is aware he is at risk of abuse in the community."

The provider took steps to manage risks to people's safety and welfare. Where people were at risk of showing behaviours which might harm themselves or others, staff were trained in physical interventions as a last resort. One staff member said they had never had to use physical methods of restraint, and the last record of a physical intervention was in August 2017. Staff kept records of examples of unwanted behaviours, so that people's reviews and assessments could be based on accurate and factual information.

Staff were aware of risks associated with people accessing the community unaccompanied, and took steps to reduce the risk. These included assessing people's mood and mental health before they left the home, and agreeing times for their return or making contact by mobile phone.

The provider assessed and managed other risks, including the risk of people not taking their medication when away from the home, suffering a decline in their mental health, and misusing alcohol or other substances. Staff used screening tools to identify risks related to people's physical health, such as choking or poor nutrition. Risks associated with people's chosen physical activities were assessed, and guidance was available, such as making sure people wore appropriate clothing and remained hydrated. There was information on the home notice board about "advice for protecting ourselves and others in the heat".

The provider took steps to make sure people lived in a safe environment. Appropriate risk assessments included falls, using a barbecue, using a computer, and night time emergencies. There were personal evacuation plans where people might need individual support during an emergency evacuation, and general guidance for people on "keeping yourself safe". There had been an independent fire risk assessment in October 2017. All actions identified had been followed up and completed. People could be confident necessary steps were taken to keep them safe.

The provider made sure there were sufficient numbers of suitable staff deployed to keep people safe. There

was a robust recruitment process for new staff. This included an interview with two interviewers who both kept records of the interview. Records were kept to show that the necessary checks were made before new staff started work. These included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working in a care setting.

The induction for new staff included a week to get to know people, and their needs. This was followed by a period of shadowing senior staff, which also included discussions about people's mental health conditions and how to support people to manage them. Inductions were based on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

Staffing levels took into account people's independence both in the home, and when accessing the community. We saw staff were able to go about their responsibilities in a calm, professional manner, and had time to engage with people in conversation.

There were appropriate processes in place to make sure people received their medication as prescribed and that medication was managed safely. At the time of our inspection one person was responsible for their own medication. Staff were responsible for checking and auditing this person's medication records. Where people were working to become self-reliant in respect to their medication as part of their recovery, there was an agreed plan in place with checkpoints and milestones to make sure this was achieved safely.

Staff who supported people with their medication were trained, and had their competency signed off once a year. There was a list in the medication room of staff who were accredited by the provider to administer medication. Processes were in place for the ordering, storage, administration, recording and checking of medication. People took part in the process by countersigning the staff records of medication administered. The medication processes included protocols for homely, over the counter, medicines and medication prescribed to be taken "as required". Processes and records covered medication supplied in blister packs or in its own packaging, as well as creams, ointments and prescribed toothpaste. People were protected against risks associated with their medication by thorough and detailed processes.

The provider had processes in place to protect people from the risk of the spread of infection. Where people kept food in the shared freezer, they had individual shelves for their own use. Food in the refrigerator which was no longer in its original packaging was labelled with a "dispose by" date. There were monthly audits of infection prevention and control (IPC) processes including food hygiene, the cleanliness of the kitchen, en-suite bathrooms, laundry, medication room. Audits included staff training, and the control of substances hazardous to health (COSHH) processes. In line with government guidance there was an annual IPC statement which showed there had been no instances of infection in the previous year.

Where concerns were raised about people's support and recovery, the provider had "reflective practice" sessions which allowed staff to learn from their, and others', experience. Records of these sessions were kept in a folder so that lessons learned could be shared with all staff. Actions arising from the sessions included identifying staff training needs.

Good

# Is the service effective?

## Our findings

People's care and support were based on thorough and individual assessments and care plans, which were reviewed regularly. Assessments covered people's family history, weight, alcohol and drugs, smoking, fitness, dental, skin and nail care, sleeping, sexual health, and medication. They included people's personal health needs, and any routine tests. The provider had input about people's mental health diagnosis from mental health professionals, their GP, care manager, and, where appropriate, consultants and keyworkers from previous placements.

Care plans were detailed, consistent and took the whole person into account. The registered manager was able to have guidance from a psychologist, senior behaviour practitioner, and clinical lead within the provider's organisation. This meant people's assessments and care plans were based on professional guidance and expertise. Staff had access to guidance about people's mental health conditions and, where appropriate, alcohol and substance misuse. The provider had a track record of people responding positively to the care and support they received at Appleton House. For some people, this was their longest continuous placement, others could show positive progress, such as having no instances of self-harm since living at the home. Others had progressed such that they could move out into more independent services. People's assessments and care planning resulted in effective outcomes for them.

The provider made sure staff had the necessary skills and knowledge to support people effectively. Following staff induction there was a programme of training the provider had identified as mandatory in the first six months. This included training in equality and diversity. All staff received training in approved physical intervention techniques used as part of a programme of strategies for managing people's behaviours, which also focused on prevention, early intervention and calming strategies. Training was also available in individual mental and physical health conditions.

There was an effective system for tracking completed and planned training, which meant staff were prompted to attend refresher training in a timely fashion. The provider used staff supervisions to follow up and reinforce training. At Appleton House the registered manager held supervisions every two months. These were preceded by a self-assessment by the staff member, which meant there were frequent and regular opportunities for staff to identify training needs.

While respecting people's rights to make their own choices about food and drink, staff encouraged and supported people to eat a healthy diet. They had identified one day a week as "Healthy eating Wednesdays", and had used a recent football match on TV to promote healthy snacks such as raw vegetables with a dip. People told us these had gone down well. There was information about healthy food choices available to people in the home, and we heard a staff member discussing their choices with a person who had gone out to buy their lunch.

Staff worked with teams in other services to make sure people had effective support and treatment. Records showed people attended appointments with their GP, and at hospital as an out-patient. Another person attended A&E following an accidental fall, and another attended the local NHS community mental health

clinic for a regular injection. Other records showed people attended appointments with their dentist, optician, social worker and other specialist healthcare professionals.

Staff supported people to lead healthier lives. Where people had long term medical conditions, such as diabetes or asthma, there were specific care plans in place for them. People were able to attend training to help them understand and take responsibility for the management of such conditions. People's care plans had individual guidance about how the person could manage their lifestyle. There was general information to people in a "healthy eating" folder, which contained guidance on diet, exercise, lifestyle, smoking, heart health, and oral hygiene. People had access to the necessary information if they chose to make changes in their lifestyle, and some had routines which involved physical exercise.

The design and decoration of the home was appropriate for a group of single men living together. People had their own rooms where they could have privacy and keep their own possessions. The shared lounge and dining area had a large screen TV, board games, packs of cards and a pool table. There was also a quiet area which people could use if they had visitors. There was an enclosed garden where people could sit out and barbecue. The provider had adapted an upstairs room for medication, which meant people's medication could be kept more securely and people had more privacy when taking their medicines. Plans to refurbish the shared kitchen had been approved and funding agreed with the provider.

The Mental Capacity Act 2005 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 Act. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards.

We checked whether the service was working within the principles of the Mental Capacity Act 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider followed the first principle of the Act, which was to assume people had capacity. People were able to consent to their care and support at the home. Staff had carried out a capacity assessment for one person, which had concluded they had capacity to consent to their care plan. Afterwards they had agreed to be accompanied when in the community and to plan visits home with a member of staff. The provider had a deprivation of liberty screening tool to identify if people were at risk of being deprived of their liberty. This had been used for one person living at the home at the time of our visit, and had shown they were not at risk. The provider and staff were mindful of all legal requirements in this area, and people's human rights were respected.

Good

# Is the service caring?

## Our findings

Staff had developed caring relationships with people. They set clear professional boundaries, and, where needed, received training in assertiveness to allow them to maintain these. Within the boundaries of their professional roles, staff were interested and involved in people's lives. They supported them in their choices, and shared their progress towards recovery. Staff were aware they could be seen as role models for people working towards a more independent life.

We saw positive, friendly relationships with joking and light-hearted conversations. Staff shared discussions about subjects important to people, and were aware of their life stories, family background, interests and needs. They shared activities with people, such as listening to music, and playing cards and pool. People's care plans included guidance on how and when staff should give emotional support to people, and use de-escalation and redirection techniques when required.

One person had been admitted to hospital at the time of our visit. Staff had spoken with him on the phone every day to keep in touch and maintain contact. Staff had been able to reassure him that his possessions in his room would be safe and looked after. The service also provided informal support and kept in touch after people moved out into services where they could be more independent. Staff also sympathised with people, and shared their disappointment when they felt they had been let down by other agencies.

Staff supported and encouraged people to express their views and take an active part in making decisions about their care and support. There were monthly support sessions between people and their keyworkers. These used a picture based system called a "recovery star" to record people's perception of their progress in various aspects of their recovery: managing their mental and physical health, living skills, social networks, work, relationships, addictive behaviours, responsibilities, identity and self-esteem, and trust and hope.

People's care plans were written to encourage participation. In one person's plan it stated, "[Name] needs to be supported to be involved as much as he can in the creation and review of his care plan." Some people were less willing to take part in formal reviews and meetings about their care. Staff kept records of significant things people said about their support or progress in casual conversations so that they could be shared with all staff.

Where they wished to, people's families were invited to take part in care and support reviews, and records were kept of all family contacts. People were encouraged to take part in decisions about the service they used. They helped during the recruitment of new staff, had been involved in decisions about the new kitchen refit, and were helping to plan a camping trip to the Isle of Wight.

There was a strong focus on encouraging people to increase their independence. Peoples' recovery plans included developing the skills necessary to live more independently. Staff helped people find employment, educational opportunities and, eventually, their next placement or accommodation.

Staff respected people's privacy and dignity. The language used in care plans and other records was

appropriate for describing adults. Agreements about people's conduct and behaviours were documented as "contracts". These included agreements about not playing loud music at times when it could disturb other people or neighbours, plans to reduce a person's smoking, and agreements about what a person needed to do before they could take responsibility for their own medication. People were treated as full participants in their support and recovery.

Good

# Is the service responsive?

## Our findings

People told us they received care and support that met their needs and reflected their wishes. One person said, "Staff look after us well." Another person said, "Everything is going well. There is nothing else to say." A third person, for whom their placement at Appleton House had been their longest single placement, was described in their monthly review record as "the best he has been".

Staff kept records to show people's care and support was in line with their assessments and care plans. Daily records included the times people got up and went to bed, their food, personal care, planned activities and any "as required" medication. There were also records of any behaviours staff found challenging, interventions, accidents and acute illness episodes. If it was felt a person's mental health was in decline, observation charts were in place to support their assessment and reviews.

People's care and support took into account their right to a family life. People were supported to stay with friends or visit their family as they wished. One person at the time of our inspection went "home" to their family three days a week.

People had communication care plans which described any support they needed to express their own views or understand others. The care took into account any risks arising from declining mental health or medication people took which might affect people's communication skills. In most cases, people did not need reasonable adjustments to allow normal communication to take place. In some people's communication care plans, staff were advised to speak slowly, using short, clear sentences if people had difficulty understanding or concentrating. Staff were also aware where people might need support with reading.

People's care plans contained information about their preferred activities, employment and regular appointments. People were largely independent with respect to activities such as accessing the community, shops, healthcare appointments and family events. One person had attended a football match with their key worker, another had taken part in a sponsored walk. Where their risk assessments required direct support from staff, people were able to prompt for this.

The provider organised group events within the home and in cooperation with other nearby homes. Examples of these were a barbecue hosted at Appleton House for people living in other homes, parties, music festivals and sports tournaments. There were Monday cinema trips, and a camping holiday had become a regular annual event.

People had their own computer games, smartphone applications and music. Where activities formed part of their recovery plan, significant milestones and events were recorded in their personal achievement files. People had recorded achievements such as passing their provisional motorcycle test, working in the provider's maintenance department, or as a DJ, taking responsibility for their medication, independent attendance at college, and independent travel to see their family. People could participate in a variety of activities which improved their wellbeing and supported their recovery.

The provider had a complaints policy, and instructions how to complain were available to people in an easy read format. The complaints file showed there had been 10 formal complaints in the last 12 months. These had been from people who used the service, family members and a neighbour. They had been investigated and managed professionally, with escalation to an area manager for resolution in one case. Records showed the outcome of the complaint was communicated to the complainant, and, where possible, their confirmation they were satisfied with the outcome.

Where people were willing to discuss decisions about future care and their preferred options for funeral arrangements, their wishes were recorded. Most people living at the home at the time of our inspection had declined to discuss any end of life care, and this wish was respected.

Good

# Is the service well-led?

## Our findings

There was a registered manager in post. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are "registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service had a clear vision to deliver high quality care based on the provider's corporate values, "committed and passionate, integrity, dignity and respect, excellence, trustworthy and reliable". This vision was communicated to people using the service by means of a written service user guide. This included commitments to support people to promote their independence in the community and manage their mental health by building confidence and self esteem. The service would provide a clean and safe living environment where people could develop life skills such as cooking, taking medication as prescribed, and budgeting. The service would support people to find employment and educational opportunities, and build personal relationships.

Staff working at the service shared the provider's vision. A care worker at Appleton House was awarded the provider's "employee of the month" recognition in November 2017. The provider had a corporate programme for developing the leadership skills of team leaders and deputies. A previous deputy manager at the service had taken on a role as the provider's epilepsy champion and trainer. A care worker at Appleton House had been promoted to team leader after six months, recognising their skills and abilities.

There was an effective governance framework designed to maintain and improve the quality of the service people received. The registered manager produced a weekly governance report and undertook a monthly internal audit. This checked that processes in place to meet the fundamental standards people can expect were followed by staff and produced effective outcomes. This was monitored monthly by the assistant regional director, who supported the registered manager with regular visits as well as the formal monthly review after which the registered manager developed and updated their action plan.

The provider's quality assurance team reviewed the service once a year. At the most recent of these reviews, Appleton House was found to be meeting 97% of the provider's standards in the areas reviewed. These included care plans, health action plans, finances, accidents, equipment, staff files, supervisions, medication observations, training, physical interventions log, key working, complaints and management records. A corporate risk assessment of Appleton House in September 2017 had identified no actions required.

The provider had a system of expert auditor reviews. These were carried out by people using the service from another of the provider's homes. In April 2018 an expert auditor had found Appleton House to be "excellent" in all the areas covered. They had commented, "The house was very homely and well cleaned and tidy, and they welcomed me."

Quality monitoring included unannounced spot checks by senior management, including out of hours. There were regular internal checks and audits covering health and safety, infection control, complaints,

safeguarding and accidents. The registered manager used the provider's regular quality bulletin as the basis of discussions in team meetings. This allowed the experiences of other homes, including positive and negative findings from internal and external inspections and audits, to be shared.

The provider engaged with staff by means of regular meetings and supervisions, as well as continued informal contact between the registered manager and staff on a day to day basis. Staff meetings were timed so that night shift staff were able to attend, and supported by the attendance of senior managers.

People's families were encouraged and supported to attend and take part in care reviews and informal social events at the home. People using the service had been invited to complete a quality assurance survey to share their views of the service. These had been used to inform the registered manager's development plan, which was also used to track actions from internal audits and checks. There was an interlocked system to sustain and improve the quality of service provided.

The registered manager was supported by their line management, and a network of peer managers working for the provider. They had access to a trained psychologist, the provider's clinical lead, and positive behaviour practitioners. There was continuous partnership working with people's care managers and the community mental health team to drive positive and effective outcomes for people.