Community Integrated Care

Redlands Lane

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 2 November 2016 and was announced. At the last inspection on 18 October 2013 the service was found to be meeting the Regulations assessed.

Redlands Lane is part of a national organisation called Community Integrated Care which is a social care charity. It is situated in a domestic property rented from a local housing association. The property is converted into two flats.

Two people with complex learning disabilities used the service. Both people were supported on a one to one basis because of the complexity of their needs. We were unable to speak or observe care being provided because of the complexity of the service users' needs and their lack of tolerance of people unknown to them.

There was a registered manager 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.

People were safe at the service. Measures were in place to ensure people and staff were safe from harm. There were no concerns about the cleanliness of the home. However, bathroom areas were in need of refurbishment to make sure facilities remained fit for purpose. Staff supported people to manage their finances and this was recorded in their care plans.

Staff had been trained and knew how to report safeguarding concerns. They had received training in safeguarding adults.

A variety of risk assessments were in place for each person and risk management plans were in place to make sure people and those around them were supported to stay safe. Fire safety procedures were in place for the home and staff knew what they should do should there be a fire in the premises.

There were enough staff to make sure staffing levels were maintained. Staffing arrangements were flexible to meet people's needs. There was one vacancy at the time of our visit. However, existing staff were managing to cover the shortfall until someone was recruited.

Safe recruitment practices were followed with appropriate background checks of prospective staff carried out.

Staff were knowledgeable and knew people well. They received induction training when first starting to work at the service and received regular supervision.

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

Meal times were flexible to meet each person's needs. Drinks and food was available as required. People had regular access to healthcare services as appropriate.

People experienced care that was personal to them from a compassionate staff team. Staff treated people as individuals and encouraged them to do as much for themselves as possible. People's privacy and dignity was respected.

People received the care and support they needed, were listened to and had their choices respected. A variety of communication techniques were used to ensure people were engaged with and involved in making decisions about the support they wanted. People's needs were regularly assessed and reviewed. Activities were organised on an individual basis and were meaningful to them.

People were given the information to tell them how to complain. No complaints had been received about the service since the last inspection.

There was good leadership at the service. Quality audits were completed which supported the registered manager and senior managers to assess the overall quality of the care and support being 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.

Staff knew how to keep people safe from harm and arrangements were in place to make sure people had adequate oversight with regard to their finances.

There were enough staff on shift to meet people's needs and keep them safe. Risk management plans were in place to manage people and risks. A robust recruitment procedure meant that only suitable people were employed.

Medicines were handled appropriately meaning people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff received regular training and supervision. Staff demonstrated a good understanding of people's needs and how they liked to be supported.

People were supported to have enough to eat and drink. Healthcare services were accessible to people as required.

Staff were working within the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were treated as individuals and experienced care that was appropriate from kind staff.

People were able to express themselves because staff knew them well and how best to communicate with them.

Staff respected people's privacy and dignity when completing personal care.

Is the service responsive?

Good

The service was responsive.

People had their choices respected. Staff made sure people were engaged with and involved in making decisions about the support they wanted.

People's needs were regularly assessed and reviewed.

Activities were organised on a personalised basis. People were supported to carry out the activities they found meaningful.

People were given the information to tell them how to complain. No complaints had been received about the service since the last inspection

Is the service well-led?

Good

The service was well led. There was a registered manager employed at the service.

There were clear values in place and staff were supportive of one another. Staff confirmed they felt supported to do their work and were able to raise any concerns about the service or explore new ideas.

Quality audits were in place to ensure the on-going quality of the service was monitored

Feedback received from relatives and healthcare professionals was positive.

Redlands Lane

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 2 November 2016 and was announced. The inspection was carried out by one adult social care inspector. We gave the service 48 hours notice of the inspection because we needed to be sure that there would be someone available to speak with us.

Prior to the inspection we reviewed previous inspection reports, safeguarding records and other information received about the service. We spoke with the inspector for the service to gather any information they might have. We checked if notifications had been sent to us by the service and reviewed them. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with the registered manager and the regional manager. We spoke only briefly to the members of staff on duty as their time was taken up supporting people. We looked at the care plans of people who used the service, toured the premises and looked at the records relating to the running of the service. These included three staff recruitment, staff induction and training, quality assurance and servicing and maintenance records for the service.

Good

Is the service safe?

Our findings

We saw there were detailed safeguarding guidelines and policies in place, which were in line with the local authority safeguarding procedures. There had been several safeguarding issues raised over the last twelve months but all of them had been dealt with appropriately by the registered manager. Following discussions with the registered manager we were confident that they were responding appropriately to any concerns raised. Staff had received appropriate training and demonstrated an understanding of safeguarding issues and the procedures to follow if they witnessed poor practice which would constitute abuse.

Risk assessments relating to the safety of the environment were comprehensive and were completed where a risk was identified. For example there was a fire risk assessment and evacuation plan which gave staff instructions to ensure people's safety. We observed that the environment was clean. The provider was the appointee for one person's finances which meant that they managed people's finances. They had a financial support plan and there were clear records of each transaction. Each person had a risk assessment in place relating to the way in which their finances were managed. These records were audited monthly.

Individual risk assessments in relation to people's health had been completed, reviewed and amendments made when people's needs had changed. Risk management plans identified triggers for people's distress and these were very detailed and personal to individuals. For example, it was noted that very busy noisy places could trigger distress for one person. It outlined the manner in which verbal interaction by staff should be structured to ensure the best outcome for the person.

There was a behavioural support and intervention policy for staff to follow when supporting people who became distressed. The policy promoted non-physical intervention. Following one incident a wellness recovery action plan was completed.This is a self-directed approach to help people monitor uncomfortable feelings and behaviours, through planned responses to reduce, modify or eliminate them. In addition learning logs were completed and shared with the team in order to ensure lessons were learnt for the benefit of people who used the service.

Recruitment processes were robust. We looked at three staff recruitment files. Background checks of prospective employees, such as Disclosure and Barring Service checks (DBS) and two references had been undertaken. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Prospective employees also completed an application form, which formed the basis of an interview. Staff were interviewed away from the service but were then invited to visit and meet the people living at the service.

Staffing levels were arranged on a one to one basis over twenty four hours. Staff absences and vacancies were covered by existing staff. The registered manager was not rostered but worked as part of the staff team in order to provide support, cover and to maintain their relationship with the people living at the service. This ensured that people who used the service were well supported.

People received their medicines safely. Medication was stored securely in each person's flat. Medication

administration record sheets were looked at and had been completed. There was a medicines risk assessment and care plan in place for each person. In one person's plan we saw they needed to be told what each medicine was for on every administration. Staff audited medicines on a regular basis to make sure people were receiving their medicines as prescribed and there were no omissions in recording.

There was an emergency plan in place in case of an unexpected adverse event such as adverse weather, failure of utility services and fire. This ensured that staff were aware of what to do in these circumstances in order to make sure people remained safe.

All equipment, including fire safety, gas supplies and electrical installations were maintained and serviced regularly.

Good

Is the service effective?

Our findings

Staff completed an induction programme and shadowed more experienced staff when they were new to the service. Their knowledge and skills were then tested to make sure they were competent before they were able to work with people on their own. Training considered to be essential by the provider was provided in topics such as health and safety, safeguarding, medicines and first aid. Staff also completed specialist training around areas such as autism awareness, the management of potential aggressions, de-escalation and potential triggers to behaviour which may challenge. In addition staff completed the care certificate which set out learning outcomes, competences and standards of care that were expected from all staff. Training was provided in different formats such as eLearning, skills work books and face to face. This ensured they had the knowledge and skills required to care for people who used the service.

As part of the on-going supervision of staff the service ran a performance and development programme. This programme included different areas which looked at people's development. We saw records which demonstrated staff met regularly with their manager and had an opportunity to discuss any concerns and development opportunities with them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 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 saw from peoples care plans that mental capacity assessments had been completed and best interests meetings were being held if the person lacked capacity to make their own decisions. The registered manager demonstrated a good understanding of MCA and DoLS and had made appropriate applications to the local authority that had responsibility for assessing whether or not an authorisation was appropriate. Where restrictions were in place these had been clearly recorded and where necessary best interest decisions had been made. The registered manager told us independent advocates had been used in best interest decision making. We saw records of this. For example where larger amounts of money were to be spent, best interest decisions had been made in consultation with the independent mental capacity advocate (IMCA) and professionals. An IMCA is mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. They are a legal safeguard for people who lack the capacity to make specific important decisions.

Meals and shopping were individual to each person. People who used the service participated in shopping and deciding what meals they would like. Staff prepared the meals. A photo board was used to help one

person communicate their wishes. Staff knew how best to use this communication tool to be effective in assisting this person to communicate. They also used plain language to give verbal and physical prompts to assist the person to move between tasks or activities.

The environment was suitable for the needs of the people who used the service but the bathroom would benefit from some refurbishment in order that it remained fit for purpose. We discussed this with the registered manager at the time of the inspection who told us they would follow this up with the provider.

Good

Is the service caring?

Our findings

We were able to hear staff interacting with people in their flats. We heard staff speaking kindly to people and giving them time to make choices about the task they were undertaking. We heard staff using a range of different communication methods to make sure the person they were supporting understood what they were being asked. We saw that one person used a photo board to assist them in planning their day. Staff confirmed they always asked people what they wanted to do to help maintain their independence. They knew people well and knew how to support them in a way which suited the person

We heard and observed positive and caring interactions between members of staff and people who used the service from a distance as people who used the service would have been upset by our presence. One person had been supported to re-establish a relationship with someone who was close to them and this had had a positive impact on the person. Staff told us and records showed they were rebuilding that relationship with support from staff.

There were effective systems in place to access advocacy support. An advocate can help people express their needs and wishes, and weigh up and take decisions about the options available to them. The advocate is there to represent people's interests, which they can do by supporting people to speak, or by speaking on their behalf. We saw that Independent Mental capacity advocates (IMCA's) had represented people's interests when decisions had to be made.

We heard staff knocking and asking if they could come in before entering a person's room and staff closed doors when they were supporting people with personal care. This showed they respected people's dignity and privacy. We saw staff had supported and assisted people with their general appearance and wellbeing.

People had individual rooms and these were decorated according to their own tastes. People's rooms were personalised with items they liked.

Good

Is the service responsive?

Our findings

The people who lived at Redlands Lane had done so for over 20 years and so were very familiar with the service and staff. This ensured consistency in people's daily lives.

People's care plans were person centred and covered every aspect of their life. There were documents outlining details of the person under the headings, "All about me", "Things you love about me", "Favourite things", "Worst day", "Annoying things" and "information passport." This information gave a clear picture of the person, their preferences, likes and dislikes. We saw a relationship circle in one persons care record which gave details of everyone involved in this persons life which enabled staff to recognise their wider family and friends. The person planned their own weekly activities. They enjoyed looking at the Radio Times as an activity.

Care plans were reviewed regularly and there was a process of revisiting goals and achievements personal to each person. Documentation was produced in a pictorial format to assist people to be part of this process. Regular observations of people's behaviours and interactions were noted and then used to develop the support plans and risk assessments over time. This meant that people's changing needs were recognised and staff practice adapted to meet those needs.

We saw people had individualised dental, and hospital passports which provided detailed information for health specialists who may be treating them. The information was useful in telling other professionals how to support each person with treatment or health interventions to ensure they received consistent care. We were told one person had been supported over a period of time to become familiar with their GP surgery in order that they could attend appointments without becoming distressed.

The complaints procedure was available in a pictorial format. No formal complaints had been made since the last inspection. Informal matters were dealt with immediately by the registered manager. The procedure gave staff guidance about response times, any investigations and resolution timescales.

Communication books and handovers between shifts were used to communicate any information amongst staff. This included details about each person for that day, such as healthcare appointments, activities and additional requests for staff to review people's care plans and risk assessments. This meant that staff were aware of any changes or additions to people's daily lives or needs and provided a prompt so that things such as appointments were not missed.

Activities were personalised and people were supported to carry out the activities they found most meaningful and enjoyable. One person did not like visiting noisy places but another enjoyed going out in the community. Their individual wishes were supported by staff in accordance with their wishes in order to avoid social isolation.

Good

Is the service well-led?

Our findings

Redlands Lane is part of a national organisation. The national organisation Community Integrated Care (CIC) is a social care charity which has 90 locations registered with the Care Quality Commission(CQC). The charity was founded in 1988 in response to the 'Care in the Community Agenda' with the aim of supporting people leaving long stay, institutionalised hospitals to live in the community. The charity has a board of 13 trustees to provide support to the executive team of six officers. They in turn support four regional directors who oversee the services in their areas. A registered manager was employed at Redlands Lane and also had overall responsibility for three other small services in the area. They told us they were able to manage these effectively and had good regional support in place. There was an effective on call procedure which was followed by the registered manager.

There were support and development opportunities for managers included exploring planning, working with people, providing direction and leading others. The registered manager told us this worked well and helped them focus on making improvements across the service. They were supported by a regional manager who completed a monthly report about the service which covered areas such as care plan audits and reviews, staff training and supervision. Any safeguarding, complaints and staff issues also formed part of the formalised visits. Following the monthly audit an action plan was developed and timescales set for actions. This was followed up each month by the regional manager to check for completion demonstrating that the service was identifying areas for improvement and acting upon that information.

There was a system in place to analyse, identify and learn from incidents and accidents and safeguarding matters. Events trackers were completed and an investigation was undertaken by the registered manager within 48 hours. This involved actions and learning which were discussed with staff.

A number of audits had been completed to assess the quality of the home. Annual Service Quality Assessment Tools (SQAT) had been completed by the registered manager. This document helped senior managers identify areas of improvement for the service. The SQAT focused on areas such as care planning, nutrition, health and safety, medication management, environment, staffing arrangements and complaints. Once the SQAT was completed, an action plan was developed highlighting the areas that required improvement and who was responsible.

Staff told us they enjoyed their work and they respected that they were working in the person's own home. Questionnaires had been sent to relatives and healthcare professionals involved in the home. Responses were shown to us and were positive about the service.

We saw that the registered manager worked and staff alongside other professionals to ensure good outcomes for people.