

Aspire In The Community Ltd







199 Burton Road

Inspection report

199 Burton Road
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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	

Overall summary

This inspection took place over two days on 8 and 14 May 2015. On 8 May 2015, the inspection was unannounced. An unannounced inspection is where we visit the service without telling the registered person we are visiting. On 14 May 2015 we gave the service short notice that we would be visiting. This was because we needed to look at information that was kept at the registered persons head office.

199 Burton Road is a residential care home registered to provide personal care for up to four people who have a diagnosis of a learning disability and/or mental health. At the time of our inspection three people were living at the service.

The service had a registered manager although they were no longer managing the service at the time of the inspection. A new manager commenced on 1 September 2014 and has submitted an application to become the registered manager. A registered manager is a person

Summary of findings

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 and associated Regulations about how the service is run.

The service have had one previous inspection on 4 November 2013 and were compliant with the regulations inspected at that time.

Systems and processes were in place to protect people from harm. A relative we spoke with did not raise any concerns about mistreatment or inappropriate care provision of their relative. Staff told us they were aware of how to raise any safeguarding issues and were confident the senior staff in the service would listen to them and respond.

Safe systems of work were in place to manage risks to individuals and the service, for example, individual risk assessments and maintenance of the building, but improvements were needed with fire safety.

We found a system was in place to identify the numbers of staff on duty and staff spoken with felt there were sufficient numbers of staff on duty to meet people's needs.

Recruitment procedures were in place and appropriate checks were undertaken before staff started work. This meant people were cared for by suitably qualified staff who had been assessed as safe to work with people.

The home had effective systems in place to manage medicines in a safe way and to ensure there were sufficient quantities of medication available to meet people's needs. Improvements were needed with support plan documentation to correspond with this.

Staff received induction and training relevant to their role and responsibilities. Staff had received regular supervision and an annual appraisal.

The registered manager had received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguard (DoLS) training, but we found that the arrangements in place for obtaining consent for decisions did not follow the principles of the Act.

Meals were based on a weekly menu for each person, considering their preferences and what they would eat. The service worked with people to encourage a healthy diet.

Although assessments, support plans and risk assessments were in place and reviewed, we found some inconsistencies and gaps in the plans. There were detailed plans for people with behaviour that challenged. This meant that staff had guidance to reduce the distress causing the behaviour and minimise any risks. A relative told us they had been included in the completion and reviews of their relative's support plans and in response to any changes in the support provided. We saw information in people's care files that health professionals were contacted in relation to people's health care needs, which included involvement from doctors.

We saw that staff interactions with people were patient and caring in tone and language. People's rooms reflected their needs, personalities and interests. Staff told us they enjoyed caring for people living at the service and were able to describe people's individual needs, likes and dislikes and the name people preferred to be called.

A relative, all health professional and a social care professional made positive comments about the staff and told us staff treated people with dignity and respect.

We saw the service promoted people's wellbeing by taking account of their needs including daytime activities.

A complaints process was in place and concerns and complaints were taken seriously.

Quality assurance systems were in place to monitor and improve the quality of service provided. However, we found there were no clear audit schedules, and the audits seen had been completed in an ad hoc manner, which meant that information was difficult to retrieve. The audits did not identify the person responsible for any actions, the timescale for actions to be completed and confirmation that the improvements had been achieved.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

There were systems in place to make sure people were protected from abuse and avoidable harm. Staff had training in safeguarding and were aware of the procedures to follow to report abuse.

The registered person had systems in place to manage risks to people in terms of the environment, individual risks and the recruitment of staff. However, not all risks associated with fire safety had been managed.

The numbers of staff were in accordance with assessment of people's needs.

Appropriate arrangements were in place for the safe administration of medicines.

Good



Is the service effective?

The service was effective.

There was a system in place for staff to receive an induction, training, supervision and appraisal relevant to their role.

The registered manager had received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguard (DoLS) training, but we found that the arrangements in place for obtaining consent for decisions did not follow the principles of the Act.

We saw information in people's care files that health professionals were contacted in relation to people's health care needs such as doctors.

Good



Is the service caring?

The service was caring.

A relative and other stakeholders made positive comments about the staff. Both told us staff treated people with dignity and respect. The staff were described as being friendly and approachable.

Staff were respectful and treated people in a caring and supportive way.

Staff enjoyed working at the service and knew the people they supported well.

Good



Is the service responsive?

The service was responsive.

People's support planning was centred around the person. Support plans were reviewed regularly and in response to any change in people's needs, but we did find inconsistencies and gaps in some plans.

The service promoted people's wellbeing by providing daytime activities, that were suitable for each individual, stimulating and engaging them to improve their wellbeing.

Concerns and complaints were taken seriously.

Good



Summary of findings

Is the service well-led?

The service was well-led.

A relative and other stakeholders knew who the registered person was and knew they could speak with them or staff at the service if they had any concerns.

The registered person actively sought representative's views, but reports had not been formulated to support this.

Staff made positive comments about the staff team working at the service. Staff meetings took place to review the quality of service provided and to identify where improvements could be made.

There were some checks completed by the registered person and staff within the service to assess and improve the quality of the service provided.

Good



199 Burton Road

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 checked 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 over two days on 8 and 14 May 2015. On 8 May 2015, the inspection was unannounced. An unannounced inspection is where we visit the service without telling the registered person we are visiting. On 14 May 2015 we gave the service short notice that we would be visiting. This was because we needed to look at information that was kept at the registered persons head office.

The inspection was carried out by an adult social care inspector.

Prior to our inspection visit we reviewed the service's inspection history and current registration status and other notifications the registered person is required to tell us about, including information about safeguarding.

We contacted commissioners of the service, safeguarding, the integrated care home team, the local authority

complaints department and Healthwatch to ascertain whether they held any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

This information was used to assist with the planning of our inspection and inform our judgements about the service.

During the inspection we used a number of different methods to help us understand the experiences of people who lived in the home as we were not able to communicate verbally with people who used the service. We spent time observing the daily life in the home including the care and support being delivered. We spoke with the manager and three members of staff. We also telephoned two social care professionals and two relatives. We were able to speak with one relative, one social care professional and a health care professional. We looked round different areas of the home, including, communal areas and three people's rooms. We looked at a range of records including two people's care records, three people's medication administration records, one person's personal financial transaction records and three staff files. We also looked at a sample of the service's policies and procedures and audit documents, training and supervision matrixes and service documents.

Is the service safe?

Our findings

We checked the systems in place for how the service protected people from harm and abuse.

We were not able to communicate verbally with people who used the service, but were able to observe their interactions with staff during the inspection. Those interactions were relaxed and people did not display any anxiety when staff were in their presence. A relative we spoke with had no concerns about mistreatment or inappropriate care provision of their relative. They told us their relative showed no distress on returning to the service after a visit home.

Notifications we received from the service about allegations of abuse. This told us systems were in place and followed to respond to and record safeguarding vulnerable adults concerns.

Staff received training in safeguarding vulnerable adults. It was clear from discussions with staff that they were fully aware of how to raise any safeguarding issues and they were confident the manager would take any concerns seriously and report them to the relevant bodies.

We checked the systems in place for safeguarding people's money.

The service managed some money of people who used the service. We looked at the records of one of those people. We found a record of financial transactions and that in the main receipts were available to verify money that had been spent. In the main, transactions were signed by a second person to verify each financial transaction. The record of monies and actual monies was checked twice daily by staff to minimise any errors in the management of people's finances and identify any discrepancies as soon as possible.

We checked the systems in place for how the service managed risks to individuals and the service to ensure people and others were safe.

We found systems were in place to manage risk to individuals and the service. For example, maintenance of gas, electric, equipment and legionella was in place. Appropriate insurance cover was in place.

We found that no fire drills had been completed. This placed people and staff at potential risk, as they had not

been provided with an opportunity to practice what action they would take in the event of a fire and whether this would be effective in practice. We brought this to the attention of the manager and during the inspection the manager updated the fire risk assessment and held a fire drill. We found that Individual person emergency evacuation plans required implementing, which the manager said he was now able to do after the fire drill had been held and people's response assessed.

Individual risk assessments were in place for people who used the service in relation to their support and care, so that staff could identify and manage any risks appropriately. The purpose of a risk assessment is to put measures in place to reduce the risks to the person. These were reviewed and amended in response to their needs, for example, accessing the community. We observed the strategies identified to minimise the risk identified for one person, such as the numbers of staff and where the person was seated in the car. This was in accordance with the identified risk assessment. Individual management plans were in place for when people displayed behaviour that challenged.

A relative we spoke with said there were very few incidents between people, an ethos that they wanted. A social care professional also described that the management of behaviour that challenged was very person-centred with adaptations made to the environment and no 'blame' attached to individual people.

We found that sufficient numbers of suitable staff were available to keep people safe and meet their needs.

The manager explained the registered person identified through initial assessment the number of care hours each person needed and this was identified within their contract with the service. We saw evidence of this and this confirmed the staffing ratios the manager described.

During the inspection we spoke with a relative and health and social care professional about the availability of staff. All told us staff were available when people needed their assistance.

We observed that staff were available to meet people's needs when needed.

We looked at staff rotas to verify information on each individual's assessment. We found in the main the rota confirmed the numbers of staff that should be available.

Is the service safe?

We reviewed the recruitment policy. We found the policy did not refer to all the information and documents as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, but when we checked three staff's recruitment records, appropriate information and documents were in place. For example, a full employment history, with a written satisfactory explanation of the reason for any gaps. However, care needed to be taken to maintain consistency of obtaining satisfactory conduct in previous employment concerned with the provision of health or social care and vulnerable adults or children. The information also included identity documents and documentary evidence of the staff member's previous qualifications and training had been obtained. There was also documentary evidence of a Disclosure and Barring Service check (DBS). A DBS is to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults.

We looked at how people's medicines were managed so that they received them safely.

The service had policies, procedures and systems for managing medicines and copies of these were available for staff to follow.

All staff were responsible for people's medicines after they had received training and had their competency to deal with medicines assessed. Having well trained staff reduces the risk of making mistakes with medicines.

We observed staff give people their morning medicines. Staff were patient and caring when administering medicines. We saw the procedure staff used and that this was safe. For example, two staff members were present when medicines were administered. The staff explained this was to verify the medicine was administered. This meant errors with medicines were minimised or identified immediately. We observed the staff member administering medicines check the medication administration record (MAR) against the actual medicine, ask the second member of staff to verify the amount, give the person their medicine and then sign to say when the person had taken their medicine.

We found people had a medicines plan that identified how people liked to take their medicines and any allergies they had. The plans included guidance for people who were administered medicines 'as and when required', but there were some inconsistencies in those plans.

Is the service effective?

Our findings

We checked that staff had the knowledge and skills to carry out their roles and responsibilities.

The manager used a staff training spreadsheet to monitor the training completed by staff. We looked at the training matrix to confirm the training staff had undertaken. We found all staff had received an induction on commencement of employment. Other training included, moving and handling, fire, food safety, infection control, health and safety, first aid, conflict management training, safeguarding, Mental Capacity Act (2005) (MCA), Deprivation of Liberty Safeguards (DoLS), dignity, medicines management and autism. This showed that a range of training was provided to staff to make sure they had the skills needed to support people.

The manager had a supervision and annual appraisal schedule in place for staff. Supervision is a regular, planned and recorded session between a staff member and their manager to discuss their work objectives and wellbeing. An appraisal is an annual meeting a staff member has with their manager to review their performance and identify their work objectives for the next twelve months. We saw evidence on staff files that they had received regular supervisions and an appraisal where appropriate.

When we spoke with staff they told us they felt supported by the manager and were encouraged to maintain and develop their skills. This told us that staff were supported to develop their skills and deliver safe care to an appropriate standard.

We checked that people consented to care and treatment in line with legislation and guidance.

The Mental Capacity Act (MCA) 2005 is an act which applies to people who are unable to make all or some decisions for themselves. It promotes and safeguards decision-making within a legal framework. The MCA states that every adult must be assumed to have capacity to make decisions unless proved otherwise. It also states that an assessment of capacity should be undertaken prior to any decisions being made about care or treatment. Any decisions taken or any decision made on behalf of a person who lacks capacity must be in their best interests.

Support plans contained the question whether a capacity assessment in line with MCA needed carrying out or a DoLS implementing. These had not been completed by staff, which meant the decision making process in terms of people's of support was not clear.

The manager described examples of when a best interest decisions had been made.

We looked at people's files where the manager had told us a best interest decision had been made. There was documentation in one person's file of that decision, which confirmed the best interest decision had been made involving the person's doctor and family, with the reason given. There was no record that a mental capacity assessment had been undertaken prior to that decision being made. The manager rectified this during the inspection, but it showed the service had not fully followed the MCA Code of Practice at the time the decision was made. Likewise, for another person in terms of their finances.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We found DoLS were in place for everyone using the service, in respect of the decision for them to live there.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked how people were supported to have sufficient to eat, drink and maintain a balanced diet.

When we spoke with a relative they described how staff tried to make the food healthy, but that could be difficult because of the person's needs. They told us they had seen that fruit bowls were available for people to help themselves to, which they did.

Staff described how meals were based on a weekly menu for each person, considering their preferences and what food they would eat. They told us staff encouraged people to eat a healthy diet, but that wasn't always possible. When

Is the service effective?

new foods were introduced, they explained how they observed people's reaction to the food to see if it was a food item they would eat again. This told us that people's preferences and dietary needs were being met.

We checked that people were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support.

In people's records we found evidence of involvement from other professionals such as continence advisors, chiropodists, psychiatrists and dentists. We found specific health action plans were in place.

During the inspection we spoke with a healthcare professional. They told us people who used the service seemed happy and that staff were welcoming and attentive to people. The healthcare professional told us it was the service that had sought their advice, which was appropriate in order to manage and hopefully improve a specific aspect of the person's care. They told us staff had implemented those instructions, such as recording the person's drinks and urine output. A support plan had been implemented to support those needs.

Is the service caring?

Our findings

We checked that people's privacy and dignity was respected and how the service supported people to express their views and be involved in making decisions about their care, treatment and support.

When we spoke with a relative they described the home as "Near perfect", "It's home" and "less institutionalised than previous placements". They said staff all seem to be caring and understand their relative's needs and engaged with the family.

It was clear from our discussions with staff that they enjoyed caring for people who used the service. Staff were able to describe people's individual needs, likes and dislikes and the name people preferred to be called. One member of staff described the outcome of caring for people would be that people who used the service were happy and stress free.

We observed the interactions between people and staff. Staff had a relaxed approach with people and interactions were patient and caring in tone and language. Relationships between people and staff were open and friendly.

Staff we spoke with were able to describe how they maintained people's dignity and respect and gave examples of how they would implement this. This included practice such as ensuring personal care was provided discreetly and maintaining confidentiality.

Staff were also able to describe the communication styles of people and how they used this to identify for example when they were in pain. For example, some people used a picture exchange communication system, a system used for people with autism to convey their thoughts and needs. However, records we viewed did not provide this level of detail, which meant important information was not recorded about how people communicated.

We observed staff giving care and assistance to people throughout the inspection. They were respectful and treated people in a caring and supportive way. We also observed that staff adapted their communication style to meet the skills, abilities and preferences of the person they were supporting. For example, staff knew through one person's actions whether they were giving a positive or negative response to choices they were given. For another, they responded with the same sound one person had made to acknowledge they were listening to them.

We saw people could choose where to spend their time and people moved around the home as they wished. People's rooms reflected their needs, personalities and interests.

People who used the service had regular contact with their families and formal advocacy services were not used. Advocacy is a process of supporting and enabling people to express their views and concerns, access information and services, defend and promote their rights and responsibilities and explore choices and options.

Is the service responsive?

Our findings

We checked that people received personalised care that was responsive to their needs.

We spoke with a social care professional. They told us they were very happy with the outcome of the transition of the person's placement to the service. They explained they asked the registered person several times how they intended to meet the person's needs. They described how the service were very good communicators and open to questioning. They explained how the registered provider liaised with both themselves and family about how to best meet the person's needs. Support plans were developed during the assessment period in conjunction with everyone. At the last review the social care professional stated the family were very complimentary about the level of care their relative received. The social care professional described how the services approach is very person-centred and described an aspect of this. They explained the service will work through solutions and adapt the environment, rather than 'blaming' the person's behaviour. They also said the service were very considerate of the needs of other people who used the service, so that people lived together in harmony. The social care professional described how the service encouraged visits both to the family home and the service.

When we spoke with a relative of a person who used the service they felt their relative enjoyed living at the service as far as they could tell and they had been involved in the assessment process. They were confident the service involved them in decision making of the care to be provided to their relative.

We found assessments were completed, involving the person and their families. When we spoke with relatives and other stakeholders they told us they had been involved in identifying people's needs, choices and preferences and how they might be met. We found that those needs had been set out in written support plans that described what staff needed to do to ensure personalised care was provided. We found that where people moved between services or from home to the service the move was planned, with an awareness of the potential difficulties that might be faced and strategies in place to manage them and maintain continuity of care.

We sampled aspects of people's support plans. The support plans were thorough and reflected people's needs, choices and preferences. We found people's support planning was individualised and focussed on the person's whole life, including their skills and abilities. The plans showed evidence of regular updates, but there were some gaps and inconsistencies. For example, one person was in bed, but was sleeping directly on the mattress and there was little in the way of decoration in the room. A staff member explained that the person often removed their bedding and items from the room, as that is how the person liked it. The person's care file did not identify this.

Since our last inspection we found that one person who had used the service had been helped to move to a supported living service. This demonstrated staff had responded to the person's needs and preferences so that the person could live as full and independent life as possible.

Another person who continued to use the service had improved their level of independence, now being able to complete some tasks independently, with prompts from staff, rather than staff providing that support for them.

The checked how the service promoted people's wellbeing through the provision of activities.

When we spoke with a relative they told us the service took a lot of information from them regarding what their relative liked to do and they had noticed they took part in those. In addition, they had introduced new activities their relative hadn't tolerated before.

We observed that during the inspection people spent their time as identified in their support and activity plans. For example, on one day of the inspection two people went to the Concord Centre to engage in activities external to the service. On another day, two people were engaging with a staff member. One person had a familiar picture in their hand, the other had their toys around them, throwing them and feeling their texture. This meant staff were spending time with people engaging with them in activities they had shown they liked.

The social care professional we spoke with also described how they had observed staff engaging with people who used the service and that this was appropriate with what the person liked to do and what their family had said they had enjoyed in the past.

Is the service responsive?

We checked how the service listened and learnt from people's experiences, concerns and complaints.

We viewed the complaints procedure that had been reviewed in October 2014. It needed reviewing to take account of the new regulations that came into force on 1 April 2015.

When we spoke with a relative they had not been told about the complaints process, but did not have any concerns and if they did they would speak with the appropriate person.

We reviewed the service's complaints log. We found the service had responded to concerns, investigated them and taken action to address those concerns.

Is the service well-led?

Our findings

We checked that the service demonstrated good management and leadership, and delivered high quality care, by promoting a positive culture that was person-centred, open, inclusive and empowering.

The service have had one previous inspection on 4 November 2013 and were compliant with the regulations inspected at that time.

A new manager commenced at the service on 1 September 2014 and had submitted an application to become the registered manager. When we spoke with the manager they told us they felt supported by the registered provider. Likewise, staff felt supported by the manager and said they led by example. Staff described managers as "Friendly", "Passionate", "Helpful" and "Professional".

We spent time observing the culture and openness of staff. We saw staff were inclusive with people who used the service. They interacted with each other in a friendly and helpful manner. The atmosphere was friendly and welcoming and there was transparency amongst staff when dealing with people.

When we spoke with a relative they described how "Management are engaged with both their relative and family".

We found a quality assurance policy/procedure was in place identifying the steps taken to assess and monitor the quality of the service. This included stakeholder feedback and survey forms, complaint monitoring, team meetings, audits of the service and review of policies and procedures.

We found staff meetings were held, which meant staff were provided with an opportunity to share their views about the care provided. We attended a staff meeting during the inspection. We found there was a collaborative approach in discussing aspects of the service and how improvements might be made. All staff present were comfortable in voicing their opinions about the service. We saw how concerns that had been identified within the service were discussed to identify the cause, and actions to be taken so that a similar event did not occur again.

When we spoke with staff they understood their role and what was expected of them. They were happy in their work, motivated and had confidence in the way the service was managed. The discussions identified managers were available for guidance and support. One member of staff described how the ethos of the service discussed at interview was carried out in practice, that is the service is person-centred. Another staff member said, "I've no issues. It's a great company. It's a good team, with a good support network. You're never scared to ring and ask for support." At the same time the staff member explained how the registered person also appreciated staff. The service operated an employee of the month. Staff felt this showed the registered provider valued staff and felt it was good for staff morale.

A quality assurance policy was in place that had been reviewed. It described how quality would be assessed and monitored and included service user meetings, surveys, a programme of audit and regular visits from the registered person. We asked the manager for records of these. The manager provided audits of the kitchen and care plans, but discussions identified there was no clear process of audit scheduling, and there was an ad hoc method of filing the audits, so that they were not easily retrieved. The audits themselves did not identify who was the person responsible for any actions, with timescales or that the improvements had been acted upon.

Service user meetings did not take place, because the manager said that was not the appropriate format for the current people who used the service to share their views about the service. Previous surveys had been sent to relatives who used the service, but a report of the findings had not been formulated.

The managers of the services registered by the provider had held a management meeting to discuss the new regulations. An audit strategy had been implemented from 1 April 2015 to assess the service against the new essential standards of quality and safety and the new regulations.

We found policies and procedures were in place, which covered various aspects of the service. The policies and procedures had been updated and reviewed as necessary.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>Care and treatment of service users must only be provided with the consent of the relevant person. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the Mental Capacity Act 2005.</p>