Accedo Care Ltd

Thurlestone Avenue

Inspection report

22-24 Thurlestone Avenue,
London, N12 0LP
Tel: 020 3418 8180
Website: www.accedogroup.org.uk

Date of inspection visit: 16 January 2015
Date of publication: 20/04/2015

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 unannounced inspection took place on 16 January 2015. The service was registered with the Care Quality Commission (CQC) in February 2014 and this was the first inspection since registration.

Thurlestone Avenue is a care home that provides accommodation and support with personal care for up to eight people with learning disabilities. The people who live there also need support to maintain their mental health and some have autism spectrum disorders. Each person has their own bedroom with ensuite bathroom and small kitchenette area and shares a communal lounge, dining area and kitchen. Located in the Friern Barnet area of the London Borough of Barnet, the service has a rear garden and sensory room for people to use. At the time of our inspection five people lived there.

The providers of Thurlestone Avenue are required to have a manager registered with CQC as a condition of the service's registration. 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.

Summary of findings

At the time of our inspection the service did not have a registered manager in post, however the service manager had submitted an application for registration and was awaiting the outcome.

We found that the managers and staff of Thurlestone Avenue provided person-centred, quality care for the people who live there. Staff supported people to achieve their goals and ensured their needs were safely met in a responsive way.

Care records were up-to-date and personalised and documented people's needs, wishes, goals and preferences for their support. People were listened to by staff and the managers and encouraged to maintain their independence and develop new skills. Staff supported people to undertake a range of activities within and outside the service and ensured their health needs were met.

Some of the people who use the service do not communicate verbally and their communication needs were understood by staff. Staff communicated with people using a range of mechanisms to ensure they understood and people were involved in day-to-day decisions about their care and how the service was run. Where people did not have the capacity to consent to their care and support, 'best interests' decisions were made and recorded. People were only deprived of their liberty for their own safety when this was approved by the relevant supervisory authority in accordance with the Deprivation of Liberty Safeguards.

Risks associated with people's support were assessed and strategies in place to support staff to manage those risks safely. Staff used physical response techniques such as restraint only when necessary to keep people safe, and all instances of the use of physical restraint were clearly documented and reviewed.

The service manager checked staff before they started work and people who use the service were involved in recruitment decisions. Staff had the appropriate skills and qualifications to meet people's needs and had opportunities to develop their skills through training. Staff received appropriate supervision to review and discuss their work and an appraisal system was in place but had not started at the time of our visit due to the short period of time the service had been operating.

The service had an open and transparent culture and encouraged people to provide feedback. Staff and the managers checked the service regularly and took action to make improvements.

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?

Good

The service was safe. Risks associated with each person's support were assessed and measures put in place to ensure people's safety.

There were enough staff with the appropriate skills and experience to support people safely and according to their needs. Medicines were stored and administered safely and securely, as prescribed.

People were safeguarded from the risk of abuse. Staff knew what to do if they had concerns about a person's safety.

Is the service effective?

Good

The service was effective. People were supported by staff who were appropriately trained and supported in their work. Staff supported people to access facilities to ensure their health care needs were met.

People chose the food they ate and staff supported them to develop their skills relating to meal preparation. People were assessed and supported to maintain good nutrition.

Staff understood the requirements of the Mental Capacity Act 2005 and worked within them. People were only deprived of their liberty for their own safety where this had been authorised by the relevant supervisory body.

Is the service caring?

Good

The service was caring. Staff understood people's communication needs and ensured they made informed decisions about their care and support.

Staff were caring, kind and compassionate.

Is the service responsive?

Good

The service was responsive. People received personalised care that met their needs. The service employed additional health care professionals to work directly with people when this was indicated by their care plan.

The service managers and staff encouraged feedback from people who used the service and their representatives through a range of mechanisms.

Is the service well-led?

Good

The service was well-led. There was a highly personalised, open and transparent culture that encouraged good practice and professional development.

Staff had additional responsibilities within the service, and staff and managers regularly checked the service to improve the support people received.

Thurlestone Avenue

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 16 January 2015 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed the information we held about this service including notifications the provider must send to us about important events. During the inspection we spoke with four people who used the service, three care workers, two team leaders, the service manager, the operations manager for the provider organisation and two health professionals who work with the service.

We reviewed the care and support records for all five people and looked at staff personnel files for three care workers. We also reviewed records relating to the management of the service such as emergency plans and records, policies and procedures, records of checks and audits undertaken, medicines records, staff and "resident meeting" minutes and equipment and premises maintenance records. We also observed the care and support people received from staff throughout the day.

Good

Is the service safe?

Our findings

People told us they felt safe living at Thurlestone Avenue. One person told us, "The staff help me to look after myself as I can't be safe on my own." Another person said, "The staff help me to work out my problems. I feel edgy sometimes but they help me to stay on the right track."

Staff were aware of procedures to safeguard people from abuse and told us how they would respond if they were concerned a person had been abused. One staff member said, "I would make sure the service user was safe and okay first. Then I would inform the manager or the senior person in charge straight away, and report it to social services so it was attended to." Records showed that all staff had been trained in recognising the signs of abuse and safeguarding adults procedures. Information about reporting abuse was displayed on noticeboards in the entrance to the service premises, in the staff office and in the manager's office. The service user guide also contained pictorial information on how to report abuse, and residents' meeting minutes showed this had been discussed in a recent meeting.

At times, some of the people who lived at the service displayed challenging behaviours, behaviours that may pose a risk to themselves, other people or property. A comprehensive risk assessment and behaviour support plan was in place for each of these people with clear guidance for staff on how to support the person safely through each stage of an occurrence of such behaviours. Staff had been trained in strategies to support people to change these behaviours and in how to respond safely when they occurred. We saw that each incident was recorded in detail with specific records, including body maps, for each use of restraint. These records showed that restraint was only used as a last resort to ensure people's safety when other calming and de-escalation techniques were unsuccessful.

Other risks associated with people's support were also assessed and risk assessments contained guidelines for staff on how to mitigate those risks. For example, one person enjoyed swimming and their risk assessment outlined ways the staff supporting them ensured their safety while swimming. Staff supported another person to improve their cooking skills and there were measures in place to ensure their safety while doing so.

Medicines were stored and administered according to guidelines. Medicines were stored in a locked cabinet. We saw that each person's medicines were clearly marked and stored in a separate part of the cabinet to reduce the risk of errors. Each person's medicines administration records (MAR) included a page about their allergies and specific considerations for taking their medicines. One person did not regularly take their medicines when they needed to and so an assessment of their capacity to understand the consequences of not taking their medicines was carried out, and a 'best interests' meeting held. A process for covert administration of their medicines was agreed by their GP and clearly documented in their records.

Some medicines were prescribed to be taken as needed (known as 'PRN medicines') and there were clear guidelines for staff on the circumstances in which these should be administered. Records showed that these were not used outside these guidelines and sedative and calming medicines were not over-used to control people's behaviour.

The service manager had a system in place to check staff were of good character to work with people who need support. Each of the staff personnel records we checked contained references from previous employers, a criminal record check and checks to ensure the staff member had the legal right to work in the United Kingdom.

Staff rotas showed there were enough staff on duty to ensure people's safety. We saw there was flexibility in the rota to ensure that staff were available to support people outside of the home when they needed it. One person told us, "There is always enough staff. They take me to the doctor or out to the café whenever I want to." The service manager told us they had a bank of staff they used to provide cover if a permanent member of staff was sick, on training or on leave. He told us this ensured continuity of staff which was important for the safety of staff and people who use the service.

Each person had a personal emergency evacuation plan which outlined their specific needs in the event of an emergency evacuation. These included their physical needs as well as behavioural and emotional considerations to ensure a smooth evacuation should that be necessary. Each person's records also contained a 'grab sheet'

Good

Is the service safe?

outlining their needs, communication styles and other individual considerations should they need to be reported missing or in other extenuating circumstances such as emergency admission to hospital.

Records showed that fire evacuation drills took place every two months and all fire safety equipment was checked weekly. We saw that other checks relating to health and safety, such as water temperature checks and procedures to reduce the risk of Legionella, took place as outlined in the service's health and safety policy. One person who used the service told us, "I know what to if there is a fire. I have to stay calm."

Good

Is the service effective?

Our findings

Staff had the knowledge and skills they needed to support people safely and according to their needs and preferences. One person who used the service told us, "The staff are lovely and help me to work out my problems. I have no complaints. They know what they are doing." A care worker told us, "There is so much training! Any training I ask for is approved." A healthcare professional involved with the service told us, "The staff team have a lot of knowledge and are skilled at their roles."

Staff underwent an induction programme based on the Skills for Care Common Induction Standards when they started working at the service. One team leader told us, "I had three days of induction training before I could work. I shadowed other staff for a week before I could work on my own with the service users. It really helped me get to know them and their needs." Staff told us, and records showed, that they were encouraged to undertake other training relevant to their role such as therapeutic management of aggression, person-centred care, equalities and diversity, food hygiene and health and safety. We saw that the service manager assessed staff competency after training in some areas, such as medicines administration, before the staff member was permitted to undertake the associated tasks without supervision.

Records showed that all staff held an appropriate qualification before being employed at the service such as the Diploma in Health and Social Care to level two or three. Staff and the service manager told us staff would be provided with the opportunity to undertake additional qualifications if needed.

The service manager maintained a system of appraisal and supervision. Staff had one-to-one supervision meetings with the service manager approximately every two months and he told us he was training a team leader to also undertake supervision of care workers to reduce his workload. The service manager also had an annual appraisal system in place, however these had not yet started as the service had only been operating for 11 months at the time of our visit. Staff told us they valued their supervision meetings as an opportunity to gain support, discuss practice issues and to highlight any changes in people's support needs. Bank staff told us they also received regular supervision.

Staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and worked within these. We saw that all staff had been trained in the MCA and we observed staff supporting people to make day-to-day decisions about their care and support. For example, staff supported one person to make a choice about the food they ate during our inspection.

Each person's care and support records contained a number of documents relating to consent such as consent to administer medication and consent to receive support with personal care. Each of these documents was signed by the person and they also signed to show they agreed with their care plans. Four of the five people who use the service were subject to Deprivation of Liberty Safeguards (DoLS) which had been authorised by the relevant supervisory authority to ensure their safety, for example for keeping the kitchen door locked so people could not harm themselves with sharp knives. We saw records of assessments of people's capacity to make and understand decisions about their support, and of best interests meetings to ensure decisions made were in the person's best interests.

Staff provided people with a range of food and drink that met their needs. Each person's care and support records included an assessment of their dietary needs and preferences and we saw that specialist assistance had been sought when staff had concerns about a person's weight or level of fluid intake. Each person was weighed monthly and their weight recorded. One person's records showed that they had a specific programme to ensure they drank enough fluid that involved staff trying to encourage them again within a set timeframe if the person refused to drink and was at risk of becoming dehydrated.

People chose what they wished to eat and drink. The menu was planned a month in advance but we saw that people were supported to choose meals that weren't on the menu when they wished to. In the kitchen we saw a set of cards with pictures of different meals, foods and drink products from which people could choose. Staff also supported people to improve their skills relating to meal preparation. One person told us, "I wash and chop the vegetables. I love cooking!"

Staff supported people to access a range of health and other services when necessary. Each medical appointment was recorded with outcomes and actions for staff and the

Good

Is the service effective?

person. Each person had a Health Action Plan for guidance on their health needs, and a hospital passport to ensure hospital and other medical staff were aware of their needs while receiving medical care.

Good

Is the service caring?

Our findings

People told us the staff at Thurlestone Avenue were kind and caring. One person said, “I love it here. The staff are very kind and I can have a shower whenever I want to. I wouldn’t change anything about living here.” A healthcare professional involved with the service told us, “Staff here are motivated by the residents. They work instinctively and are very caring. Their hearts are definitely in the right place.” A staff member said, “The support here is very person-centred. You find ways to relate to people even when they can’t talk to you by getting to know them very well. That’s the only way you can build a rapport and meet their needs.”

Staff demonstrated a high level of knowledge and understanding of the people they supported. People who did not communicate verbally were encouraged to use other means such as Makaton signing, pictures and objects of reference and staff were aware of these. One staff member said, “You have to be aware of the person’s body language, gestures and other noises they make. That way you can always tell how they are feeling and what they might need or want.” Many documents in the service were produced in pictorial format so they could be more easily understood by people who didn’t read.

One person who used the service did not express themselves using the English language so the service manager had engaged a support worker who spoke their language to facilitate communication.

People actively participated in making decisions about their care and support whenever possible. Care plans were developed using person-centred planning techniques, such as essential lifestyle planning, and included people’s likes, dislikes and preferences for their support. Care plans also named people important to the person and who played a role in their support from outside the service such as their families, friends and other professionals. We saw that people chose the gender of the staff supporting them with intimate personal care and people told us this was respected.

Information about community advocacy services was made available to people through a poster displayed on the service’s noticeboard and in the service user guide. Records showed that staff supported people to access community advocacy services when required.

Staff maintained people’s privacy and dignity when supporting them with personal care and other tasks. We observed staff discreetly reminding a person to use the toilet, and saw that each person had their own ensuite bathroom to ensure privacy and dignity was maintained. People were supported to undertake their own personal care tasks whenever possible to develop and maintain their independence. One person told us, “I shave myself. The staff make sure I don’t hurt myself but I do it.”

People’s personal care and support records were kept in a locked cabinet in the staff office, which was usually also kept locked. We also observed staff moving away from other people to discuss people’s personal information to ensure they were not overheard.

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their needs. One person told us, “My goal is to get my own flat and the staff are helping me to learn everything so I can. I like it here but I don’t want to live here forever. I know I’m not ready for my own flat though, I still have a lot to learn and the staff help me.” A staff member said, “You are constantly re-evaluating people’s support to make sure you are meeting their needs.”

Each person had a care plan that we saw was reviewed regularly or when their needs changed. Reviews included people who were important to the person as well as staff from the service and other services involved in the person’s support. Outcomes for people’s support were noted and recorded when they were achieved. A staff member told us, “I gain lots of pleasure from seeing people achieve their goals, progress and better themselves. That’s why I do this job.” The service provided people with the support and equipment they needed, for example we saw that one person’s ensuite bathroom had been converted into a wet room as they were not able to use the original bathroom safely.

Staff encouraged people to maintain relationships both within and outside the service. People told us they could have friends and family visit whenever they chose and staff supported them to contact people by phone and video-calling on the computer. One person said, “I speak to my father in [another continent] whenever I can. The staff helped me to learn how to call him on my tablet [computer] and now I can do it myself.”

Each person had a range of activities staff supported them to undertake within and outside the service. The service noticeboard had a large weekly activities timetable/ planner which showed what each person did during the week and any resources they needed. Activities included swimming, college, arts and crafts, shopping, day trips and attendance at day centres and other organised community activities. One person was supported by staff to improve their job skills as they were looking for employment.

During our visit we saw that staff supported people to make pizzas of their choice which the service manager told us was a weekly activity known as pizza club. One person told us, “I choose what I do and when I want to do it.” A health professional involved with the service told us, “They involve everybody in activities and have a lot of fun. They have lots of ideas – there is a nice spirit of including everybody here, you can see they are trying to build a community.”

The service employed an occupational therapist and a psychologist to work directly with people when this was indicated as part of their care pan. A speech and language therapist had also been employed until recently and the service manager told us they were in the process of procuring another. These professionals also worked closely with staff to ensure people’s needs were met through their support. For example, the occupational therapist told us they had trained staff in different activities and therapies they could use to ensure people gained benefits from the activities they were supported to undertake. The psychologist told us they had worked with the staff to coach them on strategies to use to safely help one person to keep calm.

The service manager had systems in place to ensure people were asked for their feedback about the service. Each person had a keyworker who was their main liaison and contact for their support. We looked at the minutes of monthly meetings each person had with their keyworker, and these showed that people were encouraged to share their views of the service and improvements that could be made. There was also a suggestion box in the service entrance. Complaint records showed that complaints were recorded and people were satisfied with the outcome of their complaint. “Resident” meetings were also held each month and the minutes recorded that people were asked for suggestions to improve the service.

Good

Is the service well-led?

Our findings

We found that the service had an open and transparent culture. People told us they were encouraged to participate in how the service was run. One person said, "I interview staff before they start working to make sure I like them! I wrote some of the questions for the interview too."

Staff told us they were well-supported and encouraged to develop professionally by the managers and by the provider organisation staff. One staff member told us, "They use people's talents and develop them when they can." Staff told us they were encouraged to apply for promotions when they became available.

Records showed that staff meetings had been held every two months since the service opened and staff told us these were valuable to discuss practice and service issues, and to support each other. A professional involved with the service told us, "The managers are excellent with lots of experience and expertise. The managers are very good role models for the staff, who in turn are very good role models for the service users. They also provide me with any resources I ask for to improve the service."

Each staff member had a specific area of responsibility within the service such as health and safety or activities, and received specific training in relation to their responsibilities. One staff member told us, "They know our strengths and weaknesses very well."

The service did not have a registered manager in place as required by the Care Quality Commission (CQC), however the service manager had submitted his application for registration and was awaiting the outcome when we visited. Notifications of serious events affecting the service were submitted to CQC in a timely manner as required.

The service manager had a system of regular checks he carried out to ensure the quality of the service and make changes when necessary. The provider organisation's operations manager also conducted a monthly audit of various aspects of service delivery, such as communication and records, customer service and environmental cleanliness. Some staff also conducted regular checks according to their specific area of responsibility, for example cleanliness and infection control. Each of these checks was documented and, where indicated, resulted in action taken to improve the service. For example, a system had been recently introduced at the time of our visit to ensure that activities were properly recorded as checks had identified some gaps.

Staff told us, and records showed, that incidents and accidents were documented and discussed by the staff and managers in order to learn and improve the service. Records clearly documented what occurred and we saw that staff were provided with opportunities to debrief, counselling and time off work when necessary after significant incidents.

The service had signed up to the "Social Care Commitment", a programme in which services promise to deliver high quality care. The service manager told us he encouraged each staff member to also sign up as individuals and most had done so. The service manager participated in several forums and information-sharing mechanisms such as the local authority's provider forum and the registered managers' forum through the National Skills Academy for Social Care. He told us this helped him to discuss practice issues, gain support and ensure he was aware of local and national initiatives that affected the service, staff and the people they supported.