Housing & Care 21

Housing & Care 21 - Woodridge

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 13 April 2016 and was unannounced. The service was last inspected on 21 May 2014 and met the regulations we inspected against at that time.

Woodridge is registered to provide personal care to people living in their own flats within an extra care housing complex. There are 39 flats within the scheme and at the time of the inspection there were 25 people in receipt of a care service.

At the time of our inspection the service did not have a registered manager. However, the person managing the service had applied for registration. 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.

Staff had a good understanding of safeguarding and were confident in their role of safeguarding people. Any safeguarding concerns were investigated with the outcomes recorded and practices changed where necessary to prevent reoccurrences.

People had risk assessments in place and associated care plans. Some care plans lacked sufficient detail to inform staff how to provide support to people. The housing and care manager explained they were in the process of reviewing and updating all care plans with people to provide details of how care and support was to be provided. They also told us people's personal preferences including likes and dislikes would be included.

Medicines were managed safely with people receiving their medicines appropriately. Most records were complete and up to date. A small number of gaps had been identified during weekly audits. Those were investigated by senior care workers and appropriate action was taken.

Staff were recruited in a safe and consistent manner with all necessary checks carried out. Staffing requirements were assessed in line with peoples' needs. From staffing rotas we saw staffing levels were consistent. Agency staff were not used at the service as staff worked together to cover holidays and sickness.

Staff had up to date training in areas such as moving and handling, safeguarding, health and safety and nutrition and wellbeing. Competency assessments were carried out in relation to specific areas, including the management of medicines. Regular direct observations were carried out in between supervision sessions. Staff received annual appraisals otherwise known as 'Valuing Individual Performance' (VIP).

People told us staff were "nice" and they were happy with the service they received. Staff talked to people in a friendly, respectful manner and supported people whilst maintaining their dignity. People were also

encouraged to be as independent as possible.

People knew how to raise concerns and felt confident they could complain to the housing and care manager if they were not happy with the care they received. Records showed the service had received one complaint in the last 12 months which related to the grounds. We saw the complaint was investigated and the housing and care manager took appropriate action to resolve the issue.

The service communicated with people using a variety of methods such as tenant meetings and newsletters which the housing and care manager created and delivered to each person's flat. Newsletters contained information in relation to the service, staff, activities and any other significant information relevant to people.

The housing and care manager operated an open door policy. During the inspection we saw staff entering the manager's office to discuss various issues.

Staff met on a regular basis to discuss the service, any changes in service provision, people and potential developments. Staff completed recorded handover's twice a day to update staff who were starting their shift about any specific information about people including if people were unwell or any appointments required with health professionals.

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 told us they felt safe living at the service.

Staff were confident in the role of safeguarding people.

People had appropriate risk assessments in place when required.

There were enough appropriately recruited staff to meet people's needs.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had up to date training in areas such as moving and handling, safeguarding and nutrition and wellbeing.

Staff received regular supervisions, direct observations and competency assessments. They also received annual appraisals.

People had access to health professionals when required, including GPs, community matrons, district nurses and occupational therapists.

People were supported to meet their nutritional needs, including any special dietary needs they had.

Is the service caring?

Good

The service was caring.

People told us they liked staff members and thought they were "nice".

Staff treated people with dignity and respect. They spoke to people in a warm friendly manner.

People were supported to be as independent as possible and

accessed the local community where possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Personal preferences such as likes and dislikes were not always included in assessments

People had care plans in place but they varied in detail. Most care plans were reviewed regularly but some were not up to date.

People felt confident they could raise concerns.

The service communicated with people on a regular basis including tenant meetings, newsletters and face to face contact.

Is the service well-led?

Good

The service was well-led.

Staff attended regular staff meetings and contributed to the improvement of the service.

The housing and care manager operated an open door policy. Staff approached the housing and care manager with queries, issues and concerns.

The housing and care manager and senior care staff completed regular audits on the service provided and ensured improvements were made wherever possible.

Housing & Care 21 - Woodridge

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 13 April 2016 and was unannounced. The inspection team consisted of one adult social care inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the main PIR document within the agreed timescale.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch. Healthwatch England is the national consumer champion in health and care.

We spoke with seven people who used the service and two relatives. We also spoke with the housing and care manager, two senior care workers and one care worker. We looked at the care records for four people who used the service, medicines records for four people and recruitment records for three staff.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe and supported living at the service. One person said, "Oh yeah I'm safe enough." People noted on recent surveys conducted by the service that they felt safe. One person wrote, 'I feel safe here.'

Staff demonstrated good understanding of safeguarding adults and knew how to report concerns. They were able to give examples of scenarios and explain which types of potential abuse related to them. One staff member gave a specific example about one person gave family members the responsibility to buy food on their behalf. The staff member had noticed food quantities in the person's flat were really low. The staff member reported their concerns to the senior support worker who in turn contacted the family and the matter was resolved.
We saw the service had a safeguarding file in the manager's office which contained a copy of the safeguarding policy and blank referral forms so they were clearly accessible. The file also contained referrals made to the local authority safeguarding team and any action taken. Records showed safeguarding concerns were investigated and managed appropriately.

The registered provider had a whistle blowing policy in place which was readily available. Staff told us they understood the whistle blowing procedures and would use it if they had any concerns.

People had risk assessments in place where required. Risk assessments were stored within care files and were regularly reviewed by the care team leader or senior care workers. All identified risks had appropriate care plans in place which detailed how people should be supported to manage those risks.

In addition to people's individual risk assessments there was a range of general risk assessments in place for premises and the environment. For example fire, legionella, laundry, manual handling and slips, trips and falls. All risk assessments we viewed up to date and relevant to the service.

Fire evacuation procedures were on display in communal areas. Each person had a personal emergency evacuation plan (PEEP) in place. The service operated a 'Stay Put' policy where people are advised to stay in their flat until they are advised otherwise. PEEPs included information about each person's level of mobility, equipment used and what type of alarm they needed. For example, vibrating pager device, standard alarm or visual alarm. They also detailed what support each person required to evacuate safely.

Records confirmed medicines were managed safely. We viewed the medicine administration records (MARs) for four people. Most records were completed accurately, with staff signatures to confirm medicines had been administered at the prescribed dosage and frequency. We saw two entries missing in the MARs we viewed. These had been identified by senior staff during the weekly audits. Investigations found that medicines had not been administered on both occasions as the person had refused on one occasion and had cancelled their call on the other. Staff had been reminded about coding the MARs to reflect these instances and to record the reasons on the back of the sheet. Competency checks were completed at least twice per year to ensure staff administering medicines were safe and experienced to do so.

The registered provider's recruitment process was followed so staff were recruited with the right skills, experience and competence. Checks were carried out for each member of staff including reference checks and a disclosure and barring service check (DBS) prior to someone being appointed. DBS checks are used as a means to assess someone's suitability to work with vulnerable people. The housing and care manager told us the central human resources team dealt with references and DBS checks. They explained that although they received confirmation when checks had been satisfactorily completed there was sometimes a delay in receiving copies of the documentation for the staff files. During the inspection we viewed evidence of checks in staff files as well as satisfactory confirmation from the central human resources team.

The housing and care manager had an electronic system in place to analyse staffing levels and ensure sufficient staff were available. The 'floor plan' system used contained a list of people who received care and support, the times support was to be provided, the number of staff required and the type of support to be provided. For example, personal care, medicine administration, meal preparation or cream application.

We reviewed the staffing rotas for a four week period and saw the staffing levels were consistent. The housing and care manager told us cover for sickness and holidays was sought from staff in the service. They also told us that additional cover could be provided by the senior on duty, a domestic worker who was trained in care provision or the housing and care manager themselves. People told us there were enough staff on duty. One person who was wearing their emergency pendant told us, "I press me button and they're (staff) there before you know it."

At the time of our inspection the care team leader was on secondment in another service. The housing and care manager informed us they were in the process of recruiting to temporarily cover the role. The role was being covered by the housing and care manager and the two senior care workers. There was no evidence to suggest the absence of the care team leader had impacted on people as they continued to receive their care.

Good

Is the service effective?

Our findings

Recent surveys the service received from people said the service and staff were good. One person wrote, 'staff are always very pleasant and helpful' and 'I find your service very good'.

Training records showed staff had up to date training in moving and handling, health and safety, safeguarding and nutrition and wellbeing. The housing and care manager explained the recent changes the registered provider had implemented around staff training. Previously, training was organised through the registered provider's learning development officer. However, this role no longer existed and more responsibility was now on the service and staff to arrange their own training.
The housing and care manager told us about the new electronic system called 'FRED' that was in the process of being implemented. Staff were to use this system to arrange their training and book themselves on courses. Once in place, the system would record training staff had completed and would flag up any refresher training when it was due. The housing and care manager would be monitoring the system on an ongoing basis when it was fully updated. They also told us that one of the senior care workers was in the process of completing a train the trainer course. Once they were trained in specific areas and deemed competent through assessment, the senior care worker would begin delivering training to staff in the service.

Staff we spoke with told us they felt well supported in their roles. Records showed staff received regular supervisions. Supervisions covered a whole range of areas including duties, observations, training, development opportunities, safeguarding and any issues the staff or housing and care manager had. They also contained discussions about new policies and procedure updates that staff members had to read and sign to confirm they understood them and any changes. Agreed actions were recorded and were followed up in the next supervision sessions.

As part of the supervision process direct observations were carried out on staff members to assess their performance around interaction with people. Areas assessed included moving and handling, delivering personal care, maintaining a safe environment and staff member's communication and attitude towards people. The observer's summary of observation and any action required was recorded and were revisited at the next supervision.

We viewed completed staff discussion forms in staff files. These forms were used to record formal disciplinary issues or general discussions with staff members in between supervisions. We saw outcomes of these meetings included additional support for a specified period of time.

The provider had a policy and procedure in place for each staff member to receive an annual appraisal. Appraisals were alternatively named 'Valuing Individual Performance' (VIP). Discussions covered staff member's roles including what they enjoyed, challenges they experienced and support they required. Other discussions covered their career aspirations, how they had developed over the year and planned further development for the coming year. Records showed that appraisals were up to date for all staff and were completed annually.

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. We checked whether the service was working within the principles of the MCA. The housing and care manager informed us that every person who received care and support had capacity to make decisions. We did not see evidence from people we spoke with or from people's care records to suggest otherwise. A senior care worker told us, "One customer has shown early signs of dementia but they are still able to make decisions (about their care and support)."

People had access to external health professionals and were supported by staff to make appointments as and when required. For example, GP, community matron, district nurse, occupational therapist, chiropodist and wheelchair services. The housing and care manager told us they had good relationships with health care professionals. They also told us there was a chiropodist and podiatrist on site also for people to use.

People were supported to meet their nutritional needs. We observed a care worker sitting with a person whilst they ate their lunch. The person told us, "I have a medical condition that could cause choking." The care worker stayed with the person to ensure they were safe whilst eating. Staff explained if they noticed people running low on food they prompted them or contacted family for those who were supported by family with food shopping. People had nutritional care plans in place which included some routines and preferences. For example, one person's care plan explained how they were supported by staff to prepare their meals but also stated, 'I sometimes like to go to the restaurant at lunch time.'

Good

Is the service caring?

Our findings

People we spoke with told us they were happy with the care they received at the service. One person told us, "Compared to my last two places this is a palace." Another person said the service had, "nice staff."

We observed care and support being provided to one person by two care workers who spoke to the person in a respectful, friendly manner, explaining what they were going to do and gained permission from the person prior to providing support. The person told us, "These two are good carers." We observed staff members knocked on people's doors before entering their flats. In the communal areas we saw staff speaking and chatting with people in a warm, friendly manner and checking they were all right and assisting them with any queries.

Staff members had access to information in people's care records about their care. Some care plan records contained information about people's preferences, including their likes and dislikes. The housing and care manager told us the care plans that lacked this information would be updated as part of ongoing care plans reviews. Care plan reviews were due to be completed for every person by the end of May 2016. The housing and care manager reassured us that care staff knew people individually and had knowledge of their needs from experience. Staff we spoke with were able to tell us about people at Woodridge, including their medical conditions and support needs.
People's individual flats were decorated and personalised to their own individual tastes. We observed family photos, ornaments, pictures and furniture in their living rooms.

Staff supported people to help them maintain their emotional wellbeing. We viewed one person's care records and saw that they received companionship support from staff. This included whatever the person wanted to do. For example, go for a walk or have a chat and a cup of tea.

A senior care worker told us they completed daily wellbeing checks for every person. There was a daily log sheet containing the names of every person. The senior care worker explained they recorded on the daily log sheet if they had seen or spoken to each person. They also recorded if people were out for the day. They explained that if they didn't see people in the communal area they try to contact them over the intercom. If they don't get an answer they'll try again a little later. If they are still unable to speak to a person over the telephone or intercom then two members of staff visited people in their flats to check they are well.

People were supported to maintain contact with friends and family members outside of the service. One person told us they went to a local pub and visited their son fairly regularly.

At the time of the inspection no one required the support of an advocate. The housing and care manager told us if anyone needed or wanted the use of an advocate they would support them to access an appropriate advocacy service.

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed prior to receiving care and support. The assessment was used to gather personal information about people to help staff better understand their needs. This included any spiritual needs people had, a life history and their existing support network. The assessment also included communication needs, finances, daily living skills, medicines and the person's social interests and aspirations. For example, one person's aspiration was to maintain their independence. Assessments lacked detail of people's likes and dislikes. The housing and care manager informed us this had been identified and all care records were in the process of being reviewed and updated with people. They confirmed this process would be complete by the end of May 2016.

People had a range of care plans in place to meet their needs including personal care, mobility, medicines and nutrition and hydration. Some care plans contained information to guide staff how to support each person but others did not specify the actual support people needed in relation to ensuring their needs were met. For example, one person's personal care plan stated, 'to be assisted by two carers with the use of a shower chair when showering,' Some care plans also lacked personal choices and preferences. This meant staff didn't always have access to detailed information on how to support people and meet their individual needs, including their preferences. The housing and care manager told us this had also been identified following a recent monitoring visit from the local authority. They explained the inconsistencies in different care plans was because they were in the process of reviewing all care plans. They told us they were, "Packing out care plans with more detail and reviewing them with people." During the inspection we noted some care plans had already been updated with more detailed information. A senior care worker explained the process they were following to ensure all care plans were reviewed and updated.

Most care plans were reviewed on a regular basis, as well as when people's needs changed. During the inspection we noted there were a couple of care plans that had not been reviewed in line with the registered provider's policy. This meant we were unable to confirm that those care plans continued to reflect people's needs. The housing and care manager confirmed the care plans would be updated in line with their plan to revise all care plans and would be reviewed regularly, in line with their registered policy as well as when people's needs changed.

People felt confident they knew how to raise concerns if they were unhappy about the care they received. One person we spoke with told us, "I can stick up for myself and know to go to the manager if needed." Another person told us, "I couldn't grumble about anything." We viewed the registered provider's complaints log which contained one recent complaint. The complaint was about litter in the grounds of the scheme and was unrelated to personal care.

The service held 'tenant meetings' which were advertised in communal areas. The housing and care manager told us that they weren't always well attended. During the inspection we viewed minutes of meetings that had taken place and included discussions around the service and activities. All attendees were included and we noted attendance levels were low. One person we spoke with told us they were aware of the next meeting arranged for 25 April 2016 but they were unsure if they were going to attend. On

occasions, meetings didn't take place due to lack of interest from people. In those instances the housing and care manager told us they created newsletters containing updates about the service, specific events that had happened and any activities due to take place. The newsletters were delivered to every person's flat.

Good

Is the service well-led?

Our findings

People told us the service was well-led. During a recent survey one person wrote, 'the new manager is making better improvements.' In response to the question about having any concerns another person wrote, 'Not at the moment as I can discuss things with our new manager.'

The service did not have a registered manager at the time of our inspection. However, the housing and care manager had been in post since September 2015 and had placed an application with CQC to become registered. They told us, "I have applied for registration and have an interview next week." The housing and care manager had submitted statutory notifications to the Commission and kept a copy in an allocated file.

The service had an open door policy to encourage staff to raise any issues or concerns and to request support if needed. The housing and care manager told us, "I have an open door policy. I like to have a relationship with the girls." They went on to say, "I talk with the senior care workers everyday so we know people inside and out." During our inspection we observed staff going in and out of the housing and care manager's office for various reasons which included seeking advice.

The service regularly sought views from people and their relatives in relation to the quality of the service. Surveys were sent out each month to a percentage of people receiving services. The housing and care manager completed monthly audits on surveys returned, summarised any issues and recorded what actions they had taken to improve the service for people. For example, people wanted a contact number for the office and another person had requested an electronic version of the survey. The housing and care manager provided every person with a laminated card containing contact numbers for the office and out of hours support. A blank copy of the monthly survey form was emailed to the person who had requested it.

Staff told us they used a communication book to facilitate staff handovers which was kept in the care staff office and was therefore available. This was used to record information such as anyone who may have had a restless or disturbed night which may mean they would still be sleeping when their call was due. Other records included calls people had cancelled and the reasons why, people who had received additional calls with instruction for staff to observe and any appointments people either had or required with health professionals such as community matron, district nurse and GP. Where actions were required, staff recorded when they had been completed. For example, they had contacted the GP for an appointment or advice. A senior care worker told us, "We complete a staff handover twice a day in the care staff office." The housing and care manager told us, "I now sign this off every morning during the week to keep up to speed and make sure staff had followed up actions."

Staff told us they had regular staff meetings which gave them the opportunity to discuss the service and air any grievances or issues. We saw meetings were held which the housing and care manager used to raise any issues such as medicine errors, dignity towards people and health and safety. Other discussions included people, training and working practices such as the floor plans. Staff were able to share any thoughts or suggestions for improving the service or raise anything they felt was important and wanted to discuss during meetings. During the inspection we viewed minutes of staff meetings and noted they included any actions

agreed.

The housing and care manager had systems in place to check on the quality of the care people received. Checks carried out included fire safety checks and medicine audits. Care plan audits had been carried out previously and the housing and care manager told us they planned to continue with those audits once all care plans had been updated to include additional information. Spot checks were carried out on staff and included general appearance of the staff member whether they wore their identity badges and if they followed infection control protocol. Other areas included documentation, medicine prompted or administered and overall performance of the staff member whilst providing support to people. From the spot checks we viewed there were no issues identified. The housing and care manager confirmed that any issues or actions identified were followed up.