Care Quality Commission

Housing & Care 21

Housing & Care 21 - Gildacre Fields

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 22 February and 10 March 2017 and was announced. We gave the registered provider 48 hours' notice as it was an extra care service and we wanted to make sure people would be in. This is the first time the service has been inspected since it was registered on 23 February 2016.

Gildacre Fields is registered to provide personal care to people living in their own apartments at an extra care housing complex. There are 100 apartments and 30 bungalows within the scheme and at the time of the inspection there were 47 people in receipt of a care service.

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

Staff had up to date training in how to safeguard people. The registered manager made referrals to the local authority safeguarding team when any concerns were reported by staff or identified by them.

People had risk assessments in place and associated care plans were clearly linked and updated in line with risk assessment reviews.

Staffing requirements were assessed in line with people's support needs. From staffing rotas we found staffing levels were consistent and staffing cover was provided by existing staff. Staff were recruited in a safe and consistent manner with all necessary checks carried out.

Medicines were managed in a safe way. Records were complete and up to date with regular medicine audits being carried out. Any errors identified were investigated and acted upon.

Staff had up to date training and competency assessments were carried out in relation to specific areas, including the management of medicines. Regular direct observations of staff practices were also carried out as part of the supervision process.

People had capacity assessments and best interest decisions were made in relation to specific activities or topics. These were recorded and decision specific.

People were supported to meet their nutritional needs, including where people had special dietary needs.

People were supported to access services from a range of health care professionals when required. These included district nurses, GPs, speech and language therapists, occupational therapists and falls team.

People's care plans were detailed, personalised, and reflected their current needs. Staff used them as a

guide to deliver support to people in line with their choices and personal preferences.

People and relatives knew how to make a complaint or raise concerns and would feel comfortable in doing so. Some people confirmed they had no complaints about the care they received and they were happy with everything. Other people told us they had complained previously and that the registered manager dealt with and resolved their complaints satisfactorily.

People, relatives and staff told us the registered manager was approachable and operated an open door policy.

A range of regular audits was carried out that related to the service the scheme provided, as well as the premises and environment.

The service received a number of compliments and thank you cards from people who received care and their relatives about the support and professionalism of staff.

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.

Staff understood the principles of how to safeguard people and concerns were referred to the local authority safeguarding team.

Risks to people's safety and wellbeing were managed.

Staff were recruited in a safe way with pre-employment checks carried out.

Is the service effective?

Good

The service was effective.

The service was effective.

Staff received regular supervisions, direct observations and training.

People had capacity assessments and best interest decisions in place where appropriate.

People had access to health care professionals.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were friendly and they went over and above what they needed to.

Staff treated people with respect and maintained their dignity while providing support.

Advocacy services information was readily available.

Is the service responsive?

Good

The service was responsive.

People and relatives told us the service met their needs and reflected their personal preferences and wishes.

Care plans were detailed, up to date and reflected the individual needs of each person.

People and relatives knew how to raise concerns if they were unhappy with the service.

Is the service well-led?

Good

The service was well led.

Staff told us they felt that the registered manager was supportive, approachable and operated an open door policy.

The registered manager and management team completed regular audits on the service.

The registered manager and the deputy manager had a visible presence in and around the scheme ensuring good quality and personalised care was delivered to everyone.

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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 22 February and 10 March 2017 and was announced. We gave the registered provider 48 hours' notice as it was an extra care service and we wanted to make sure people would be in. One adult social care inspector carried out the inspection.

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. This was completed and returned within the required deadline.

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 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. No concerns were raised.

We spoke with four people who used the service and one relative. We also spoke with the registered manager and two care team leaders. We looked at the care records for four people who used the service, medicines records for four people and recruitment records for three staff. We also looked at records about the management of the service, including training records and quality audits.

Good

Is the service safe?

Our findings

People told us they felt the service was safe. One person said, "For me personally, I feel safe with the service."

Staff demonstrated a good understanding of how to safeguard people and knew how to report concerns. They had all completed relevant training that was up to date. Staff we spoke with were able to give examples of potential warning signs to look out for. The registered manager had raised safeguarding concerns with the local authority safeguarding team in line with their agreed policy and procedure. They also raised low level concerns through an agreed process with the local authority for issues that didn't meet safeguarding criteria. Safeguarding concerns mainly related to errors with medicines. We saw from records that appropriate action had been taken to deal with each of these issues and measures had been put in place to reduce reoccurrences. For example, colour coordination to highlight medicines with varying administration frequencies and dosages.

The provider had a whistle blowing policy in place which was readily available. Staff we spoke with were aware of and understood the whistle blowing procedures and felt confident they 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. For example, preparing food with a specific consistency for people at risk of choking.

Records confirmed medicines were managed safely. We viewed the medicine administration records (MARs) for five people. All records were completed accurately, with staff signatures to confirm medicines had been administered at the prescribed dosage and frequency. Competency checks were completed regularly to ensure staff administering medicines were safe and experienced to do so. Regular medicines audits were carried out by the care team leaders to identify any errors in administering or recording. Where errors had been identified the care team leaders investigated and took appropriate action. For example, removed staff from administering medicines until further training had been undertaken and satisfactory competency checks had been completed. Staff discussions had also taken place which formed part of the provider's disciplinary procedure.

The care team leaders used an electronic system to calculate staffing requirements. The 'floor plan' system contained a list of people who received care and support, the times support was to be provided and the type of support required. For example, personal care, support with meals, medicine administration or companionship. We viewed staff rotas and found staffing levels were consistent. The care team leaders told us they tried to plan for the same staff to support people where possible, for consistency and comfort of people. This was confirmed by a relative who told us the service tried to be consistent with staff supporting their family member. They also told us, "They inform us if staff are changing and new staff are going to provide [family member] with support. Knowing that we know staff who are there caring for [family member]

is comforting."

We received mixed views from people regarding the timeliness of their calls. One person said, "They're (staff) pretty much on time all the time. They'll ring ahead if they're going to be late." Another person told us, "They're often late." They went on to tell us they sometimes had to wait up to 20 minutes after the agreed time for staff to arrive. We asked the registered manager about this and he explained there was an understanding of a 15 minute grace period both before and after the usual arranged times. This was to allow flexibility for occasions when either additional or less time was required in previous calls. The registered manager went on to explain that he monitored durations of calls and referred back to social workers if they identified patterns of continuing additional support required for people. This was to allow for people's needs to be reviewed by the responsible local authorities so care packages could be updated.

We looked at the recruitment records for three members of staff who had recently been appointed. We found that recruitment practices were thorough and included application forms, interviews, the requesting and receiving of two references from previous employers and checks with the Disclosure and Barring Service (DBS). DBS checks help employers make safer recruitment decisions by preventing unsuitable applicants from being employed to care or support vulnerable people using services.

There was a personal emergency evacuation plan (PEEP) in place for every person. Plans included details about each person's dependency, level of mobility, equipment used and how many staff were needed.

The care team leaders maintained a log of all accidents and incidents within the service. Records included details of people involved, what had happened and any immediate and follow up action taken. The registered manager told us they analysed accidents and incidents to identify any potential trends. At the time of the inspection there were no trends identified.

Good

Is the service effective?

Our findings

People told us they felt staff were trained and capable of supporting them with their needs. One person said, "I know they have ongoing training all the time. I know they need to keep their mandatories up to date but they do more. There's always some course they are doing like hoisting and fire." A relative told us, "They are very professional in how they deal with sensitive matters and provide really effective care. All the way from trainees up to senior management, they are all brilliant."

Staff received regular training. Care team leaders showed us the system they used to monitor what training each member of staff had completed and when refresher courses were due. Training records showed staff had up to date training in areas such as safeguarding, nutrition, moving and handling and health and safety.

Records showed staff received regular supervisions. Discussions covered a range of areas including matters arising from previous supervision, feedback from monitoring and practical observations, training, safeguarding, medicines, absence management and records. Any actions agreed during supervision sessions were recorded and revisited during the next supervision sessions to review progress.

As part of the supervision process direct observations were carried out by care team leaders and senior care workers to assess individual staff member's performance around their interaction with people while providing support. The observations focussed on how staff engaged with people, how they demonstrated knowledge of people's needs and the quality of care and support staff provided to people.

Gildacre Fields is a relatively new service and celebrated being open for one year at the time of our inspection. The majority of staff had worked for the service for less than a year and had therefore not received an annual appraisal. We did note some staff had received these and further appraisals were planned for staff. The registered manager explained that the provider was introducing a new appraisal scheme which would replace the existing system and all staff would receive this in due course.

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.

We checked whether the service was working within the principles of the MCA. Staff understood the principles of MCA and care plans contained capacity assessments and best interest decisions where required. Capacity assessments we viewed in care files were decision specific. For example, storing medicines in a lockable cupboard within a person's apartment.

Staff supported people with nutrition in line with their assessed needs. Care plans detailed the level of support people needed with eating and drinking. One person's care plan stated, 'I would like care staff to ask me what I would like for my breakfast giving me choices of what I can have. I would normally have

scrambled eggs, porridge and a hot drink of tea with two sugars and milk or a milky coffee with two sugars.' One person told us, "They make breakfast on a morning." Support provided was predominately focused around meal preparation rather than supporting people to eat.

People had access to external health professionals and were supported by staff to make appointments as and when required. Records confirmed people had regular input into their care from a range of health professionals including district nurses, GPs, speech and language therapists, occupational therapists and the falls team. One relative told us, "They used their initiative and were contacting the GP to get them to come out and see [family member] every week because they were only drinking water and staff didn't feel they were drinking enough." They went on to tell us they lived out of town and said it was "peace of mind" to know the service were in contact with their family member's GP.

Good

Is the service caring?

Our findings

People and a relative told us the service and staff were caring. One person said, "They always say 'is there anything else you want us to do'. There's nothing that they won't do for you." Another person said, "They're good." A relative told us, "They deliver a really good service. They go over and above the call of duty."

People told us staff treated them with respect and maintained their dignity while supporting them with personal care. One person told us, "They put a towel across my lap (when providing personal care)". Another person said, "They help me have a shower every morning. I'm comfortable with all of them". A third person said, "Oh yes, dignity always."

People were supported to be as independent as possible. One person told us when staff supported them with personal care they only washed areas the person wasn't able to wash themselves. They explained that staff didn't make any assumptions of their capabilities and they maintained independence where possible. Care plans included information about people's capabilities. One person's personal care plan stated, 'I am able to wash my top half of my body but need assistance with the rest. I am able to brush my teeth myself, however staff are to hand me the toothbrush with the toothpaste on.'

We observed staff treated people with respect. We saw staff knocking on people's apartment doors and waiting for permission to enter. In the communal areas we saw staff greeted people in a warm, familiar manner.

Staff supported people to help them maintain their emotional wellbeing. We viewed records and found that some people received companionship support from staff as part of their care packages. This included whatever the person wanted to do. For example, one person's care plan stated, 'I may want to go to the town shopping or for a coffee. I will decide on the day and let you know what I want to do.'

Care team leaders and senior care staff completed daily wellbeing checks for every person living in Gildacre Fields, unless they did not wish to receive one. Senior staff recorded on a daily log sheet if they had seen or spoke to a person. They also recorded if people were unavailable for reasons such as they were away on holiday or out for day. If staff hadn't seen or spoken to people they contacted them using the internal intercom system or visited their apartment to carry out a welfare check. During the inspection we observed a person informing the registered manager that they were going out for the day so they didn't worry about them.

Staff members had access to information in people's care records about their preferences, including their likes and dislikes. Copies of people's care records were stored securely in locked cabinets which were located in offices that were either occupied or locked. People also had a copy of their care files in their apartments along with daily records staff completed when providing support.

At the time of the inspection no one received support from advocacy services. We spoke to the registered manager about what they would do if people required services. The registered manager informed us he

would support people to access appropriate services and said, "I would contact social services." During the inspection we observed information regarding local advocacy services on display on the noticeboard in the main communal area. This meant information was readily available for people to access services independently if they needed.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs, wishes and preferences. One person we spoke with said, "Everything is all right. Everything's done that should be done. Overall it's very, very good." A relative told us, "They've done a really great job for my [family member]. They are really good at listening to people and their families with what they want. If [family member] had stayed in their own home, I don't think they would have been with us now."

People had their needs assessed prior to receiving care and support. Assessments were used to gather personal information about people to help senior staff better understand their needs and to inform plans of care. Information gathered included medical and life history and existing support networks. Assessments also included daily living needs, medicines, communication needs and social interests.

People had a range of care plans in place to meet their needs including personal care, nutrition and hydration, medicines and mobility. Care plans were detailed, personalised and included people's choices, preferences, likes and dislikes. For example, one person's personal care plan stated, 'I like to wear underpants and tracksuit bottoms and socks. I do not wear shoes in the house.'

Care plans contained detailed information to guide staff how to meet the specific needs of each individual from the first point of contact at the person's front door. For example, whether to knock and waiting for people to answer the door or call them to enter the apartment or to let themselves in and how to greet the person. For example, shouting their name to let them know who was entering their home.

Care plans were reviewed every six months, as well as when people's needs changed. All care plans we viewed were up to date and reflected the needs of each individual person. People told us they felt in involved in the planning of their care. One person we spoke with said, "Yes I'm involved in care planning and reviews when things need to change and six monthly." Care records showed people were involved in care plan reviews. This meant people were involved in planning their care on an ongoing basis.

People knew how to raise concerns if they were unhappy about the care they received. One person said, "I have no problems. If I needed to complain I would. If there was anything I wasn't happy with." Another person told us about a complaint they had made regarding a staff member. They explained how the registered manager addressed their concerns and how they were happy with the outcome.

The registered manager maintained both an electronic record of any complaints and concerns received on the provider's system. We noted complaints and concerns were investigated by the registered manager and appropriate action was taken. Concerns received related to housing issues.

Good

Is the service well-led?

Our findings

People and relatives told us the service was well managed and the registered manager was available when they needed them. One person said, "[Registered manager] is great, very amenable and very helpful. He's got a good rapport with all the residents. He's not a manager who just sits behind a desk. He's out on the floor and you can come and see him at any time." When asked if management were approachable and accessible a relative told us, "Always yes, all the team. They have an open door policy all the time."

The service had a registered manager in post. They had been pro-active in meeting their responsibilities in relation to submitting relevant notifications to the Care Quality Commission. The registered manager operated an open door policy. Throughout the inspection we saw staff approach the registered manager in their office and in communal areas to seek their advice.

Throughout the inspection visits there was a management presence in the service with the registered manager and care team leaders readily available for staff, people who received support, relatives and other professionals to speak to. There were also senior care workers on duty for care staff to seek immediate support and guidance from.

Staff meetings took place on a quarterly basis or more frequently if required. Discussions viewed from minutes included new staff, people, training and policies and procedures. Other discussions included specific procedures such as when emergency calls come in and seniors passing them on.

The registered provider had systems in place to check on the quality of the care people received. Checks carried out included medication audits, care plans and risk assessment reviews, safeguarding concerns and complaints received. Specific spot checks were carried out on staff and included general appearance of the care worker, whether they wore their identity badges and if they followed infection control protocol. Other areas included documentation, medicines prompted or administered and whether staff promoted people's independence while providing support. From the spot checks we viewed, there were no actions required.

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 and those returned were analysed by the registered manager to identify any areas of development. Questions covered areas such as staff punctuality and attitude, activities, management and premises. Feedback received about staff and the service was positive. In January 2017 seven surveys had been returned and were all positive. Responses included comments such as 'very satisfied' and 'keep up the good work'.

The service had received a number of compliments and thank you cards from people who received support and relatives. Comments included "kindness", "care and compassion" and "friendly and helpful" staff.