Community Homes of Intensive Care and Education Limited

Boxgrove House

Inspection report

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Date of inspection visit:
26 April 2016
27 April 2016

Date of publication:
02 June 2016

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 the 26 and 27 April 2016 and was unannounced.

Boxgrove House is a care home, which is registered to provide care (without nursing) for up to 11 people with autistic spectrum conditions and learning disabilities. The home is a detached building on the outskirts of Reading, but within West Berkshire and is close to local shops and other amenities. People had their own bedrooms and use of communal areas that includes an enclosed private garden. The people living in the home need care and support from staff at all times and have a range of care needs.

The home has a manager who works full-time and is in the process of registering with the Care Quality Commission (CQC) as the registered manager. A deputy manager who also works full time within the service supports the manager. 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.

There were effective systems to regularly assess and monitor the quality of service that people received. Various formal methods included unannounced visits by one of the organisations regional directors and health and safety audits completed by the manager, which included night spot checks. Since becoming the manager in October 2015, the manager has made substantial improvements following audits of the service. These have included improvements to the environment, people's records, staffing, staff support and meaningful activities that have promoted an open and positive culture within the home.

The home was clean and comfortably furnished. People had their own bedrooms, which were personalised with their own belongings. Staff had received health and safety training that included infection control, moving and handling and positive behaviour support. People's nutritional needs were met with meals that were appetising and cooked to meet individual needs.

People who use the service used a range of communication methods. These included non-verbal to limited verbal communication. Individual methods were supplemented by the use of pictures and objects of reference to indicate their needs and wishes, which were clearly understood by staff.

People received good quality care. Staff treated people with the utmost respect and kindness at all times and were passionate about providing a quality service that was person centred. People were encouraged to live a fulfilled life with activities of their choosing and were supported to keep in contact with their families.

There were robust processes in place to monitor the safety of giving people their medicine. People were supported to eat a healthy diet and they were helped to see their GP and other health professionals to promote their health and well-being.

The recruitment and selection process helped to ensure people were supported by staff of good character. There was a sufficient number of qualified and trained staff to meet people's needs safely. Staff knew how to recognise and report any concerns they had about the care and welfare of people to protect them from abuse.

People were provided with effective care from a staff team who had received support through supervision and training. Their care plans detailed how they wanted their needs met and these were regularly reviewed to ensure they were person centred. Risk assessments identified risks associated with personal and health related issues. They helped to promote people's independence whilst minimising the risks.

The service had taken the necessary action to ensure they were working in a way which recognised and maintained people's rights. They understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and consent issues, which related to the people and their care.

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 were supported by staff of good character who knew how to protect them from abuse.

People received their medicine safely.

There were sufficient staff with relevant skills and experience to keep people safe.

The provider had robust emergency plans in place, which staff understood, to promote people's safety.

Is the service effective?

Good

The service was effective.

People's individual needs and preferences were met by staff who had received the training they needed to support them.

Staff met regularly with their line manager for support to identify their learning and development needs and to discuss any concerns.

People had their freedom and rights respected. Staff acted within the law and protected people when they could not make a decision independently.

People were supported to eat a healthy diet. They were helped to see their GP and other health professionals to promote their health and well-being.

Is the service caring?

Good

The service was caring.

People benefitted from a staff team who were committed to ensuring their needs were met throughout all stages of their life.

The relationships between staff and people receiving support demonstrated dignity and respect at all times.

Is the service responsive?

Good

the service was responsive.

Staff knew people well and responded quickly to their individual needs.

People's assessed needs were recorded in their care plans that provided information for staff to support people in the way they wished. These were reviewed continually to promote person centred care.

Activities within the home were individual to each person around the choices they had made.

There was a system to manage complaints and people were given regular opportunities to raise concerns.

Is the service well-led?

Good

The service was well-led

The manager was open and approachable and promoted a positive culture.

Staff had confidence that they would be listened to and that action would be taken if they had a concern about the services provided.

There were audits completed by external agencies such as the local authority and assessments by health care professionals.

Processes were in place to monitor the quality of the service and the running of the home. These included audits of health and safety and reviews of people's care and support plans.

Boxgrove House

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 the 26 and 27 April 2016. It was carried out by one inspector and was unannounced.

Before the inspection the manager completed 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. We looked at the PIR and at all the information we had collected about the service. This included previous inspection reports and information received from health and social care professionals. We also looked at notifications the service had sent us. A notification is information about important events which the service is required to tell us about by law.

During our inspection we observed care and support in communal areas of the home and used a method called Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We spoke with the manager, deputy manager, regional director, cook, activity coordinator and eight staff. We also received feedback from a local authority care quality officer, four health care professionals and an advocate of one person who uses the service.

We looked at four people's records and records that were used by staff to monitor their care. In addition we looked at three staff recruitment files and an agency staff profile. We also looked at staff training records, duty rosters, menus and records used to measure the quality of the services that included health and safety audits.

Good

Is the service safe?

Our findings

People were unable to tell us if they felt safe. They were protected against the risks of potential abuse. Staff were able to provide a robust response in relation to their understanding of safeguarding. They had received safeguarding training and where fully aware of the provider's whistleblowing policy. They also told us that if they had concerns and were not listened to by the manager or within their organisation, they would report their concerns to the local safeguarding authority or Care Quality Commission (CQC).

It was evident throughout our two-day visit that people felt confident approaching staff and were given every opportunity to express any concerns they had. Risks associated with their care and support had been identified and managed appropriately with the aim of keeping people safe, yet supporting them to be as independent as possible within the community and home.

People were protected when others presented behavioural challenges. Staff redirected people who presented with behaviours that may have placed them and/or others at risk. They did this in a composed and natural manner that did not draw attention, whilst they calmly continued to support people. An external health care professional stated, "When one of the client's was exhibiting some challenging behaviour the staff quickly made safe space for him. They ensured the safety of the other clients, themselves and me. This was through either moving from the space or monitoring within the space".

Staff spoke of triggers that could lead to people presenting behavioural challenges, such as a change of routine. They had received training that focused on proactive methods to identify triggers and to recognise early behavioural signs. The training provided ways in responding to a person should they be in crisis, through diffusion, verbal and non-verbal calming techniques and as a last resort, physical interventions to keep people safe. Staff completed behaviour observation charts when people presented behavioural challenges. The record detailed significant events that had happened in the person's life on the lead up to the behaviour. These were reviewed by the manager and psychologist and the behaviour monitored by a psychology team. The information helped to identify possible triggers and to develop strategies to provide positive behaviour support without the use of restraint interventions, wherever possible.

There was an alarm within one person's room and also within an annex where one person lived, should staff require immediate assistance. The manager told us that there were sufficient staff to support people and provide assistance without the need of alarms within the main building. However, on one observation a staff member was on their own in the main lounge with four people for approximately two minutes. One member of staff went to get some black bags, whilst another had popped into the kitchen. This had identified a potential risk for people and staff should a person present a behaviour that challenged. The manager took immediate action to ensure staff stayed within the area they were deployed. Within 24 hours of our visit we were informed that staff had been provided with a personal wrist alarm to summon support if required.

There were two full-time staff vacancies. These were covered by staff, which included bank and agency staff, to ensure there were sufficient staff to support people safely. This included one to one and two to one support when required within the home, and to support people to access the community. There were seven

staff in the morning and six in the afternoon. Additionally there was a full time manager, deputy manager, activity co-ordinator, cook and domestic staff. A psychology team employed by the provider also supported the service. On call contact numbers were available for staff to summon help or assistance in the event of an emergency.

The provider had effective recruitment practices, which helped to ensure people were supported by staff of good character. They completed Disclosure and Barring Service (DBS) checks to ensure that prospective employees did not have a criminal conviction that prevented them from working with vulnerable adults. References from previous employers had been requested and gaps in employment history were explained. However, one staff member's employment history identified the year of employment only, as opposed to year and month. The manager confirmed that he would ensure the record was rectified and reasons for gaps identified.

The service had a contract for the removal of clinical waste and staff had access to protective clothing such as disposable gloves and aprons. Washing machines had a pre-wash / sluice cycle and soiled items were placed into a red, water-soluble bag before being placed in to the washing machine. Staff had received infection control training and were committed to providing a clean and comfortable home for the people who lived there.

There were risk assessments individual to each person that promoted people's safety and respected the choices they had made. Fire safety, legionella and monitoring of hot water outlets to minimise risk from scalding were undertaken. Incident and accident records were completed and actions taken to reduce risks were recorded.

People were given their medicines safely by staff who had received training in the safe management of medicines. Staff competency assessments included a written and oral assessment and two practical assessments before they were signed off as competent to support people with their medicine. There was detailed guidance for staff to follow for people who had been prescribed medicine as and when required (PRN). For example, one staff to administer and one staff to witness. The service used a monitored dosage system (MDS) to support people with their medicines. MDS meant that the pharmacy prepared each dose of medicine and sealed it into packs. Medicines were stored securely and could only be accessed by staff. Staff were aware of individuals preferred method of receiving their medicine and of the maximum dose of medicines given as required, such as pain reliever. The medication administration records were accurate and showed that people had received the correct amount of medicine at the right times.

Good

Is the service effective?

Our findings

People had access to health and social care professionals such as their GP, dentist and speech and language team and could attend appointments when required. People had a health action plan, which described the support they needed to stay healthy. For example, "things you should know / things that are important" to the person and details of their "likes and dislikes". This was used to promote positive communication of people's needs between services and to minimise unnecessary anxiety for the individual when attending health care appointments.

Staff were fully updated on health appointments people had attended and people's care records detailed outcomes from relevant health care appointments. For example, a person visited the dentist during our inspection. They came back from their appointment with advice on the food they could eat and on pain relief. A handover meeting for staff ensured all staff were informed of the outcome and how to support the person. The information was fully detailed within the person's records.

People were encouraged to make healthy living choices regarding food and drink from picture menus and symbols and/or by use of limited verbal communication. Meals were prepared and well presented to meet people's individual needs and alternatives of the main meal were offered. Appropriate referrals were made to the dietitian and speech and language therapists when staff had concerns about people's wellbeing.

A speech and language therapist spoke of referrals they had received from Boxgrove House. One was for communication and two were for eating and drinking. The professional told us that, "the referrals had been appropriate for speech therapy and presented a clear issue requesting help". Additionally they stated that they had spoken with the new manager about a previously missed appointment and that staff had not passed the information to relevant people. They told us that the new manager had apologised and worked with them for a satisfactory resolve. This had identified speech therapy input was not required for the person. The professional stated, "this was an excellent and prompt outcome for both our service and the client".

Staff had access to a range of training to develop the skills and knowledge they needed to meet people's needs. The provider had signed up to the care certificate, which is a set of 15 standards introduced in April 2015 that new health and social care workers need to complete during their induction period. The manager confirmed that staff training was linked to the new standards, and also for existing staff to refresh and improve their knowledge.

Staff told us they had the training and skills they needed to meet people's needs. They had completed training, which included moving & handling, as well as training to support specific individual needs such as epilepsy, autism and learning disabilities. Staff were given the opportunity to attain qualifications such as diplomas in health and social care. They told us that they felt supported by the new manager and were very positive about working together effectively as a team. They had attended staff meetings and had received one to one supervision and appraisal that supported their development needs.

People's rights to make their own decisions where possible, were protected. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Nine people using the service were subject to authorisation under the Deprivation of Liberty Safeguards. The registered manager and staff had a good understanding of the MCA and had received MCA training.

Good

Is the service caring?

Our findings

People received care and support from staff that had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. A health care professional stated, "I have seen the staff talk with the people who live at Boxgrove House and I thought they used appropriate language and manner that was affective and respectful".

People were clearly understood by staff when they made choices and expressed their views. Where they were unable to verbally communicate, they expressed smiles in recognition of what was being said to them. Staff had received dignity and values training and demonstrated throughout our inspection their commitment to ensuring people were treated with the utmost respect at all times. A member of the staff team said, "I would say it is pretty good here, there are some really good staff who are passionate and caring".

Staff knew people's communication skills, abilities and preferences, which had a positive impact on people's lives. People used various methods of communication that included verbal, body language, signs and pictures of reference. Their preferred method was detailed within their care plan. For example, a communication profile detailed any known difficulties such as with hearing. The profile confirmed the person's concentration span and comprehension level such as, "able to follow simple spoken instructions containing two or three words". Others stated, "communicates well verbally for what he wants, but will not carry on a meaningful conversation" and "(name) will communicate what he likes and dislikes and you can tell by facial expressions".

We observed some excellent interactions between people and staff that came naturally and provided a positive impact for people. During the changeover of staff, a staff member approached a person and said, "how has your day been (name)". They were greeted with the response, "good". Staff asked a person to speak slower so that they could understand them; this was met with acknowledgement for the person, followed by positive and friendly bantering. One person who could not verbally communicate clearly understood what was being said. He responded to staff with positive eye contact and smiles in acknowledgment of what was being said. Staff described people's understanding ability. For example, "(name) is very much a person of routine, but it can be difficult to read him" and "(name) can speak with you and has some understanding". Staff said that one person who used non-verbal communication methods, "will choose their clothes by touching what they want and will open food cupboards to select what they want".

There was a range of other ways used to make sure people were able to say how they felt about the considerate and caring approach of the service. People's views were received through care reviews and day-care one to one meetings with the activity co-ordinator. We overheard the activity co-ordinator say to a person, "shall we have a meeting in day-care or in your room". She was very patient and respectful of the person and made sure the person was fully involved in the decision made. Day-care meetings made people feel valued and gave them a formal opportunity to talk about changes within the home, activities they enjoyed, interests and activities that they were no longer interested in doing.

People and their relatives and advocates who acted on their behalf were asked for information that would support decisions by the person about their last wishes for end of life care. Where necessary, people and staff were supported by palliative care specialists. Staff told us that they had experienced a recent death of a person who lived in the home for a number of years. A health care professional said, "A resident we had placed at Boxgrove House passed away last year. They (staff) did work well with them and were very supportive in making them feel as comfortable as possible during that time". Staff worked extra hours over this period to ensure a member of the staff team was with the person at all times, up until the person's death. Staff told us that this had been a sad experience for them, as they spoke fondly of the person. They spoke of the support they received from palliative care nurses and by the community nurse to ensure the person was comfortable and that their death was met with dignity and respect. A compliment letter from the person's family showed that they had felt involved and supported by staff. The manager told us that although they had an end of life care plan for the person, he felt this was an area that could be improved. Further training was planned for staff and care plans referred to as "My End of Life Book" were being completed for each individual. A letter was sent to people's relatives and / or to the person acting as their advocate requesting further information about their relatives/appointees last wishes.

An independent advocate of person stated, "I have been visiting Boxgrove House about once a month as I currently have one client there. I have no concerns and have been impressed with the commitment of staff and their understanding of the residents in their care. This included in one case assisting in re-establishing contact with family after many years of no contact and supporting the resident to attend his brother's funeral".

The home was spacious and allowed people to spend time on their own if they wished. One person who lived in the annex received one to one support from staff at all times. The main house was designed to enable people to be safe as they walked around the home and grounds freely. There were no restrictions observed, other than where it was not safe to go, such as cupboards that held cleaning products. People's rooms were secure so others could not enter, but the individual could access with support and leave independently. One person had a key to their room that promoted their independence.

People's records were securely stored to ensure the information the service had about them remained confidential at all times. Information about each person was only shared with professionals on a need to know basis.

Good

Is the service responsive?

Our findings

People had their needs assessed before they moved to the home. Information was requested from the person, their relatives and professionals involved in their care. The information was used to inform their care plans. An overview of a person's life, "My Story", detailed a number of placements the person had throughout his life until moving to Boxgrove House. The story described the person as a "happy chatty man who can become anxious when leading up to social events". This was something we observed throughout our visit as staff spent time with the person and reassured them on a number of occasions when he had spoken of a planned party.

People's care plans centred on their needs and detailed what was important to them such as contact with family and afforded choice. The information promoted people's independence. Their needs were reviewed regularly and as required. Where necessary health and social care professionals were involved. A health care professional stated, "I found the staff to be friendly and supportive. The clients always seemed cared for and looked after. I have had no concerns with the service provided".

The manager was in the process of reviewing people's records to make sure all information required was readily available for staff to support people. These included daily reports and monitoring records about each person's life. The manager stated that there had been some gaps from daily reports that they were making progress to improve. The service had implemented a tool called "Living the Life", which sets goals for people in five key areas. These were described as learning and development, good relationships, busy and having fun, caring and contributing and content, being well and happy". Staff told us that they felt there was enough detailed information within people's records to support them in the way they wanted.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure each person's progress was monitored. Staff spoke of their role as a named keyworker. They told us as an example, the keyworker was responsible for ensuring the person's records were up to date, health care appointments attended, and that the person had sufficient toiletries and clothing. One of the staff said, "as keyworker we had the option of putting down things that we thought they (the person) could or could not achieve. The psychologist reviewed what we had written in their living the life booklet as part of their review". Another member of staff stated, "I am keyworker to (name). He has a strict routine and will instruct us when he wants personal care".

People were supported to maintain their independence and access the community. There were activity records individual to each person that detailed what they liked to do. These included day trips, exercise, such as swimming, riding a bike and special events such as parties and entertainers to the home. There was a full time activity coordinator who met with people regularly to establish what their interests were. This was to develop a plan that centred on what the person wanted to do that added value to their lives.

The provider had a complaints policy that was accessible to people and their visitors. In the twelve months prior to this inspection, the service had received one formal complaint that was resolved. The service had also received seven compliments about the service.

Good

Is the service well-led?

Our findings

There was a manager at Boxgrove House who had commenced the process to register with the Care Quality Commission (CQC) to become the registered manager. The manager and deputy manager were both present during our visit.

The manager listened to what people and staff had to say. Staff comments about the manager included, "He Is really good, he is one of those managers you can always talk to". "If you need a hand on the floor he will come and help". "You only have to go to the office, say you have a problem and he deals with it". The manager told us that when he came to the service staff supervision had not been carried out regularly and that people's care plans and risk assessments were not up to date. He stated, "we are now getting things in place. We are definitely going in the right direction".

A local authority quality control officer completed an annual visit to the service in August 2015. They said, "I left there feeling there were possible issues and arranged a follow up visit". They returned October 2015, after the manager had come into post. The professional stated, "The manager had been working very hard to address the issues highlighted and I have seen excellent progress". "Staffing levels had increased and were at a safe level and staff supervisions were of a better quality and regular".

People and those important to them had been given full opportunity to feedback their views about the home and quality of the service they received. One to one meetings were held to enable people to comment about the service. Feedback had been received from people, their families and advocates through care reviews and a survey completed in 2014 had asked people their opinion about the service. The survey identified positive feedback and identified areas for improvement, which included a clean environment and more activities that were external. These were clearly actioned when the manager came into post. The home was clean and people were supported to access recreational events and trips within the community more often.

Internal processes were in place to monitor the quality of service and the running of the home. These included audits of health and safety such as fire, legionella and hot water outlets to minimise the risk of scalding. Staff training and people's care and support plans were reviewed regularly to ensure staff had the knowledge and skill to meet people's needs safely and effectively.

Staff described the manager and deputy manager as open, approachable and supportive. They both regularly worked alongside staff, which promoted a positive culture. Staff told us that the manager kept them informed of any changes to the service provided and needs of the people they were supporting.