Community Integrated Care

Hightown Road

Inspection report

75 Hightown Road
Ringwood
Hampshire
BH24 1NH

Tel: 01425461269
Website: www.c-i-c.co.uk

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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

Our inspection took place on 30 and 31 July 2018 and was unannounced.

The last inspection of Hightown Road took place on 11 March 2016 and the service was rated as good. We rated the 'safe' domain as requires improvement due to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff had not received the training they required to support people safely and infection and environmental risks had not been fully assessed or mitigated to reduce the risk of harm to people. We found at this inspection that the provider had acted to mitigate risks of harm noted at our last inspection and that staff had completed appropriate training courses. The service was no longer in breach of this regulation.

Hightown Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hightown Road provides accommodation, care and support for up to four people with learning disabilities. The home is a purpose built residential property with two ground floor, and two first floor bedrooms.

There were four people living at Hightown Road when we inspected.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Processes and checks were in place to ensure the safety of the premises and equipment was maintained. Some checks were completed on behalf of the housing association landlord by external contractors. The provider did not have copies of these records. We recommended that the fire alarm and water safety monitoring check records, to include a copy of the legionella risk assessment, should be kept on site.

Recent good weather had caused temperature levels in the medicine store to exceed safe levels. Staff had managed to reduce the temperature by opening windows however the room housing the medicine cabinet was in a warmer part of the house. We recommended that these actions and readings are recorded and that a permanent solution is sought to maintain safe medicine storage temperatures.

Prescribed fluid thickeners were stored in the kitchen on the top shelf of a cupboard that people living in the home could not access. We asked that the registered manager risk assess where the thickening granules were stored.

People's needs were assessed before they moved into the home then regularly reviewed and care plans

updated to reflect changing needs.

People were protected from being cared for by inappropriate staff by a robust recruitment procedure. Staff were trained to ensure they had appropriate skills to support people and sufficient staff were deployed to care for people.

People were supported with their nutritional needs. Advice was sought from healthcare professionals such as the GP, speech and language therapist and dieticians to ensure people were provided with appropriate meals prepared as per individual needs.

Activities were provided in the home alongside some people attending day services. People were encouraged to participate however could take time to relax as they wanted.

Positive feedback was received from relatives and staff about the registered manager and senior support worker.

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 had improved to good.

Relatives told us they thought the service was improving and kept people safe.

Risks were assessed and reviewed and actions put in place to mitigate concerns.

The provider took calculated positive risks to ensure people had fulfilling lives.

Medicines were safely managed and audited weekly.

Is the service effective?

Good

The service remained effective.

The provider completed a range of assessments and complied necessary, person-centred care plans.

Staff understood and applied the principles of the Mental Capacity Act 2005.

Staff had worked in the service for many years and were familiar with the needs and wishes of people living in the home.

Is the service caring?

Good

The service remained caring.

Staff were respectful of people and provided person-centred and dignified care.

Staff tried different approaches when people were distressed and were skilled at interpreting non-verbal communication.

The provider arranged events for friends and family members to maintain and develop new relationships.

Is the service responsive?

Good

The service remained responsive.

Activities were programmed and ad hoc activities were offered when time allowed.

There was a complaints procedure however no complaints had been received since our last inspection.

Care plans were person-centred and focussed on how best to support people to have a good day.

Is the service well-led?

Good

The service remained well-led.

Positive feedback was received about senior staff in the home.

The provider audited aspects of the service internally and used peer audits by other service managers to ensure an impartial review took place.

The registered manager had support from the provider to remain current about legislation and good practice in care settings.

Hightown Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

Our inspection took place on 30 and 31 July 2018, was unannounced and carried out by one social care inspector.

Before inspecting Hightown Road, we reviewed all information we already held about the location. We looked at previous inspection reports, feedback from health and social care professionals and notifications. A notification tells us information about important events in the service that the registered manager is required to inform us about.

We reviewed the provider information return (PIR). This is information supplied to us by the service annually which provides key information about what they do well and any forthcoming improvements. The PIR was completed in February 2018 so we checked to ensure this information was still current.

During this inspection we spoke with the registered manager, a senior support worker, three staff members, one person who lived in the service and two relatives. Most people living in the home were unable to communicate with us. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at records compiled by the service. We checked staff recruitment and supervision records, health and safety checks, cleaning schedules and accident and incident reports.

We looked at audits and quality assurance survey results and people's care files and daily notes.

We checked the building and grounds to ensure it was suitable for the client group and that it was safe and clean.

Good

Is the service safe?

Our findings

At our last inspection on 11 and 18 March 2017 we found the service to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that staff had the necessary training to keep people safe from harm and neither the environment or risk of infection had been adequately assessed to mitigate risks to people.

When we inspected on 30 and 31 July 2018 we found that the provider had improved some areas in the home and risk assessments had been completed to minimise risks of harm to people. Staff had also received training to ensure the safety of people in the home. The provider was no longer in breach of Regulation 12.

Relatives of people living in the care home told us they believed their family members were safe and that the home had improved. "It's [the home] is so much better … there have been a few changes in staff and the senior support worker is excellent, we couldn't speak more highly of them and some of the other staff, the home has improved a lot".

We looked at the environment of the home to see if the premises were safe and clean. Whilst repairs had been made to the tiles and flooring we identified at our last inspection, we noted new concerns about the safety and maintenance of the premises. We saw flooring that was beginning to split in a bathroom, painted woodwork that had split and chipped and the kitchen was in poor repair. Drawers had already been fixed, cupboard doors were not well fitted and work surfaces did not show soiling due to the pattern causing hygiene concerns. We saw that some areas of the kitchen had not been cleaned effectively. For example, dust, food scraps and dirt were noted to have accumulated in drawers and the inset pattern on the wooden cupboard doors held crumbs and other soiling.

We saw staff wearing personal protective clothing (PPE) when needed including when cooking meals and supporting with care tasks. An annual infection control audit had identified there were concerns with fixtures and fittings and these had been discussed with the housing provider. The kitchen and bathrooms were usually deep cleaned on Mondays, and there was a cleaning schedule to ensure all areas were regularly cleaned. The weekly deep clean was delayed due to our inspection however this had been completed before we returned the following day.

We looked at the service's maintenance logs and there were several instances where either the process of getting works completed had been subject to delays or issues raised by the provider were not considered to be problems to the housing association. This included concerns about uneven and weed covered block paving in the garden. There had also been a two-week delay before works to clear drain blockages had been completed even though the provider had alerted the housing association to the problem as soon as it was found. We spoke to the registered manager about these concerns. They told us that the housing association that owned the property had inspected the premises that month and had not noted any required work and had considered areas raised by staff in the home to be unnecessary. The registered manager agreed to raise our concerns with the housing association to arrange improvements to ensure that people remained safe.

We asked that they report back to us to keep us informed of progress. The registered manager had committed in their PIR to improve the working relationship with the housing association and confirmed that they now had a named contact person. Since our inspection, the registered manager had arranged to meet with the housing association and had discussed flooring concerns, the kitchen and other issues. In addition, we did not see any negative impact of these environmental issues upon people using the service during our inspection nor were we told of any by the registered manager.

A weekly health and safety check by staff took place to ensure the safety of the premises. Staff, familiar with the needs of people in the home, checked to ensure there were no specific risks to them from the environment. Gas and electrical safety checks had been completed and the fire alarm system had recently been upgraded and extended. New fire doors and door frames were being fitted the week after our inspection. The fire alarm and door closers were checked by an external contractor every week who also checked emergency lighting each month. We saw records of fire drills that had been completed by the provider. An external contractor also attended the home weekly to undertake checks of the water safety within the service to prevent risks associated with legionella.

When we inspected, the only records held on site of fire alarm and water safety monitoring were signing in books where engineers had logged their visits. The provider managed to obtain copies of the records from the housing association. We recommended that a copy of these records be kept on site in order that the registered manager can be reassured that all necessary checks have been performed regularly and the outcome of these visits are recorded and any actions escalated.

The provider had a clear recruitment procedure and all relevant checks were completed before staff commenced their employment. Staff recruitment files contained completed application forms, full work histories and two references. Staff were also subject to a Disclosure and Barring Service (DBS) check. The DBS check highlights potential issues around criminal convictions and shows if someone is barred from working with vulnerable people. This ensures that staff employed at the service are suitable to work there. Staff were provided with an induction and their performance monitored during a probationary period.

Staff were trained and checked for competence before administering medicines. Medicines were supplied in individual, tamper proof pods. The supplying pharmacy also provided medicines administration records (MARs). The MAR sheets and the medicine packaging had colour photographs of people and contained all the necessary information needed to ensure the safe administration of people's medicines. The provider had a weekly audit system for medicines and a clear ordering and receipt process. We found one packet of eyewash pods that had passed their expiry date's however these were not currently in use. The senior support worker arranged for these to be disposed of immediately. All other medicines including PRN medicines were in date and labelled when opened. PRN medicines are prescribed to be taken as needed and not as a regular dose.

Medicines were stored in a locked cabinet in a room only accessed by staff or people who were supervised. The room was in a very warm part of the house and the temperatures recorded in the cabinet had exceeded the safe range of between 15 and 25 degrees Celsius, and had at times reached 30 degrees due to the very hot weather. Staff had reduced temperatures significantly by opening windows in the room and had attempted to source an air conditioning unit. The registered manager told us that additional measures to maintain safe temperatures included the use of cold packs in the cabinet and staff could move medicines to a cooler area. The registered manager also confirmed that if the temperature had exceeded the recommended levels, staff took additional readings and actions until the temperature had sufficiently reduced. The registered manager had also sought advice from their pharmacist to ensure that medicines would still be effective.

People had a person-centred medicine plan. This described what their medicines were for and any risks associated with the medicines. We saw that one person had been prescribed fluid thickeners. These were stored in the kitchen on a top shelf in a cupboard which people living in the home could not access. We have asked the registered manager to ensure this is risk assessed and is suitably secure.

Risk assessments had been completed and a full review completed every six months. Support people needed to stay safe was recorded and additional learning about people was added to files between reviews. Logs detailed risks such as from medical conditions or financial abuse.

Good

Is the service effective?

Our findings

Before moving into the care home, people were assessed as to their suitability in terms of whether their needs could be met by the service and if the environment and other people in the home would be suited to them. One person had moved into the home more recently and the registered manager had discussed existing care plans with the commissioner and had agreed how to progress while the person settled into the service and was assessed by the provider. This helped to ensure that transitions into the home were managed sensitively and effectively.

The service used a person-centred method of assessment and care planning. Widely available person-centred 'tools' were used including the 'circle of support', 'what we like and admire about the person' and 'what is a good day'. These tools gathered information about the person and their preferences and informed how people should support them.

People's needs were assessed in a range of areas including, health, food and drink, equipment and behaviour. Assessments were holistic and aimed to 'really get to know' the person and involved exploring all the things that were important to the person, such as their friends and family. Care plans were person centred and outcome focussed. For example, one person hoped to learn to swim independently, take a holiday and go sailing. Support plans showing how needs were to be met were in place and were updated regularly, either when achievements were made or if new learning about the person indicated a different approach may be needed.

The provider was about to pilot a scheme using an electronic care system with staff using tablet devices to record or update information about the person. The registered manager told us they hoped that the new system would allow staff, "More time with residents and less time spent doing paperwork".

When staff started working at Hightown Road, they participated in an extensive induction including general courses such as health and safety training, safeguarding and fire safety. Training was then tailored to their specific role; these courses included communication, client group awareness and infection control. Finally courses specific to services were undertaken and included moving and positioning, positive behaviour support and administration of medicines. Reflective practice was used to indicate competence.

Continual staff training was provided using an online training provider that was accessed by staff both at work and at home. Records showed that staff training was up to date. One staff member told us about the training, "I really enjoyed it and did everything. I have asked for more courses". Qualification training was available if staff wished to complete it.

Staff received regular supervisions (1-1s) with their line managers and had an annual appraisal. Supervisions took place approximately monthly and staff told us they found the meetings useful. They told us they spoke about, "Mixed things, concerns, how we are finding things and what we want to improve". They also discussed people living in the home, what was working well and what they needed to consider changing.

The service supported people in the home with their nutritional needs and, if possible, involved them in shopping, menu planning, preparing and cooking meals. Specific nutritional needs were detailed in care plans along with information received from the Speech and Language Therapy Team (SALT) who had provided additional guidance which helped to ensure that staff were able to meet people's nutritional needs effectively. Pureed meals were provided for people along with healthy options for managing weight. Meals were a mix of home cooked and some ready-made options. Each week after shopping, staff sat with a person to work out the week's menu which was based on the likes and dislikes of people in the home. Lunchtimes were flexible and usually consisted of sandwiches so that people could take packed lunches into the community.

When we inspected there were no concerns in terms of people's weight, one person was trying to lose a little weight for health reasons and was being supported to do so. People were also supported to eat their meals and had fluids thickened as prescribed. People were offered drinks throughout the day and could have snacks as they wanted. Staff had participated in training in food hygiene, nutrition, fluids and diet, allergens and dysphagia.

Staff shift patterns ensured continuity of care. Staff worked one day, remained for the sleep-in shift and worked the following day. There were no formal hand-over's however staff read updated daily notes and constantly shared information about people.

Most people had lived in the home for many years and staff were familiar with their needs. Although people were unable to communicate their needs, staff knew them well and could identify if they were unwell and needed to be reviewed by a healthcare professional. We saw care records showing that GP's had been informed when people showed symptoms of possible health concerns.

The premises were a purpose built four-bedroom care home. There were spacious communal areas and the bedrooms could accommodate equipment such as hoists and profiling beds. Bathrooms contained both a wet room area and a bath with a powered seat. The premises looked homely, like a domestic house with a large kitchen, where people had their meals and joined in cooking activities. Hazardous areas such as the laundry and the front garden were kept secure and there was a secure, rear garden. We did note some concerns about the premises which we have reported on elsewhere in this report.

People could choose and decorate their rooms as they liked. One person had a working model railway and responded to the sound when it was moving, another had a sensory lamp with bright colours that provided comfort at night time. Other people needed low stimulation environments. Rooms were tidy and clean and we saw staff supporting people to tidy their rooms. People spent time both in their rooms and in the communal areas when they were at home. We saw people moving around the home as they wished.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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.

Staff were aware of the principles of the MCA and had received training to enable them to support people as per the legal framework. People's care plans had person-centred information about how staff should support them to make decisions and choices in a person-centred manner. Mental capacity assessments had been completed where necessary. Staff presented information to people in a way in which they could understand this. This helped people make choices as much as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where restrictions were in place to ensure that people were kept safe, the provider had made relevant applications for a DoLS. These had either been authorised or were awaiting authorisation by the local authority.

Good

Is the service caring?

Our findings

Relatives told us they thought staff members were caring. One person living in the home told us when asked about the staff, "I like it here…. they're my little friends". We saw kind and compassionate care delivered by a consistent staff team who had all worked in the home for several years and knew people well.

People's care files had person-centred information about them and their life so far, some of which was supplied by their families. Information was held about people's families, childhood, holidays, health and what made them happy. This gave staff ideas as to what people may want to talk about or do. One person who was non-verbal and had lost their sight enjoyed staff talking to them about people in their personal photo album. Staff would describe what people were doing and wearing and talk about who they were from the labels provided by their family. Another person's family had told staff which books they liked and when staff had read to them they laughed and showed enjoyment when often they chose not to interact.

We observed another staff member trying a variety of ways to support a person who was distressed for an unknown reason. We asked if the person could be in pain and a staff member told us, "No, that is a different cry, more of a cry, then a whimper". Staff spoke to the person, moved them to different rooms and played different types of music to them and eventually they became calm again. Staff knew the person well and tried different approaches until they found the right one.

We saw information about how best to communicate with people in their care plans. We were told that one person would go to the fridge if they were hungry and they would touch their belt if they needed the toilet. The staff we spoke with were familiar with this information.

Staff told us they enjoyed their work and we saw positive, caring and fun interactions throughout our inspection. One staff member told us, "I don't see the disability, I just see the person. Sometimes they are a joy to be with and sometimes they might be stubborn and harder to work with." They also told us they were mindful that peoples moods changed fast and they needed to adapt their approach when this happened. For example, on one occasion a person entered the room and looked tense. The staff member immediately tried to find out what was wrong and redirected them to doing something they enjoyed and distracted them from their worries. On another occasion, a staff member heard someone calling out and immediately left to support them. Staff focus was on providing care for people living in the home.

Staff told us they respected people's privacy and dignity. One person did not enjoy having personal care delivered. A staff member told us they would knock on their door and explain what it was they wished to help the person with. and talked to the person throughout the intervention. This had proved to be an easier experience for both the person and staff member. They also told us they looked at ways of making things less distressing. A person did not like having their nails cut but gently brushing their hair at the same time had made the experience more acceptable to them.

The service had developed positive relationships with people's family members. When someone new had moved into the home the provider held a family barbeque so that everyone involved with people in the

home could meet them. A relative told us that they had been touched when their family member had been driven by staff to see them and take them a birthday gift. Staff had also supported a person to attend a funeral which meant their family did not need to worry about them through the day.

Good

Is the service responsive?

Our findings

Staff showed they knew people well and were skilled at interpreting communication such as body language and gestures. Staff told us they would try different approaches in situations until they found the right solution to a person's problem.

People had person-centred assessments and care plans which included information from relatives. Life histories, likes and dislikes and preferences as to how care should be delivered were supplied by family members and were integral to providing person-centred care to people. If possible, the provider obtained assessments and care plans from previous services when someone moved into the home. These were used alongside new care plans to ensure nothing had been missed when they first arrived. These were also archived if they appeared no longer relevant, for example, one person had a behaviour support plan, however they did not show any behaviours which might been seen as challenging to other people so this was archived in consultation with their social worker.

Care plans showed how best to support people with their care and new learning was added to the plans by staff. Care plans were clear and reflected aspects of people's care including how a good day would look and what activities should be included in a good week. Care plans also provided instructions as to how someone would 'get the most from their day'. This was information about usual routines, such as which seat they liked in the car when they went out, where they liked to go, what they liked to do and their likes. Another section gave a detailed account of how they liked to end the day.

People participated in activities in the home and some attended day services and activities and clubs run by other organisations. For example, one person went sailing, swimming, on train trips, had lunches out, walks and attended a club. On the second day of our inspection this person was going out, but as there was some spare time before going out staff supported them to bake cookies, keeping them occupied and entertained.

Activities were person-centred and if someone felt they needed to rest, perhaps due to their medical condition, they could do so and staff might read to them or sit and talk with them as they relaxed. People's activities reflected their interests, for example one person who liked trains accessed the train regularly as a means of transport, or just for fun, instead of using the car.

Staff supported people to maintain relationships with friends and relatives. One person was supported to meet a friend regularly and other people were supported to visit family members and attend family events.

Technology was in use in the home and there was a plan to change to an electronic care record and medicine system.

The service had a complaints procedure, however there had been no complaints received since our last inspection. Relatives told us they had complained some time ago and had been happy with the outcome. The provider had a central phone line that could be used for complaints, if people were not happy to raise

these directly with the registered manager.

No-one living at the service was currently receiving end of life care. Should people become unwell, senior staff told us they would expect them to remain in the home until they could no longer meet their care needs and would be supported by healthcare professionals such as district nurses. The provider had noted in the PIR that they would spend time working with relatives and people about their end of life plans over the next 12 months.

Good

Is the service well-led?

Our findings

Staff and relatives told us they had confidence in the management team. Relatives told us, "[Senior support worker] is brilliant, we couldn't speak more highly of them, … the home has improved a lot". A staff member told us, "They [management team] are approachable and supportive. If I have any problems we can discuss and solve them". Another staff member said, "The management team are really good, supportive, helpful, fun, easy to talk to and let off steam. [Senior support worker] is really good and [registered manager] also, just on the end of the phone".

There was a registered manager in post. A registered manager 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.

The registered manager was responsible for this and another care home registered by the provider. They divided their time between the services and much of the day-to-day management was completed by the senior support worker.

Staff demonstrated a clear commitment to the provider's values which included, enabling people to achieve their aspirations, promoting choice and aspiring to be the best. People and staff were treated as individuals and all had one-page profiles to tell others a little about themselves.

The staff team at Hightown Road were well established and settled. Agency staff had not been used for more than three years and staff covered for each other. The consistency in the team had strengthened the approach at the service through staff's extensive knowledge of the people they worked with and their relatives.

The registered manager had completed the provider information return (PIR). This tells us the provider's progress and commitments to improvements over the last 12 months and for the next 12 months. The provider was committed to staff development and had offered training to enable staff to achieve personal goals and obtain diplomas in relevant areas. In addition, they were encouraging staff, through training in positive risk taking, to develop a wider range of activities to ensure people had fulfilling lives.

The service quality was monitored by the registered manager, by regional management and a 'quality excellence partner', a colleague from another of the provider's services that visits and works with the management team to audit and improve. The regional manager's audits were completed each month and the registered manager or senior support worker also completed audits such as the audit of medicines each week. Accidents and incidents were monitored and systematically reviewed by the provider who looked for patterns and learning that could then be passed to the registered manager to cascade to the team.

Both the registered manager and the senior support worker were visible in the service and supported the staff team. Both were familiar with the people living in the home and the senior support worker worked with

people, completing care tasks and taking them out during activities. The registered manager was contactable if not on site and there was a clear and robust system of 'on call' for out of hours support.

The registered manager was supported to remain current in their knowledge. There were regular meetings with senior management and other registered managers within the provider's services during which good practice was shared and new information such as policy updates cascaded. Policies and procedures were developed centrally and additional training was available for management level staff.

The provider had ensured that it met the requirements of registration. Statutory notifications had been returned as needed and the last CQC report and rating were on display in the service. This was not prominent, however as the home was small and tried to be as domestic as possible, the location of the rating was appropriate.

Staff told us they would approach the management team with ideas to improve the service. They had suggested activities that had been actioned already and believed that both the registered manager and senior support worker welcomed ideas. The provider awarded staff, nominated by their line managers, for good practice and support. The 'Little Acorns' award was given to staff deserving of specific recognition and was shared through the organisation in a published company magazine. Staff were also confident that if they had to report poor practice that it would be dealt with confidentially and professionally and would not negatively impact them. The provider also had a 'hotline' for staff to alert concerns, which was particularly useful if senior staff were the subject of staff concerns.

The provider had forged positive relationships with relatives. These had improved in recent years and staff were proud of the relationships they had developed. Staff phoned relatives with updates and concerns and it was evident from care records that families were well informed about their family member's progress and well-being. Staff had recently worked with relatives to source and purchase a new bed for one person and had taken people to visit their families on numerous occasions to ensure they retained positive and frequent contact with them.