Home from Home Care Limited

The Old Vicarage

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

Overall summary

The Old Vicarage is registered with the Care Quality Commission (CQC) to provide care and accommodation for a maximum of 14 adults who have a learning disability. It is situated in the village of Stallingborough near to Grimsby.

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.

This inspection was unannounced and took place over two days. The previous inspection of the service took place on 27 January 2014 and was found to be compliant with all of the regulations inspected.

Medicines were kept safely and were stored securely. A locked controlled drugs cupboard was attached to the wall for medicines requiring tighter security. Records confirmed medicines were handled only by suitably trained staff.

The registered provider had policies and procedures in place to safeguard vulnerable people from harm and abuse.

Summary of findings

Risk assessments clearly identified hazards people may face and provided guidance to staff to manage any risk of harm.

Staff told us they had been recruited into their roles safely. Records confirmed references were taken and staff were subject to checks on their suitability to work with vulnerable adults.

Staff told us they felt there were enough staff on duty and that they were well trained and supported by the management.

The care plans we reviewed contained assessments of the person's capacity when unable to make various complex decisions. When people had been assessed as being unable to make complex decisions there were records of meetings with the person's family, external health and social work professionals, and senior members of staff.

We saw lunch being prepared by the care staff in the main kitchen. Fresh ingredients were being used and the meal looked appetising. In all cases people's intake of food and drink throughout the day and night was recorded using an electronic recording system.

We reviewed the staff training records and found the registered manager used an electronic system to monitor and plan training for all 40 members of staff. We saw staff received training which was relevant to their role and equipped them to meet the needs of the people who used the service.

People who used the service were supported to be as independent as possible. Although people who used the service had limited communications skills, care plans were written with maintaining and developing independence in mind.

Records showed each person who used the service was invited to the monthly meeting of their core team of care staff.

We observed high levels of interaction from staff. Staff spoke with people in a calm, sensitive manner which demonstrated compassion and respect.

Care plans provided staff with a summary about the person they were supporting including communication methods, diagnoses, allergies, and relations' birthdays. Care plans were written around the specific levels of care each person required.

Each person had an activity plan which had been discussed with them at their monthly meeting. People who used the service were supported to participate in a number of activities which included visits to the local theatre, football matches, shopping, and going to discos and other social clubs.

The registered provider had a complaints and compliments policy in place which was displayed in pictorial format around the service and was issued to people's relatives.

There were monthly records of accidents, incidents, injuries, and safeguarding referrals. These had been evaluated and action plans created to address any shortfalls.

Records showed people who used the service and the relatives were frequently asked for their views at the various monthly meetings and at the 'my review, my say' meetings held every six months.

Staff meetings were held monthly in which the care for each person who used the service was discussed.

There were systems in place to monitor the quality of the service. Monthly audits included: medicines management, pressure care, infection prevention and control, and care plans. Again, action plans had been created to address any shortfalls.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Risks to people and others were managed effectively. People were involved in decision making as much as possible.

People's medicines were stored, handled and administered safely by suitably trained staff.

There were sufficient staff to meet people's needs. Staff were recruited safely and understood how to identify and report any abuse.

Is the service effective?

Good

The service was effective. Staff had a thorough understanding of the Mental Capacity Act 2005 and knew how to ensure the rights of people with limited mental capacity to make decisions were respected.

Staff understood the Deprivation of Liberty Safeguards (DoLS) and worked with the local authority to make applications for all thirteen people who used the service.

Staff had received up-to-date training, induction and support. This meant people at risk were protected from members of staff who did not have the skills or knowledge to meet their needs.

People received a healthy and nutritionally balanced diet. Advice from external professionals such the Speech and Language Therapy team (SALT) was followed.

Is the service caring?

Good

The service was caring. People were treated with kindness and as an individual. People enjoyed good relationships with the staff.

People's privacy and dignity were respected. Staff respected people's personal space and always asked permission to enter their rooms.

People were able to express their views at regular meetings.

Is the service responsive?

Good

The service was responsive. Care plans contained up-to-date information on people's needs, preferences and risk management.

People participated in a wide variety of activities, many of which were tailored to their individual needs.

People were aware of how to make a complaint.

Is the service well-led?

Good

The service was well led. There were systems in place to monitor the quality of the service.

Accidents and incidents were monitored and trends were analysed to minimise the risks and any reoccurrence of incidents.

The registered manager and assistant manager promoted an ethos of teamwork and staff felt they were supported.

The Old Vicarage

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 registered 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 unannounced inspection took place on 31 March and 15 April 2015 and was carried out by an adult social care inspector.

The local authority safeguarding and contracts teams were contacted before the inspection, to ask them for their views on the service and whether they had investigated any concerns. They told us they had no current concerns about the service.

We used a number of different methods to help us understand the experiences of the people who used the service. We used the Short Observational Framework for Inspection (SOFI) in two communal areas. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with one person who used the service, three care workers, one senior care worker, and the assistant manager.

We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

We looked around the premises, including people's bedrooms (after seeking their permission), bathrooms, communal areas, the laundry, the kitchen and outside areas. Five people's care records were reviewed to track their care. Management records were also looked at, these included: staff files, policies, procedures, audits, accident and incident reports, specialist referrals, complaints, training records, staff rotas and monitoring charts kept in folders in people's bedrooms.

Good

Is the service safe?

Our findings

Only one person who used the service was able to talk with us and tell us they felt safe. Their comments in response our question, "Do you feel safe?" was, "Yes."

We saw medicines were kept safely. The service had a dedicated room in which to store medicines with a sink for staff to use for hand hygiene. We observed staff using a hand gel to clean their hands before they handled each person's medicines. Medicines used every day were stored in a trolley secured to the wall and additional medicines were stored in a locked cupboard or in a bespoke medicines fridge. A locked controlled drugs cupboard was attached to the wall for medicines requiring tighter security. A check of controlled medicines and found stock matched the register. Stock balances were checked daily. We found the register was accurate and had been signed by two members of staff when they administered controlled medicines to people who used the service. We saw procedures were in place to dispose of medicines appropriately.

We reviewed the medicines administration records (MARs) for seven people who used the service and found they were completed accurately; this had been checked daily by the senior staff and by the assistant manager as part of a monthly audit. Records confirmed medicines were handled only by suitably trained staff.

We saw the registered provider had policies and procedures in place to safeguard vulnerable people from harm and abuse. We saw all staff had received recent training in safeguarding vulnerable adults. Staff were able to describe to us what types of abuse may occur and what signs to look for. They also said they were confident the management would act appropriately and swiftly to address any concerns they raised. Staff were aware of the registered provider's whistle blowing policy and how to contact other agencies with any concerns.

The assistant manager showed us records of referrals make to the local clinical commissioning group's (CCG) safeguarding team and we noted the deputy manager had worked with them to investigate any concerns.

We reviewed the risk assessments in five people's care plans. We saw the assessments clearly identified hazards people may face and provided guidance to staff to manage any risk of harm. Care plans contained risk assessments for mobility, medication, falls, nutrition, dehydration, and behaviours which may challenge the service and others. Each risk assessment used a traffic light grading system to indicate the severity of the risk and went on to clearly describe the means staff should use to reduce any risk.

Although there was a set monthly schedule for the formal review of risk assessments, the assistant manager showed us the electronic care record system which allowed staff to update risk assessments and records at any time to reflect any changes in people's needs immediately. Staff told us the risk assessments provided sufficient information to assist them in reducing people's exposure to risk as much as possible.

We saw each person who used the service had a personal evacuation plan which provided emergency services and others information about how to safely evacuate the person if there should be a need, for example in the event of fire.

Information was available which accompanied people to hospital in an emergency to make the clinical staff aware of the person's needs and their level of independence and understanding.

We found equipment used in the home was serviced at regular intervals to make sure it was safe to use. External doors were linked to an alarm system. Fire safety checks were carried out regularly and the fire risk assessment had been updated.

Staff told us they had been recruited into their roles safely. Records confirmed references were taken and staff were subject to checks on their suitability to work with vulnerable adults by the disclosure and barring service (DBS) before commencing their employment.

During the day the 14 people who used the service were cared for by eight care workers. The registered manager and assistant manager were supernumerary. At night three care workers worked across this building and the adjacent service, Vicarage Lodge, although we were told at least one member of staff would be permanently based at Vicarage Lodge. The assistant manager told us that if an emergency occurred at night, a care worker and senior care worker were on call each night. There was also a plan to follow in the event of an emergency.

Our observations showed staff were attentive to people's needs and were always available. Staff told us they felt

Good

Is the service safe?

there were enough staff on duty; comments from staff included, “There is certainly enough staff during the day and at night things are actually very quiet although when one of the residents gets a bit anxious or starts displaying some heightened behaviours, extra staff are always used.”

The assistant manager told us staffing levels were kept under constant review by using a recognised dependency assessment tool so they could adjust the staffing levels flexibly if people’s needs changed.

Good

Is the service effective?

Our findings

The people who used the service were not able to tell us if they felt the service was effective. However, staff told us they were well trained and supported by the management. Comments included, "I think we are well trained and it's good training" and "I get regular supervisions and we are very much a team here as the managers are always available because they are with us all the time."

Staff told us they received regular training and felt well supported by the management and registered provider at the service. One member of staff said, "We have very regular training and plenty of support from the managers."

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure the rights of people who may need support to make decisions are protected. Training records showed all staff had received recent training in the principles of MCA. Our observations showed staff took steps to gain people's verbal consent prior to care and treatment.

The care plans we reviewed contained assessments of the person's capacity when unable to make various complex decisions. Care plans also described the efforts that had been made to establish the least restrictive option for people was followed and the ways in which the staff sought to communicate choices to people. When people had been assessed as being unable to make complex decisions there were records of meetings with the person's family, external health and social work professionals, and senior members of staff. This showed any decisions made on the person's behalf were done so after consideration of what would be in their best interests. Records also showed advocates had been involved in supporting people where necessary.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The assistant manager was aware of their responsibilities in relation to DoLS and was up to date with recent changes in legislation. We saw the service acted within the code of practice for the MCA and DoLS in making sure that the human rights of people who may lack mental capacity to take particular decisions were protected. The assistant manager told us they had been working with relevant local authorities to apply for DoLS for people who lacked capacity to ensure they received the care and treatment they needed and there was no less restrictive way of achieving this. At the time of our inspection DoLS had been approved for six people who used the service.

We saw each person who used the service had a specific eating and drinking plan which clearly identified their individual preferences. Care plans we looked at for eating and drinking had been developed with input from the Speech and Language Therapy (SALT) service, which had given specific advice on food textures and positional considerations. Records of each person's weight was seen to be monitored monthly or weekly if required.

During our inspection visit lunch was being prepared by the care staff in the main kitchen. We saw fresh ingredients were being used and the meal looked appetising. In all cases people's intake of food and drink throughout the day and night was recorded using an electronic recording system. This meant the care staff could produce reports of each person's food and fluid intake against their weight on a daily, weekly and monthly basis to identify trends or changes in need.

We saw one person received a specific autism related diet. We noted staff were given guidance using a food picture book which showed images of the foods the person could eat and where they could be purchased. This book had been put together with the input of the person using the service and their dietician. We saw there was a separate care plan for the preparation of this person's food as well as an associated risk assessment to help prevent cross contamination.

Records showed each member of staff had approximately ten supervision meetings including an appraisal with their line manager throughout the year. This showed us there was a system in place to support staff and help them develop. The assistant manager told us they had an open door policy and encouraged all staff to engage with them whenever they needed to talk about an issue or concern.

We reviewed the staff training records and found the registered manager used an electronic system to monitor and plan training for all 40 members of staff. We saw staff received training which was relevant to their role and equipped them to meet the needs of the people who used the service. The training included safe lifting and handling, breakaway and safe holding techniques, health and safety,

Good

Is the service effective?

epilepsy, fire training, safeguarding adults from abuse and basic food hygiene. The registered provider told us they considered behaviours which may challenge the service and other training as essential for all staff. We saw 27 members of staff had achieved a nationally recognised qualification in care or were working towards one.

The 13 people who used the service, some of whom had complex health needs, received regular input from external healthcare professions. Records showed people had been supported to receive input from the GP, SALT, dentist, chiropodist, and physiotherapy services.

Good

Is the service caring?

Our findings

Relatives of people who used the service told us they were happy with the care their relation received. Comments included, “The levels of care here are excellent”, “I cannot fault the care staff” and “XXX is very well cared for.”

We saw people who used the service were supported to be as independent as possible. Although people who used the service had limited communications skills, care plans were written with maintaining and developing independence in mind. For example, one person’s eating and drinking plan described how staff should encourage the person’s independence at meal times as they were trying to feed themselves with minimal support.

Records showed each person who used the service was invited to the monthly meeting of their core team of care staff. During this meeting the staff would use pictures with the person to gauge their feelings about food, activities and their care. Pictures were used to discuss food, activities and the environment. A further monthly ‘Our Voices’ meeting was held between representatives of all the registered provider’s similar services in the area to address more generic issues.

We saw records of the ‘My review, my say’ meetings which took place for each person who used the service, their relatives and other external agencies such as commissioners and social workers every six months. Records showed the preparations for this meeting had been conducted by the person who used the service and their core team. The planning included who they would like to attend the meeting and the things they would like to talk about. We saw minutes from the meetings which showed what the person liked to do or not do, what new things they would like to do, and the people they would like to support them were discussed. This showed the service involved people who used the service as much as possible in making decisions and planning their care.

Each person’s care plan had a section called ‘helping me get my message across’ which gave staff detailed information about the non-verbal reactions they may give if they were unhappy or happy about anything.

We observed high levels of interaction from staff. Staff spoke with people in a calm, sensitive manner which demonstrated compassion and respect. We observed staff using non-verbal communication methods as described in people’s care plans.

Members of staff were able to describe to us the individual needs of people in their care, including explanations of what gestures and expressions people would use to indicate their preferences, choices and wellbeing. This meant staff had developed a good understanding of how to interact and communicate with people, ensuring their needs were met. They looked directly into people’s faces when asking questions and talking to them.

We saw care plans provided staff with good information about how people who used the service wished to be treated, particularly in relation to personal care, so their dignity and privacy was preserved.

Staff told us people were able to choose when to go to bed and when to get up the next morning. We saw care plans provided staff with detailed information about people’s preferences about daily and night time routines.

Staff told us people’s relatives were free to visit at any time. We saw each person had a ‘my family and friends’ care plan.

Good

Is the service responsive?

Our findings

The people who used the service at the time of our inspection were unable to tell us if they felt the service was responsive. However comments from staff included, “People get a lot of choice about what they want to do each day”, “It is rare for anyone to miss out on anything; if there is no vehicle, we just get taxis” and “The service users get a lot of input into what they want to do; we try and cater for everybody.”

We saw each set of care records had a section called ‘all about me’. This provided staff with a summary about the person they were supporting including communication methods, diagnoses, allergies, and relations’ birthdays. Following this, each specific care plan started with a simple summary of what that particular plan was aiming to achieve. Following the summary an in-depth support plan which described how the person should be supported and what care workers needed to do to in order to care for each person’s individual needs. An appropriate risk assessment followed in order to show the staff how to achieve this level of support in a safe way. Each of these three documents was dependent on each other and provided a complete and comprehensive plan of how to deliver care to each person. Furthermore, the use of electronic care records meant all care plan documents could be updated as and when necessary thus ensuring staff delivered the most up-to-date levels of care.

We reviewed five care plans each of which were written around the very specific and detailed levels of care each person required. We saw a daily diary was kept for each person on the electronic care record; this included what time they chose to get up, what they had to eat and drink, and what medicines they had received.

We saw a handover diary was maintained during each shift. This was entered directly onto the electronic care record so that all staff could see how people who used the service had been throughout the day and night. This meant people who used the service received care that was relevant to their needs at that time.

Each person was seen to have an activity plan which had been discussed with them at their monthly meeting using pictures and simple text if appropriate. Staff told us people who used the service were supported to participate in a number of activities which included visits to the local theatre, football matches, shopping, and going to discos and other social clubs. During the course of our inspection we heard people expressed a wish to go to the local park to play football. We noted this was arranged quickly and a picnic was organised to take with them. Other activities had been organised that involved the whole service such as a May ball, an Easter Sunday party, and a ‘Glam’ masquerade ball.

People’s participation in activities were recorded in the electronic care record system and reports allowed this to be analysed on a weekly and monthly basis. Activities were recorded as to whether they were intensive or relaxing.

The registered provider had a complaints and compliments policy in place which was displayed in pictorial format around the service and was issued to people’s relatives. We reviewed the service’s complaints and compliments file and saw there had been no complaints for over a year although there had been seven compliment letters. The complaints file showed there was a system in place to record investigations and outcomes.

Good

Is the service well-led?

Our findings

Members of staff told us they were supported well by the registered manager and assistant manager. Comments included, "Yes, I feel very well supported, we are well trained and it's a good open atmosphere" and "We have a good stable staff group here, we are relaxed with each other and the care is all about the service user, that's drilled into us from the top down."

There were systems in place to monitor the quality of the service. We reviewed monthly audits for medicines management, pressure care, infection prevention and control, and care plans. We saw actions plans had been created to address any shortcomings. The electronic care record system allowed the management to analyse all aspects of people's care with up-to-date information. Changes to people's health and wellbeing over time were displayed in graphical format meaning that it was easy for staff to identify even the smallest change in a person's needs.

The assistant manager showed us the detailed assessment framework used by the registered provider's own internal assessors on their monthly quality assurance visits. This framework was broken down in to the five key questions used by CQC in this report and provided percentage scores on topics including infection control, medicines management, safety of equipment, nutrition, and effectiveness of management. We noted most of these assessment visits were unannounced. The assistant manager told us they were required to complete an action plan to address any shortfalls; records confirmed this.

Staff told us meetings for all staff were held monthly in which the care for each person who used the service was discussed. Training requirements and the sharing of best practice were also discussed. Records showed learning from incidents and errors took place during the meeting in an open and transparent manner. Copies of the minutes were made available to staff who were unable to attend in person.

Records showed people who used the service and their relatives were frequently asked for their views at the various monthly meetings and the 'my review, my say' meetings held every six months. Notes from the meetings showed people and their relatives were actively involved people's care.

We saw there were monthly records of accidents, incidents, injuries, and safeguarding referrals. Where appropriate, investigations had taken place and trends had been identified. Any issues were discussed at staff meetings and learning from incidents took place. We confirmed the registered provider had sent appropriate notifications to CQC in accordance with CQC registration requirements.