Kingswood Care Services Limited

Acorn House - Laindon

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The unannounced inspection took place on the 14 December 2015.

Acorn House provides accommodation and support for up to six persons who have learning disabilities and other associated needs.

The service is required to and did have a registered 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.

Staff had good knowledge of their responsibilities and how to keep people safe. People's rights were also protected because management and staff understood the framework of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Management applied such measures appropriately.

Effective support was delivered by staff. People's safety was ensured whilst independence and wellbeing was promoted by the staff providing the care. As part of a robust recruitment process staff were recruited and employed upon completion of appropriate checks. There were sufficient staff to meet people's individual needs. People's medicines were managed safely by trained staff.

People had enough to eat and drink and staff understood and met their nutritional needs. Staff and managers ensured access to healthcare services were readily available to people and worked with a range of health professionals to maintain good health of the people.

Privacy and dignity was valued by staff and were observed to be respectful and compassionate towards people. Staff understood their roles in relation to encouraging people's independence whilst mitigating potential risks. People were provided support in a person centred way by staff who clearly displayed good knowledge of the people they supported. People were helped to identify their own interests and pursue them with the assistance of staff. These person centred activities took place within the service as well as in the community.

The service was well led and ran effectively using quality monitoring audits which the manager and deputy manager carried out to identify any improvements needed. A complaints procedure was in place and had been used appropriately by management. Systems were in place to make sure that people's views were gathered.

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.

There was enough staff to meet people's needs. Appropriate checks had been carried out to ensure a robust and effective recruitment process was in place.

People felt safe living at the service. People's autonomy and safety was risk assessed appropriately. Support plans were in turn implemented to ensure peoples safety and autonomy.

Medicines were dispensed safely.

Medicines were dispensed safely.

Is the service effective?

Good

The service was effective.

Management and staff had good knowledge of legislative frameworks i.e. Mental Capacity Act 2005 to ensure people's rights were protected.

Staff received an initial 12 week induction. Staff attended various training courses specific to people's needs. Staff were able to apply knowledge to support people effectively.

People were supported to access healthcare professionals when required.

Is the service caring?

Good

The service was caring.

Staff and people had developed positive caring relationships and responded to each other openly and respectfully.

Privacy and dignity was respected.

People's choices were listened to and people felt able to express their views, wants and needs.

Is the service responsive?

Good

The service was responsive.

Care plans contained detailed information required to meet people's needs.

People were being supported to identify and carry out their own person centred interests.

Complaints were investigated and acted upon appropriately.

Is the service well-led?

Good

The service was well-led.

Management were respected by staff that aligned themselves with the values of the service.

There were quality assurance systems in place to identify and make improvements to the service.

The service had an open culture and they gained people's views of the service to continually improve.

Acorn House - Laindon

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.

We inspected Acorn House on the 14 December 2015 and the inspection was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law.

We spoke with three people, three members of staff, the service manager and the deputy manager. The registered manager was spoken to on 15 and 16 December 2015 after the site visit, as they were unable to attend the location on the date of the unannounced inspection due to commitments. Clarification of information was requested from the registered manager and the provided information was reviewed on 23 December 2015.
We observed interactions between staff and people. We looked at management records including samples of rotas, three people's individual support plans, risk assessments and daily records of care and support given. We looked at five staff recruitment and support files, training records and quality assurance information. We also reviewed five people's medical administration record (MAR) sheets.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service. One person said, "I feel happy and safe here."

Staff knew how to keep people safe and protect them from harm. Staff were able to identify how people may be at risk of different types of harm or abuse and what they could do to protect them. The service had a policy for staff to follow on 'whistle blowing' and a copy of the policy was kept in each individual staff file. Staff knew they could contact outside authorities such as the Care Quality Commission (CQC) and social services. One care worker told us, "I would contact the CQC if I had to but I know I haven't needed to." Safeguarding was part of the mandatory induction training programme and had recently been included in the agenda discussed in staff meetings bi-monthly.

The registered manager, deputy manager and service manager all had a good understanding of their responsibility to safeguard people and dealt with safeguarding concerns appropriately. The registered manager had sent a statutory notification to the CQC in September 2015 regarding safeguarding concerns within the location. The incident had been dealt with appropriately and all necessary steps were taken to ensure people were safe and protected from potential harm.

Staff had the information they needed to support people safely. Support plans and risk assessments had been consistently reviewed in order to document current knowledge of the person, current risks and practical approaches to keep people safe when they are making choices involving risk. For example, in one person's care records we saw a financial support plan and associated finance risk assessments. These helped enable the person, despite potential risks, to pursue financial independence when purchasing personal items. This documentation displayed how staff were to support the person and respect their freedom of choice. Where people had history of changes in mood and/or challenging behaviour, this was documented in their support plans with likely or known factors which may have been associated with this risk and how to manage them. In turn, staff undertook risk assessments and documented behaviour charts to keep people safe. These assessments identified how people could be supported to maintain their independence. We saw other risk assessments covering areas such as supporting people in the community safely, managing their medication and supporting their personal care.

Staff were trained in first aid. If there was a medical emergency staff knew to call the emergency services. We saw letters of compliments from health professionals at local hospitals and ambulance services which thanked staff for their care for one person when emergency services had been required. One care worker spoke about a person and told us, "Their breathing can deteriorate quickly so we call paramedics when we need them." Staff also received training on how to respond to fire alerts at the service.

There were sufficient staff on duty to meet people's assessed needs. Although one member of staff reported to us, "Sometimes there's only two people on shift which I feel puts extra pressure on staff I am concerned others might leave." The deputy manager told us "Management have tried to reassure people in staff meetings that recruitment is taking place and audits have been undertaken by the management to monitor the situation." Audits on staffing levels revealed out of 100 shifts there were 7 occasions when staffing levels

dropped to two staff on duty due to sickness or agency staff not attending the service. Staff meeting minutes confirmed the discussions of these statistics and current recruitment processes between management and staff. The sample of rotas that we looked at reflected sufficient staffing levels.

An effective system was in place for safe staff recruitment. This recruitment procedure included processing applications and conducting employment interviews. Relevant checks were carried out before a new member of staff started working at the service. These included obtaining references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS). The service manager told us, "The interviews are conducted by the registered or deputy manager of the home, not at head office; we can get a feel for the person and whether they will meet the requirements specific to the home and the people living here."

People received their medications as prescribed. Medication was clearly prescribed and reviewed by each person's General Practitioner (GP). Senior staff who had received training in medication administration and management dispensed medicines to people. We observed a person who asked staff for pain relief. In turn staff checked medication administration records (MAR) before they dispensed the medication and they also spoke with the person about how they were feeling, what exactly the problem was and asked if they needed a hot water bottle to help with the discomfort. We found staff knowledgeable about people's medicines and the effect they have on the person. Information regarding prescribed medication was also documented at the front of each person's MAR for ease of reference and refreshment. This helped to ensure medicines were administered in a person centred way. The service carried out regular audits of the medication and addressed any errors to ensure people's medications were always managed safely.

Good

Is the service effective?

Our findings

People received effective care from staff who were supported to obtain the knowledge and skills to provide continuous person centred care. One staff member told us, "During my supervision my supervisor told me that she thought I was very competent and thought I should push myself further, so now I have passed my medicine administration training, I feel 100 percent supported." Nine members of staff had completed nationally recognised qualifications in Health and Social Care. Staff received on-going training in elements specific to the needs of the people such as cerebral palsy, Down's syndrome, advanced autism and dysphasia training. One member of staff said, "Our training really helps me understand how the people here might be feeling and what it is they are living with every day."

Staff received a 12-week induction into the service before starting work. The Deputy Manager told us, "I feel it's necessary to have this length of induction so staff have the confidence to know they can meet people's needs, having had enough time to learn the skills they need as well as about the individual people themselves." Staff files indicated that all staff had received an induction. The induction allowed new staff to get to know their role and the people they were supporting. Additionally, the induction incorporated training such as; equality and diversity, food hygiene, fire safety, emergency first aid, infection control, health and safety and abuse of adults with learning difficulties. Upon completion of their training staff then worked 'shadowing' more experienced staff. One member of staff said, "My induction was for about 12 weeks, we learnt all different subjects, watched DVD's, did coursework, got to know people, their plans and shadowed other carers." Staff told us that supervision occurred every three months and staff also received yearly appraisals. Records we reviewed confirmed this.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager, deputy manager and staff had a good understanding of the MCA. The registered manager confirmed that some people were subject to continuous care and supervision and did not have capacity to consent to arrangements. In turn the registered manager had applied for deprivation of liberty safeguards to be put in place and people's freedom was not being inappropriately restricted. Statutory notifications had been received from the registered manager in relation to three peoples DoLS applications made to local authorities. We saw that care records contained the application for DoLS, where appropriate, and capacity assessments for individuals where specific decisions were required in their best interests. An example was provided regarding concerns staff had in relation to a person's potential lack of capacity and potential danger to themselves and staff when using transportation. Risk assessments and action plans had

been devised to protect the person's best interests in the least restrictive way.

People had enough to eat and drink and appeared well nourished. Together staff and people planned a four week rota of summer and winter menus and staff purchased food weekly. One person told us, "They [staff member] buy me croissants, they are my favourite." The activity rota also revealed one person visited a local supermarket, once a week, with a member of staff. We witnessed this person asking for and being given their weekly monetary budget from staff in order to buy and eat lunch out before attending her appointment with a staff member. Support plans contained risk assessments regarding dietary and healthy eating and drinking specific to individuals' needs and identified the importance of monitoring fluid consumption for one person. Fluid intake charts were recorded accurately for one person at risk of excessive fluid consumption. Support plans also contained monthly weight monitoring records when necessary; no gaps or adverse changes were identified in the monitoring records. Staff also supported people to be independent with the preparation of their food. Daily activities showed that once a week people helped cook dinner or made deserts such as cake or fruit salad.

People had access to healthcare professionals as required and we saw this recorded in people's care records. We noted on the day of inspection people were supported to attend their scheduled health care appointments. When required people liaised with their GP, mental health professionals and community mental health services, in addition people were supported to obtain dental care and vision tests in the community. Staff expressed how important discussions with people and each other were, in order to monitor health together. For example three members of staff all spoke of the same person who staff had individually been concerned about. One staff member told us about concerns they had been having with one person in particular and said, "When we discussed our concerns during handovers we began to notice subtle changes in one person's mood, then we reached out for the GP's help who is now monitoring the person's medications more closely with us." This information was corroborated with GP letters and care records.

Good

Is the service caring?

Our findings

Staff had positive relationships with people. Individual communication passports were created by people and staff alike as a way to maintain these positive relationships. People told us they liked living at the service. One person said, "I'm happy." Another said, "I like it here, the Christmas party we all went to last night was fun." People were supported to be as independent as possible. On the day of the inspection one person was supported to walk to the shop to buy their favourite drink. Another person was supported by staff once a week to use public transport. They also attended work experience once a week to increase their confidence and independence within the community. People and staff were really relaxed in each other's company. There was free flowing conversation and exchanges about how they planned to spend their day. One person went out independently to their dancing club during the day of inspection. All these activities endorsed people's well-being and independence was promoted.

The service had a homely feel and was decorated for the festive season. In the evening after the day's activities we saw staff and people congregate to the dining room to eat together. However, we observed one person eating dinner with a preference to eat alone as they reported they wanted privacy. Staff asked if they were ok or needed anything. The person responded that they were ok and didn't require anything. The interaction was a display of respecting people's privacy whilst ensuring their safety and wellbeing. Additionally we saw medication administration was carried out for one person as per their choice i.e. in private within the art room, which had been discussed and recorded in their care records as part of their preferred medicine administration process.

Staff knew people well, their preferences for care and their personal histories. One member of staff spoke of one individual, "They are able to go out on their own but they prefer not to because of things that have happened in the past, so we support them by going with them so they don't have to be on their own." This demonstrated that staff understood how to care for and support people as individuals. People told us that they had a key worker; this was a named member of staff that worked alongside them to make sure their needs were being met. One person told us "[Staff member] is my key worker but I can ask anyone for anything." One person had limited understanding of their support plan which had been produced and reviewed with multidisciplinary agreement in their best interests. Individual Case Review reports were created with input from each person, which creatively used pictures and easy to read sections to help people identify and express their own wants, needs and goals regularly with their key workers.

People were supported and encouraged to maintain relationships with their friends and family, this included supporting trips home and into the community. Staff confirmed people's relatives and friends could visit whenever they wanted. People told us their friends and family attended the Christmas party that had been held the night prior to the inspection. One person told us they were feeling overwhelmed by festive celebrations. Staff were clearly attentive to the person's emotions throughout the day and were vigilant of their change in mood. The person was observed in the evening laughing happily with staff and other people whilst they watched television together.

Good

Is the service responsive?

Our findings

People's care and support needs were understood well by the service. This was reflected in detailed support plans and individual risk assessments. The attitude of staff and care shown towards people was positive. Staff encouraged choice, autonomy and control for people in relation to their individual preferences about their lives, including activities, meals and friendships with one another. One staff member expressed that, "We want to provide a good quality of life for people and somewhere they can be themselves."

Before people came to live at the service their needs were assessed to see if they could be met by the service. Management told us, "Once we've reviewed that we can meet their needs they are invited to come and see the home and if we are right for them." We saw documentation which recorded the most recent admissions positive visit to the service with their family, during their pre assessment period. The registered manager met with other health professionals to plan and discuss people's transfer to the service. This process ensured that medications were organised prior to the transfer date thereby avoiding any omitting of medicines. People's needs were discussed with them and a support plan put in place before they came to live at the service. Also, support plans were produced by multidisciplinary teams for people who had limited understanding of their needs. Care was person centred and responsive to people's needs. For example, language needs were actively and routinely considered by using pictures to help direct the agenda of the meetings held by staff for people living in the service. This technique enabled staff to understand and support people's choices of interests and social activities.

Support plans were detailed and provided information that was specific to the individual. Documentation clearly stated how to best support people with their specific needs. For example, one person care records clearly outlined support which was required for the health and safety of the person and others when preparing drinks in the morning. We observed staff interacting and effectively diffusing an incident between people during preparation at breakfast. Staffs actions reflected appropriate directions within the support plan. This incident was recorded in the daily notes. Support plans were regularly updated with relevant information if care needs changed. Staff told us that when the plans were updated each staff member signed a document to state they had read and understood the change within the support plan. This told us that the care provided by staff was current and relevant to people's needs.

People's strengths and levels of independence were identified and appropriate activities planned for them. One person had been supported to attend the local gym. The person told us, "I go Tai Chi once a week now." Also, people were being supported to attend creative classes and work opportunities. Occasions and reasons when people chose not to attend their activities were recorded by staff, in order to monitor and discuss possible change in choice of activities. The deputy manager told us about how the service supported people to get involved in activities suited to the individual and they said, "In January [person's name] will be starting a new drama group at a place they are familiar with, they feel comfortable with this as they have said they don't want to attend college as they feel they are too old." This information was reflected in the person's Case Review report.

The registered manager had effective policies and procedures in place for receiving and dealing with

complaints and concerns received. The information described what action the service would take to investigate and respond to complaints and concerns raised. Staff knew about the complaints procedure and that if anyone complained to them they would notify their supervisor or manager to address the issue. One member of staff reported to us, "I had a problem which I reported to the manager and since I have reported it the problem it doesn't seem to have reoccurred."

Good

Is the service well-led?

Our findings

The service had a registered manager in place. Although the registered manager was not on site during the inspection it was apparent, through observations and communications, that staff respected and the people had a fondness for the registered manager. The registered manager, deputy manager and service manager were all very familiar to the people and staff within the service. The management team expressed a vision to employ dedicated and committed staff to provide a warm and friendly home for people where they can live a full and active life. Staff shared the same vision as management. One member of staff told us, "I feel all of us work well together as a team, we just want to make people here happy."

The attitude adopted by management to enhance the wellbeing of the people that live in the service was reinforced by a robust induction process to recruit appropriate individuals. Also, the continued learning of staff in subjects specific to the people that live in the service facilitated person centred care. Staff felt very supported by the managers. One member of staff said, "The managers will always answer their phone and help if you need them." Another told us, "People here know managers well; they come in and help out a lot." Staff received regular supervision and a yearly appraisal, which was documented within staff files.

The management maintained transparency with staff. Staff meeting minutes identified to us that management were keeping staff informed of current events and changes within the service in particular; recruitment and staffing levels. One member of staff said, "Staff levels are lower at the moment but I don't personally feel pressured and managers told us they are recruiting." Staff's opinion of management demonstrated a positive culture which was open and inclusive.

People and staff were actively involved in improving the service they received and provided. People's views on the service were gathered by management not only through regular meetings with people using the service, but on a daily basis through their interactions with people and staff alike. The monitoring and auditing of the service and responsiveness to concerns raised, displayed good leadership by management. Annual quality audits were undertaken appropriately.

Questionnaires and satisfaction surveys were distributed yearly to gain feedback on the service from people, their relatives, and health professionals. Although not many responses were gained from questionnaires in 2015 the replies revealed positive feedback. A development plan was produced from findings of questionnaires, satisfaction surveys and manager self-assessment audits to see if any improvements or changes were needed at the service. This showed that the management listened to people's views and responded accordingly, to improve their experience at the service. Also, the development plan revealed that staff files required auditing and training needs were to be evaluated during supervisions and inventories of possessions required updating. We saw documentation which revealed the requirements identified from the development plan were actioned and documented appropriately by management.

The registered manager also used further routine quality monitoring systems to continually review and improve the quality of the service provided to people. For example they carried out regular audits on people's support files, medication management and the environment. The deputy manager expressed

keenness to deliver a high standard of care to people and told us how robust quality monitoring processes keep the service under review and drive any improvements.