PSS (UK)

PSS Watford Road

Inspection report

16 Watford Road
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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

This inspection took place on 18 November 2015 and was announced.

16 Watford Road is a small care home accommodating up to three people who require support and personal care. The service specialises in caring for people who need support around mental health needs. On the day of the inspection there were two people living in the home.

There was a registered manager in post at the service. '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.'

People told us that they felt safe living in the home and with accessing the local community. Staff were able to explain the risks associated with abuse and discrimination. Risks had been reviewed with the involvement of the person. A positive approach to risk taking was used to promote independence. Risk had been reviewed following incidents.

Summary of findings

We saw that staffing levels were sufficient to meet the needs of the people living in the home. There was one care worker on duty at all times. This was supplemented by the presence of the registered manager for part of the week.

Staff were recruited, trained and supported in accordance with best practice. We found that appropriate checks had been undertaken before staff began working at the home. We saw that references regarding people's previous employment had been obtained and appropriate checks had been carried out prior to new members of staff working at the home. Staff were required to complete a probationary period which had to be signed-off by the registered manager. We saw records which confirmed that staff were given monthly supervision and an annual appraisal.

Staff were skilled and knowledgeable about their roles and the needs of the people living in the home. They were required to complete an extensive programme of training and induction. This included mandatory (required) training and training which was more specific and suited to the needs of people living in the home.

Medicines were stored and administered safely. People were supported to self-administer medicines with staff support to monitor that this had been done correctly.

People were supported in accordance with the principles of the Mental Capacity Act (2005).

We saw that people had access to regular meals and drinks and were encouraged to prepare their own refreshments.

Care records were detailed and subject to regular review. People living in the home had a person-centred plan which told staff how they wanted to be supported and what their goals were.

Staff spoke about the people they supported in a positive and caring way and they told us they cared about people's wellbeing.

We saw that people who lived at the home were involved in decisions when they needed to be made about what to do each day and what to eat. They were able to clearly communicate their needs and choices to staff.

The service had a complaints policy in place and processes were in place to record and investigate any complaints received.

People living in the home were encouraged to provide feedback through regular meetings. Surveys were issued to people and their families each year to gather information and assess satisfaction.

The home had a clear set of visions and values which were displayed in posters and other promotional materials. These visions and values were clearly linked to organisational strategy and used as one of the criteria on which quality was assessed. Staff were able to explain the visions and values of the services and applied them in their practice.

Staff understood their roles and the purpose of the home and were motivated in supporting people towards independence and to deliver quality care. We saw that staff encouraged people to be independent in all matters, but remained conscious of risk.

People were encouraged to develop links and activities within the local community.

Quality was discussed at all formal meetings including staff supervisions and review meetings. The reporting requirements for the quality assurance framework focused on a range of key performance indicators (KPI) which were mapped to the regulatory framework.

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?
The service was safe.

Staff were recruited following the completion of appropriate checks to ensure that they were suited to work with vulnerable adults.

Staff understood how to recognise and respond to abuse and neglect.

Medicines were stored and administered safely by trained staff.

Good

Is the service effective?
The service was effective.

People's health needs were monitored and recorded. Staff supported people to access a range of health care services.

Staff said they were supported and developed through induction, supervision, appraisal and the home's training programme.

The service was operating in accordance with the principles of the Mental Capacity Act (2005).

Good

Is the service caring?
The service was caring.

Staff treated people with dignity. They had a good understanding of people's needs and preferences.

People told us that they were happy with the quality of care and support.

People were supported to be independent and exercise control over their lives.

Good

Is the service responsive?
The service was responsive.

People's person centred plans and risk assessments were regularly reviewed to reflect their current needs and promote positive risk taking.

Staff understood what people's care needs were. Support was provided in line with their individual plans of care.

A process for managing complaints was in place and families we spoke with knew how to make a complaint.

Good

Is the service well-led?
The service was well led.

The home had a registered manager in post.

The registered manager provided an effective lead in the home and was supported by a clear management structure.

Systems were in place to monitor the quality of the care and standards to help improve practice.

Good

PSS Watford 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.

The inspection took place on 18 November 2015 and was announced. 48 hours' notice of the inspection was given because the service is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection team consisted of an adult social care inspector.

We reviewed the information we held about the service before we carried out the visit. Before the inspection, we usually ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not make this request before this inspection.

We looked at the notifications and other information the Care Quality Commission had received about the service.

During our inspection we spoke with two people who lived in the home. One of the people was displaying signs of anxiety and was not asked for any detailed responses. Staff told us that they were a very private person that was reluctant to engage in conversation. This was reflected in the person's care records. We spoke with the registered manager and one support worker and a relative of a person who lived in the home and sought their feedback on the service. We also spoke with a visiting healthcare professional.

We spent time observing the care provided to people who lived at the home to help us understand their experiences of the service. Our observations showed people appeared relaxed and at ease with the staff.

We viewed a range of records including: the care records for the people who lived at the home, two staff files, records relating the running of the home and policies and procedures of the company.

We carried out a tour of the premises, viewing communal areas such as the lounge, dining room and bathrooms. We also looked at the kitchen and the bedrooms of people who lived in the home.

Good

Is the service safe?

Our findings

We spoke with both people who lived in the home about their safety. One person told us, "I feel safe. I haven't had any time when I didn't feel safe." A relative said, "[Relative] is safe there." Both people accessed the community without staff support on a regular basis. We saw that risk had been formally assessed and reviewed. Protocols were in place which included action plans if people did not return to the home at an agreed time.

We spoke with the registered manager and a member of staff. Both were able to explain the risks associated with abuse and discrimination. Staff noted that the people living in the home were placed at additional risk because they were independent in the community and did not always have access to staff support. They demonstrated that they understood the risk assessment process and the protocols which had been developed. Risk had been reviewed with the involvement of the person and was used positively to promote independence. Risk had been reviewed following incidents. We saw evidence that some practices had changed as a result of this process. For example, when one person did not return to the home at the time expected a protocol was agreed that required them to contact staff on a regular basis if they were going to be later than planned. A record was kept of all accidents and incidents. The manager evaluated all incidents on a monthly basis. We saw that health care professionals had been contacted for advice when required.

The registered manager completed a series of safety checks for the home on a regular basis. These were recorded in a health and safety file and covered; security, water temperatures, routes of escape and fire equipment. Fire drills were completed quarterly. External checks on gas safety, electrical safety and fire-fighting equipment had been completed in accordance with the appropriate schedules. A covered smoking area had been installed at the back of the house to encourage people living in the home to smoke outside. People had personal emergency evacuation plans (PEEP) in place to advise staff how to support people out of the building in an emergency.

We saw that staffing levels were sufficient to meet the needs of the people living in the home. There was one care worker on duty at all times. This was supplemented by the presence of the registered manager for part of the week. One person living in the home told us, "There are staff here 24 hours."

We looked at how staff were recruited to ensure staff were suitable to work with vulnerable people. We looked at two staff personnel files. We found that appropriate checks had been undertaken before staff began working at the home. We saw that references about people's previous employment had been obtained and Disclosure and Barring Service (DBS) checks had been carried out prior to new members of staff working at the home. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff.

We looked at the medicines, medication administration records (MARs) and other records for both people living in the home. Each person had their own lockable cabinet. Medication was only administered by staff who were trained to administer medicines. Each person had PRN (as required) protocols on their files to indicate how pain relief medication should be administered. There were no controlled drugs (prescription medicines that are controlled under the Misuse of Drugs legislation) stored or used at the home. The majority of medicines were supplied in a pre-packed monitored dosage system. One person was being supported to self-administer their medication. We saw that appropriate risk assessments had been completed with the involvement of the person and a healthcare professional. An additional check had been introduced to ensure that the person was taking an important medicine as prescribed. We checked a sample of medicines in stock against the medication administration records. Our findings indicated that people had been administered their medicines as prescribed. The manager told us that medication stock was checked as part of each staff handover and we saw confirmation of this. All medication was signed for by staff after being administered.

Good

Is the service effective?

Our findings

Our conversations with staff and observations of their practice demonstrated that they knew both of the people living in the home well. They adjusted their approach to suit the needs of each person and knew their activities and routines in detail. One person living in the home told us about the local pub that they liked to visit. Another person said, "I see my mum most days. She lives local. I go on my own."

Staff were skilled and knowledgeable about their roles and the needs of the people living in the home. They were required to complete an extensive programme of training and induction. This included mandatory (required) training and training which was more specific and suited to the needs of people living in the home. This training was updated on a regular basis. A member of staff told us, "The induction was really good. It included information about PSS and a local induction."

Staff were required to complete a probationary period which had to be signed-off by the registered manager. We saw records which confirmed that staff were given monthly supervision and an annual appraisal. The training matrix and training certificates that were provided indicated that staff were compliant with the location's requirements to complete and refresh training. A visiting professional told us, "Staff are really good. They are really patient." A relative said, "The staff are good. They communicate well." A visiting professional said, "Communication [with staff] is great."

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. The provider had trained and prepared their staff in understanding the requirements of the Mental Capacity Act. Neither of the people currently living in the home was subject to DoLS but staff were able to explain the principles of the legislation.

The kitchen was clean and functional and served as a dining area. People chose individually what they wanted for each meal. Staff prepared meals for people but one person told us that they often prepared food for themselves. We saw that people had access to regular meals and drinks. We were present when one of the people living at the home discussed the quality of their lunch with a member of staff. They agreed that the quality of the food was not as good as their usual supplier and that they would not purchase that particular item again. The person was offered an alternative but declined.

Information was recorded in people's care files regarding health appointments and daily notes were written to record what people had done each day. Clear record keeping helped staff to inform/update health care professionals for appointments. Each person who lived in the home also had a health action plan which contained current information about their health needs and how they required support to maintain a healthy lifestyle. A visiting healthcare professional said, "All other healthcare is handled well. I have no concerns about the service."

Good

Is the service caring?

Our findings

During the inspection we observed that staff spoke to people in a positive, respectful and caring manner. One person living in the home told us, “Staff listen to me if I have any worries. They’ve got a good ear for what I say.” A visiting professional said, “Staff are really patient.” A relative told us, “The service is caring.”

Staff spoke about the people they supported in a positive and caring way and they told us they cared about people’s wellbeing. Staff knew the needs of the people who lived at the home well. During discussions with staff they were able to describe people’s individual needs, wishes and choices and how they accommodated these wishes through the support they gave to people. Staff spoke about the potential for people to move on to alternative models of support. This information was clearly and comprehensively recorded in people’s person centred plans.

Staff understood their roles and the purpose of the home and were motivated to support people towards independence and deliver quality care. We saw that they encouraged people to be independent in all matters, but remained conscious of risk. They were able to explain how positive risk taking led towards independence. One member of staff said, “It’s a joy to see them taking control and making decisions.”

The registered manager told us that both of the people who lived in the home had family members but that one person’s family were not actively involved in their care. Both people had regular access to and representation from a nominated healthcare professional. The registered manager told us that neither of the people living in the home accessed advocacy services although contact details for independent advocacy services were displayed in the staff office.

We saw that people who lived at the home were involved in decisions when they needed to be made about what to do each day and what to eat. They were able to clearly communicate their needs and choices to staff. Staff discussed alternatives with them and made appropriate suggestions where required. The people living in the home were able to access the community independently and had their own routines. One person living in the home said, “I can do everything that I want.”

Relatives and friends were free to visit the home at any time. A relative told us, “There’s no restrictions on visits.”

Good

Is the service responsive?

Our findings

One of the people who lived at the home was able to tell us that they were involved in planning their lives. Although people had regular routines we saw that people made choices each day about activities they wished to take part in or places in the community they wished to visit. One person told us, "I do art and go to the library and sports centre."

We saw daily records which had been completed by the staff which confirmed that people had carried out activities or been to places of their choice.

We looked at the care records for the two people who lived at the home. We found the provider completed 'person centred plans' with the people who lived in the home. These were care records that contained relevant and individualised information such as people's preferred routines, likes, dislikes and their wishes. They also showed the activities people enjoyed and the important relationships in their lives.

Support plans had been completed which showed how people needed to be supported. We observed support being provided in line with their individual plans of care. We found the plans were regularly reviewed and updated when necessary to reflect changes in people's support or health needs. We saw information had been updated for both people in November 2015. This helped to ensure the information recorded was accurate and up to date for people to receive the support they needed.

Assessments were completed before people were admitted to the home, to help ensure their needs could be met. Staff had reviewed people's needs after they had come to live at Watford Road and amended care plans accordingly. They had engaged with healthcare professionals to ensure that these needs were met.

The service had a complaints policy in place and processes were in place to record and investigate any complaints received. We saw that the complaints records made reference to one complaint from a neighbour. The complaint had been resolved in accordance with the policy. We spoke to one of the people living in the home about complaints. They said, "I would tell [registered manager] if I had a complaint." A copy of the complaints policy and procedure was displayed in the staff office of the home.

People living in the home were encouraged to provide feedback through regular meetings, but both people told us that they didn't always want to attend the meetings. A member of staff said, "We tell people everything that is going on and encourage them to take an active role." Surveys were issued to people and their families each year to gather information and assess levels of satisfaction. Because of the size of the service and the reluctance of people to contribute to the process, the returns were small. We saw that the organisation addressed this by asking for people's views when they visited the home. One person said, "I see [senior managers] every two weeks or so."

Feedback from people living at the home had led to changes in the way that they were supported. One person was being supported to look for employment. Another person was being supported to manage their finances effectively. In response to concerns raised by both people living in the home a smoking shelter had been built in the back yard.

Good

Is the service well-led?

Our findings

A registered manager was in post.

The home made use of a range of tools to communicate with people, their families and staff. Feedback was used to assess quality and make changes as required. A relative told us, "They [provider] ask for my opinions. The registered manager was knowledgeable about the communication and quality assurance processes and was able to explain how they had generated improvements in the home. Staff were equally positive about the processes and the leadership of the registered manager. A member of staff said, "We've got a good rapport. I feel comfortable asking for extra support." A registered manager told us, "[Senior manager] is always available. They offer practical and emotional support."

The home had a clear set of visions and values which were displayed in posters and other promotional materials. These visions and values were clearly linked to organisational strategy. Staff's understanding of the visions and values and the application of them in the home were used as one of the methods of assessing quality when the home was audited by senior managers. Staff were able to explain the visions and values of the services and applied them in their practice.

The registered manager clearly understood the culture of the home and its vision and values. They told us, "The home is here to help make people independent and keep their dignity. Staff share these values." Throughout the inspection we saw that these values were represented in all contact and communication with people living in the home. The registered manager understood their responsibilities in relation to the commission and their registration and spoke positively about working for PSS.

People were encouraged to develop links and activities within the local community. One person told us that they enjoyed their routine of going to a local pub. Another person told us how they accessed local leisure facilities.

Quality was discussed at all formal meetings including staff supervisions and review meetings. The reporting requirements for the quality assurance framework focused on a range of key performance indicators (KPI) which were mapped to the regulatory framework. The analysis was based on qualitative and quantitive data and was scored using a colour-coding system to aid understanding and monitoring. The quality assurance framework and its objectives were shared with staff at team meetings and through a series of roadshows. Staff demonstrated a clear understanding of the quality assurance framework. A quality audit was completed by the provider in March 2015.