K Bond Healthcare Ltd

Next Steps - The Elms

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 inspection took place on 19 December 2018 and was announced. We gave the service 48 hours' notice that we were planning to inspect due to the service being small and ensuring people were at the service. The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC). This was the first inspection of this service since being registered with the Care Quality Commission (CQC).

Next Steps is registered to provide accommodation for people who require personal or nursing care and treatment of disease, disorder or injury.

Next Steps 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.
Next Steps is registered to provide accommodation to four people in a house over two floors. There were four people living at the service on the day of inspection.

There was 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.

There was an appropriate safeguarding policy in place, staff had undertaken training and were confident they would recognise and report any concerns.

Recruitment procedures were robust and staffing levels were sufficient to meet the needs of the people at the service and were flexible to allow for extra support when required.

There were appropriate individual and general risk assessments, which were updated regularly. Health and safety measures were in place and we saw up to date certificates relating to the safety of the equipment and the premises.

Accidents and incidents were recorded and analysed on a regular basis. Any trends and patterns were addressed with appropriate actions. Medicines systems were safe and staff had appropriate training. Information and guidance was available to staff around infection control and training was in place.

Thorough assessments were carried out prior to people being placed at the home. Care files included good information about people's mental and physical health support needs.

The staff induction was thorough and the service provided regular refreshers for mandatory training as well as supplementary training.

People's nutritional and hydration requirements and food preferences were recorded and adhered to. The premises were adapted appropriately for the people who lived there.

The service was working within the legal requirements of The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff sought verbal consent when offering support and all aspects of care and support were discussed and agreed with people who used the service.

We observed staff interactions which were friendly and respectful. People's dignity and privacy was respected. Communication needs were taken into account and various methods were used to help ensure people's needs in this area were met.

All staff had equality and diversity training on induction and were aware of the importance of respecting people's diversity. There was evidence that people were fully involved in their care and support.

People were encouraged to be as independent as possible. The service was able to access independent advocates for people who used the service to ensure their wishes were articulated.

The service was committed to ensuring confidentiality and adhered to all data protection requirements.

Care files were person-centred and included information about people's backgrounds, families, interests and hobbies. People were supported to pursue their individual interests and pastimes. Those who lived at the service told us they could make choices in their daily lives.

There was an appropriate complaints policy and procedure in place and people told us they knew how to complain. People's wishes for when they were nearing the end of their lives were recorded within their care files if these had been expressed.

Care files evidenced good partnership working with other agencies. The management team were very visible around the various locations and staff members we spoke with told us they were approachable and supportive.

Staff supervisions and meetings were held regularly and there were team away days and annual conferences, which provided a forum for learning, discussion and raising concerns.

Regular surveys were undertaken for staff and people who used the service. The results of the most recent survey were positive about all aspects of service provision and evidenced a high level of satisfaction with care and support. There were a number of audits undertaken to help ensure on-going quality.

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 an appropriate safeguarding policy, staff had undertaken training and were confident to report any concerns.

Recruitment procedures were robust and staffing levels were flexible and sufficient to meet the needs of the people using the service.

There were appropriate individual and general risk assessments and health and safety measures were in place. Accidents and incidents were recorded and analysed on a regular basis.

Medicines systems were safe and staff had appropriate training. Information and guidance was available to staff around infection control and training was in place.

Is the service effective?

Good

The service was effective.

Thorough assessments were carried out prior to people being placed at the home. Care files included good information about people's mental and physical health support needs.

The staff induction was thorough and the service provided regular refreshers for mandatory training and supplementary training.

People's nutritional and hydration requirements and food preferences were recorded and adhered to. The premises were adapted appropriately for the people who lived there.

The service was working within the legal requirements of The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

Staff interactions were friendly and respectful. People's dignity and privacy was respected. Communication needs were taken into account and various methods were used to help ensure people's needs in this area were met.

Staff had equality and diversity training and were aware of the importance of respecting people's diversity. People were fully involved in their care and support.

People were encouraged to be as independent as possible. The service was able to access independent advocates for people who used the service to ensure their wishes were articulated.

The service was committed to ensuring confidentiality and adhered to all data protection requirements.

Is the service responsive?

Good

The service was responsive.

Care files were person-centred and included information about people's backgrounds, families, interests and hobbies. People were supported to pursue their individual interests and pastimes. Those who lived at the service told us they could make choices in their daily lives.

There was an appropriate complaints policy and procedure in place and people told us they knew how to complain.

People's wishes for when they were nearing the end of their lives were recorded within their care files if these had been expressed.

Is the service well-led?

Good

The service was well-led.

Care files evidenced good partnership working with other agencies. The management team were very visible around the various locations and staff members told us they were approachable and supportive.

Staff supervisions and meetings were held regularly and there were team away days and annual conferences. There were a number of audits undertaken to help ensure on-going quality.

Regular surveys were undertaken for staff and people who used the service. The results of the most recent survey were positive about all aspects of service provision and evidenced a high level of satisfaction with care and support.

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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 19 December 2018. We gave the service 48 hours' notice of the inspection due to the service being small and to ensure that people would be present at the inspection.

The inspection was carried out by one adult social care inspector from the Care Quality Commission (CQC).

We looked at notifications received by the CQC. Notifications consist of information that the service is legally required to tell us about such as accidents, injuries, deaths and safeguarding notifications. We had received a provider information return form (PIR). This form asks the provider to give us some key information about what the service does well and what improvements they plan to make. We contacted the local authority commissioning team and the safeguarding team. We also contacted the local Healthwatch service. Healthwatch England is the national consumer champion in health and care. This helped us to gain a balanced view of what people experienced when accessing the service. Comments we received were all positive.

During the inspection we spoke with the registered manager, a director of the service, a team leader and two members of support staff. We spoke with three of the four people who used the service. We also contacted four health professionals who had regular contact with the service, to gain their views. We received no negative feedback about the service.

We looked at records including all four care plans, two staff personnel files, training records, health and safety records, audits and meeting minutes. We observed care throughout the day. We did not undertake a Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us understand the experience of people who cannot talk with us. This is because it would not have been appropriate in a setting with so few people and three of the four people at the service were able to talk with us.

Good

Is the service safe?

Our findings

People were kept safe in the home via locked doors and gates, to prevent unauthorised people accessing the premises. The house was staffed 24 hours per day. People who used the service had keys to their bedroom doors, so were able to lock them whenever they wished to.

There was an appropriate safeguarding policy in place, which was displayed on the notice board in the hall. A safeguarding log was in place to keep track of any concerns raised. One potential safeguarding issue had been raised and dealt with appropriately. Staff we spoke with had undertaken safeguarding training and been issued with a hard copy of the safeguarding policy. Staff were aware of how to recognise a potential safeguarding issue and report it appropriately. They were also aware of how to whistle blow if they witnessed any potentially abusive practice and were confident to report any concerns. One staff member told us, "I have absolute confidence any safeguarding issue would be sorted out by management".

Recruitment procedures were robust as confirmed by staff files we looked at. Each file included an application form, employment history, a record of interview questions, two references, proof of identity, a job description and contract of employment. Any gaps in employment history were fully explored. All employees had a Disclosure and Barring Service (DBS) check in place. DBS checks record any criminal convictions and help employers assess the suitability of the candidate for the job. Where criminal convictions had been recorded, a comprehensive risk assessment was in place.

Staffing levels were sufficient to meet the needs of the people at the service. On the day of our visit there was the registered manager, a team leader, a support worker and a domestic. The registered manager told us there was one staff member on at night on a waking shift and there was an on-call rota for support where needed. We saw from the rotas that the staffing levels were consistent, but flexible to allow for extra activities when additional staff would be brought in to support people with these. We also saw that one to one support was provided for people during their settling in period, to help ensure this went as smoothly as possible.

Individual risk assessments were kept within people's care files. These referred to areas such as aggression, behaviour that challenges, environment, drug and/or alcohol abuse, absconding, self-harm, harm to others, fire setting, theft, damage to property/personal effects, non-compliance with treatment, keeping medicines in their room, vulnerability to others and self-neglect. One person used a mobility scooter and this had been thoroughly assessed, training on its use given and risk assessed. Risk assessments were regularly reviewed and updated as changes occurred.

There were personal emergency evacuation plans (PEEPs) in place for each of the people who used the service. PEEPs outline the level of assistance a person would require in the event of an emergency evacuation. These were kept in people's files with a summary retained by the fire panel with a plan of the building.

General risk assessments were also in place with regard to issues such as the environment, fire risk, infection

control and general health and safety. Records were regularly reviewed and were clear and up to date.

All health and safety measures were in place. There were up to date certificates with regard to insurance, gas and electrical safety, legionella testing and portable appliance testing (PAT). Staff had undertaken fire safety training and there was an up to date fire risk assessment, with all recommendations that had been made completed. Fire equipment, such as extinguishers and alarms, was in place and regularly maintained and tested. Equipment was tested regularly to ensure it remained in good working order, escape routes were checked daily and fire drills and mock evacuations undertaken every six months with any issues noted and actions followed up. Water temperatures were tested regularly and systems flushed as required to help ensure continuing safety. There was a maintenance sheet completed for any repairs required around the premises and these were followed up in a timely way by the provider's maintenance worker.

Accidents and incidents were recorded within people's care files. These were analysed by the management team on a regular basis. Any trends and patterns were addressed with appropriate actions.

Medicines systems were safe, delivered and checked on a weekly basis and audited every month. Medicines were stored in locked boxes in people's rooms, where risk assessments indicated this was safe, or in a locked box in the office where this was assessed as appropriate. We witnessed a staff member administering medicines to one person and this was done with patience and professionalism.

Staff had medicines training and their competence was assessed annually to help ensure their skills remained current. Any medicines errors were fully investigated and appropriate action taken.

There was clear information about medicines in people's care files and appropriate capacity assessments with regard issues around medicines. One staff member told us, "The files are great around support for medicines. All the information is there".

There was a file with information and guidance around infection control and how to deal with outbreaks. Staff had undertaken training in infection control. The home had domestic staff three times per week to ensure the home was deep cleaned. There were clear cleaning schedules to follow and the home was exceptionally clean and tidy in all areas, including bedrooms, bathrooms, lounge, kitchen and corridors.

Good

Is the service effective?

Our findings

Thorough assessments were carried out prior to people being placed at the home and we saw records to evidence this. Before people moved into the house there was an extensive period when they visited the home and got to know the other people living there, the staff and routines. This enabled the service to be sure that people were compatible with each other and their needs could be met appropriately.

Care files included good information about people's mental and physical health and the support they required to function well. Each file included a photograph and physical description of the person, which could be used if a person was to go missing. In some files a discussion had taken place on the terms of the placement, for example around the use of drugs, alcohol or cigarettes and any damage to the building. These were signed as agreed by the person who used the service. A health and social care professional we contacted told us they were extremely impressed with the team working with a person they had placed, who presented some significant challenges to services working with them.

People who used the service had a key worker, and this information was documented within their rooms. The key worker was responsible for managing the person's files, advocating for the person and liaising with the family as appropriate.

Assessments covering issues such as mobility moving and handling, nutrition and waterlow were in place. Weight records and regular recordings of blood pressure were retained, where required and agreed to. Care plans were reviewed and updated monthly or as changes occurred. There were incident reports, records of admissions to hospital, appointments and professional visits. Admissions to hospital were accompanied by a staff member. Staff stayed with people whilst they were an in-patient, to help ensure the stay was as comfortable as possible.

The staff induction was thorough and included a week of orientation to the company and the premises, mandatory training, shadowing experienced staff and ensuring knowledge and skills were up to Care Certificate standards. The Care Certificate is a set of standards that care staff are expected to adhere to.

Mandatory training was refreshed regularly and electronic records confirmed this. Supplementary training was supplied in a number of different ways, for example, within staff supervisions and team meetings, via team away days and an annual conference which included presentations and workshop sessions. A staff member we spoke with told us, "You are encouraged to participate and put ideas forward". They told us extra training was accessed when required, for example, if things changed or staff encountered a person with a condition they had not encountered or needed to have some knowledge of.

People's nutritional and hydration requirements and food preferences were recorded and adhered to. The kitchen had achieved a good hygiene rating of 4 stars and was clean and tidy. There was plenty food and lots of beverages available for people who lived at the service. People had had a variety of breakfasts on the day of the inspection visit, from bacon sandwiches to toast and tea. One person had gone out to a local café for breakfast as this was their preference. Staff told us people were often out over lunchtime pursuing their

interests so ate in cafes or bought sandwiches and snacks on the go. An evening meal was cooked on the premises and people who used the service had input into the menus and a choice of meals. One person told us, "Before I was here I had the same meals all the time. We get to choose what we want to eat. I chose the menu for Christmas day". One person liked to participate in cooking and was supported to do this.

The premises were adapted appropriately for the people who lived there. One person was unable to access the upper floor. Their room was on the ground floor and there was a bathroom with a walk-in shower on the ground floor as well as a bathroom on the first floor. There was ample outside space for people to enjoy in good weather and a garden shed which on person used to store their mobility scooter.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 authorizations to deprive a person of their liberty were being met.

Staff we spoke with had attended MCA training and demonstrated a good understanding of mental capacity and decision making. We saw comprehensive mental capacity assessments within care files with regard to a number of issues, such as the use of a lighter and unrestricted access to medicines. These assessments were reviewed annually or when changes occurred and we saw that these were adjusted appropriately.

All four of the people who used the service were subject to DoLS authorisations. However, the service strove to ensure that people were subject to the least restrictions possible. One person had been unable to go out alone when they first moved in due to their vulnerability to falling back into drug use. This person had been supported to work on this and was now having four hours per day unaccompanied leave. This was working well and the person was enjoying the freedom and taking responsibility for resisting the temptation to go back into previous unsafe practices.

We saw that staff sought verbal consent when offering support. For example, we observed someone's eye drops being administered and the staff member ask for consent prior to doing this. All the people who used the service were able to understand simple conversations about support and they had signed their care plans to say things had been discussed and agreed with them.

Good

Is the service caring?

Our findings

One person who used the service told us, "Staff are alright, I like it here". Another said, "It's alright here, very nice. Staff are lovely, all lovely. [Name] is very bubbly, she gets people up and going". A staff member we spoke with commented, "It is a nice family environment. I wouldn't change anything".

Although people were out for part of the day, pursuing their interests, we observed staff interactions with them whilst they were on the premises. We witnessed excellent interactions and a friendly and encouraging attitude from all staff. People were spoken to in a respectful manner and staff obviously knew people very well and were aware of the best way to communicate with each person.

People's dignity and privacy was respected and there was a dignity champion within the organisation who looked independently into care plans and advocated, where needed, for less restrictive measures. All had keys to their bedrooms and were able to lock them whenever they wished to. We saw that, when supporting a person with eye drops, the staff member offered to do it in the privacy of their room. The person chose to allow this to be done in the lounge and the staff member did this discreetly and sensitively.

Communication needs were taken into account and various methods were used to help ensure people's needs in this area were met. Where verbal communication was difficult, other methods were used to ensure understanding was reached by all.

All staff had equality and diversity training on induction and were aware of the importance of respecting people's diversity. We saw evidence that people were supported to access local events and communities which took into account their particular links and interests.

There was evidence that people were fully involved in their care and support. People had been asked if they wanted to sign care plans. If they did not want to it was recorded that staff had discussed the content with them and this had been agreed. If there were no particular issues, people were asked if they wished to have weights and blood pressure recorded regularly. People were also asked how they wanted to receive their information and if they wanted copies of their care plans. The mobile phone app relating to care records helped provide another way for people to access their information should they wish to do so. People were consulted about how often, if at all, they wished to be observed during the night and whether they gave permission for the staff to speak with their next of kin regarding illness and admissions to hospital. People were also asked about whether they agreed to students assisting them as part of their training.

People were encouraged to be as independent as possible. As referred to previously, one person had been worked with to get them to the point where they could have unescorted leave for periods of the day. They had also been given training and support to use a mobility scooter to give them even more independence and autonomy, demonstrating the service's commitment to positive risk taking.

Future planning took place via a personal futures plan. This identified areas of people's lives they wished to change or develop. We noted that one person did not wish to engage with this process and that decision

had been respected.

One person had an independent advocate to assist them to express their needs and wishes. The service was able to access independent advocates for any of the people who used the service to ensure their wishes were articulated.

The service was committed to ensuring confidentiality and adhered to all data protection requirements. There was a data protection statement within people's care files and we saw documentation that this had been discussed, agreed and where appropriate, signed by the person who used the service.

Good

Is the service responsive?

Our findings

Care files we looked at were person-centred. People's backgrounds, information about their families, interests and hobbies was documented and we saw that people were encouraged and supported to pursue their chosen pastimes. A staff member we spoke with told us, "It is really person-centred, for a lot of patients the alternatives are quite institutionalised, they have more independence [here] and can do what they want".

People's interests were diverse and included swimming, spectator sports, fashion, colouring, visiting places of interest such as museums and art galleries, holidays, baking, gardening, shopping, gym, cafes, cinema and shopping. People were supported to some of these activities on the day of the inspection.

All the people who lived at the service liked animals and one person had an adopted donkey that they could visit on a regular basis. One of the directors brought her dog in regularly and it was clear the people at the service all enjoyed having the dog around. One person liked to visit a local Turkish barber on a regular basis and another attended a number of church social groups. Reviews were undertaken regularly to ensure people's information remained up to date around their interests and pastimes.

Staffing was flexible and extra staff members could be brought in during the daytime when required. This meant that people could be supported to follow their interests more easily. There was also the capacity to provide one to one support for people new to the service or where it may be required due to behaviour that challenged the service or a change in physical or mental health.

Those who lived at the service told us they could make choices in their daily lives. They were able to choose when to get up and go to bed, what to eat and where to go or what to do during the day. We saw that people had been encouraged to join in with barbeques in the summer and could sit out in the garden when the weather permitted.

The service was working with the accessible information standard. The Accessible Information Standard applies to people using the service (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss. A director of the service, who lectured at a local university, had participated in a collaborative project to produce a paper on the subject. We saw that there were easy read publications, for example, the complaints procedure which was displayed in the hallway. There was a picture file for a person who had difficulties communicating verbally and people who used the service had access to an electronic app via which they could access their own notes. They were able to contribute to these notes and emojis were available to use for those who found writing difficult.

There was an appropriate complaints policy and procedure in place and this was outlined in a poster on the notice board in the hallway. People told us they knew how to complain and would speak to a member of staff if they had any concerns. Complaints were logged and followed up appropriately and analysed for any patterns and trends by the management team. The service had received a number of compliments and

these were also logged.

People's wishes for when they were nearing the end of their lives were recorded within their care files if these had been expressed. The registered manager told us they would endeavour to support people within their placements if they wished to remain there when they were nearing the end of their lives.

Good

Is the service well-led?

Our findings

There was 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.

Care files evidenced good partnership working with other agencies, such as the mental health team, GPs and care coordinators. One professional we contacted told us, "I would say clearly in my experience that the communication is always very good. The director [name] is always available when needed and very clear on the philosophy and approach to care and would state from my involvement that the service is responsive and fit for purpose".

The service's statement of purpose outlined their vision and values which included, "To make a positive difference to people's lives through the delivery of high quality services in a therapeutic home environment which encourages independence via planning in collaboration realistic outcome-based care". We saw evidence that these values were very much at the core of the service offered.

The management team were very visible around the various locations and staff members we spoke with told us they were approachable and supportive. One staff member said, "I really like it here, it's a good company, the people who set the company up have experience and skills. The management are supportive, I have done a lot of work with [director] with regard to the development of my own career". Another told us, "I like the flexible hours. I like the job, and appreciate it more as it is not high stress. There is always something to do, but we are never short staffed or unable to meet people's needs or to take them out. I feel pretty well supported, contact details for the managers is always available and you are encouraged to use them".

We saw that staff supervisions and meetings were held regularly and gave staff the opportunity to voice their concerns or make suggestions as well as being a forum for support and training. There were team away days, when staff from another location would stand in at the service so that all the staff could attend. These were also used for support, communication and training as were the annual conferences.

There were a number of champions within the company for areas such as dignity, infection control, health and safety and governance. These roles enabled staff to keep up to date with good practice and provided guidance and support to staff and people who used the service.

The registered manager told us they had set up WhatsApp group for staff to keep them up to date with rota changes and relevant information and give a channel for instant communication. Similarly there was also a WhatsApp group for the managers within the company. Staff also had access to a Quality Compliance Systems (QCS) app on their phones, where they could look up policies and find out about changes and updates.

Regular surveys were undertaken for staff and people who used the service. We saw the results of the most

recent survey, which were displayed on the notice board. The results were positive about all aspects of service provision and evidenced a high level of satisfaction with care and support.

There were a number of audits undertaken to help ensure on-going quality. Accidents and incidents, complaints and compliments and safeguarding concerns were logged and analysed to look at any patterns and trends and aid learning and improvement. Audits were undertaken around meaningful activities, DoLS, policies and procedures, mealtimes, clinical notes, and progress towards people's personal goals. Equipment, such as fire alarms and emergency lighting, were regularly tested and the premises were audited to ensure they were maintained to a good standard.