Hightown Housing Association Limited

The Old Forge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 27 and 28 February 2017. It was unannounced. The home accommodates four people with learning and or physical and sensory disabilities.

The service had transferred to a new provider and their registration with the Care Quality Commission was completed in October 2016. The home had a registered manager in place.

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.

Most aspects of the service were safe, however we had concerns about the level of staffing. There were times when there were not enough staff to meet people's needs. We have made a recommendation about staffing levels. The administration, recording and storage of medicine was safe. The registered manager took appropriate steps to ensure suitable people were employed to support people using the service.

The service was effective; this was demonstrated through the support staff received to carry out their roles effectively. The Mental Capacity Act 2005 (MCA) had been considered in relation to people's care and where appropriate applications for the Deprivation of Liberty Safeguards had been submitted to the local authority. People's health needs were met through contact with external professionals, and people's dietary needs were met.

The service was caring. Comments included praise for the staff regarding their competence and their caring attitudes. People were treated in a respectful way and records related to people were considerate. People appeared well cared for and their need were being met.

The service was mostly responsive. We had concerns sometimes there were not enough staff to support people to participate in activities outside of the home and the people who remained at home were not given enough stimulation. We have made a recommendation about activities. Care plans outlined people's needs and changes to people's care needs were documented. Systems were in place to manage complaints.

The service was well led. There was a registered manager in place. Staff and relatives spoke positively about them and felt supported by them. Audits were in place to identify areas of required improvement and to drive forward those improvements. Feedback we received about the service was positive. There were plans in place to introduce feedback from relatives and staff. There was a contingency plan in place to ensure continuity of service in the event of unexpected disruption.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was mostly safe.

People were protected from the risk of abuse. Staff had received safeguarding training and had a policy and procedure which advised them what to do if they had any concerns.

Medicine administration, recording and storage were safe.

The registered manager took appropriate steps to ensure suitable people were employed to support people using the service.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and on-going support through regular meetings on a one to one basis with a senior manager.

Staff had a good understanding of the Mental Capacity Act (MCA) 2005.

People and relevant professionals were involved in planning their nutritional needs.

Is the service caring?

Good

The service was caring.

People were treated with respect and dignity.

People were supported to maintain relationships with their families.

Staff knew people well and had forged positive relationships with people.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

People were supported to participate in a range of activities, however at times there were insufficient staff to provide activities and stimulation to people.

The service identified people's needs and provided a responsive service to meet those needs.

People received person centred care and support.

Is the service well-led?

Good

The service was well-led.

The registered manager and senior staff provided effective leadership and management.

Staff, people and their relatives spoke positively about the registered manager.

Quality assurance checks and audits were occurring regularly and identified actions required to improve the service.

The Old Forge

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 checked 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.

This inspection took place on 27 and 28 February 2017and was unannounced.

The inspection was carried out by an inspector. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We did not 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 planned to make.

During the inspection we spoke with five staff including the registered manager, the locality manager, the assistant lead and two support staff. We spoke with a health professional. We were not able to speak with the people who lived in the home due to communication difficulties. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three relatives. We carried out observations of care and reviewed documents associated to four people's care and two people's medicines. We reviewed records related the employment of two staff and audits connected to the running of the home.

Requires Improvement

Is the service safe?

Our findings

People's relatives told us they thought the home was a safe place for people to live. They believed people were well cared for and risks such as dangerous equipment and the fact that people were being supervised relieved any fears of an unsafe service.

One relative told us "They are grossly understaffed. It is hard on the staff. They need at least three [staff] on, they are sometimes down to two." We spoke with the registered manager about this. They told us there were two staff available between 7am and 3 pm and two staff between 2pm and 10 pm. During the night there was an awake night staff and a staff member sleeping in the home. Forty hours additional staffing hours were available to support people with activities, these hours were flexible to accommodate activities at specific times of the day or evening.

Staff responsibilities included the care and the domestic duties of the home alongside meal preparation and supporting people with activities and appointments. On the first day of the inspection two staff supported two people to go out for lunch. This left one staff member and the support lead to support two people. The registered manager was also present in the home. However, the registered manager managed two services, so they were not always available. The support lead was office based but would offer assistance if necessary to care staff and people on the days they were working in the home.

We discussed with the registered manager how the staffing levels were established. They told us it was based on the funding from the funding authority. The provider had a dependency tool which determined the staffing levels in relation to the needs of each person. Staffing levels were based on the levels set by the previous provider. These were in the process of being reviewed by the new provider who is asking the local authority to reassess the needs of the people living at the service. One staff member told us they had recently spoken to senior staff about their concerns when working on their own in the home. Because of the health needs of people they felt lone working was not always safe. Some people required two staff to help them with personal care and repositioning. Two staff were not always available if there were three staff on duty and two staff were out of the building. The registered manager planned to complete the dependency tool and to contact the funding authorities to have people's needs reassessed. In this way they would be able to establish what staffing level was required and if extra staff were needed and when. This would ensure people received a safer service. When staff shortages occurred the service used bank staff or agency staff to cover staff absences.

We recommend the provider puts systems in place regarding the deployment of staff to ensure people were supported by staff in a safe and effective way.

Some risks to people's personal safety had been assessed and plans were in place to minimise these risks. Not all risk assessments were clear or contained clear guidelines for staff on how to manage the risks. For example one person had multiple health concerns. There were no risk assessments in place to guide staff on indicators that the person's health condition may be deteriorating. During the inspection risk assessments were improved upon. Further work was needed to improve other care plans and risk assessments. We were

told this was work in progress. Risk assessments were in place to ensure people's care was provided in a safe way, for example, moving and handling risk assessments and epilepsy risk assessments.

One person required staff to intervene when their behaviour became a risk to themselves and others. Guidance was available in their care plan with regards to this behaviour. However more detailed guidance was needed to support staff in managing the behaviour safely. Training was planned to be held for staff in the Management of Actual or Potential Aggression (MAPA). A referral had been made to psychiatric services for support for the person. Once guidance had been provided the care plan would reflect the advice given and ensure continuity and safety of staff practice. This meant the person could be supported in a safe way. It also meant the staff could practice appropriate and safe interventions when necessary.

People's money was managed by the staff in the service. We saw that receipts were obtained and accurate records were kept of people's expenditure. Audits were undertaken to ensure the accuracy of the records tallied with the amount people had spent.

Records relating to recruitment of staff contained relevant checks. These included an application forms, references, and proof of identity and Disclosure and Barring Service (DBS) checks. The DBS service hold records of people who are barred from working with children and adults. We looked at the records of a staff member who had been internally promoted. Records showed a reference had been completed by their previous manager. No recent recruitment had been undertaken although a vacancy for one new staff member had been advertised.

Where people required assistance with medicines these were administered by trained staff. Medicines were stored securely, and only appropriately trained staff had access to them. We undertook checks to ensure the storage, administration and records related to medicines were safe. The Medication Administration Record (MAR) charts were up to date, properly maintained and were easy to follow. We checked the stock of "as required" medicines against the recorded amounts that had been administered. We found the stock balanced with the records, which demonstrated accurate administration and record keeping in relation to medicines. Records also described how people preferred to take their medicines and gave descriptions of how people may display the need for "as required" medicines. Staff knew how to dispose of unwanted or no longer required medicines. One staff member was responsible for obtaining sufficient supplies of medicines and checking new deliveries of medicines were matched correctly against each person's prescription.

Staff were aware of their roles and responsibilities when identifying and raising concerns about safeguarding people. The staff felt confident to report concerns to the registered manager. Procedures for staff to follow with contact information for the local authority safeguarding team were available. Staff were able to identify signs of abuse and knew how to report them.

Health and safety checks were carried out. Environmental risk assessments had been completed, so any hazards were identified and the risk to people either removed or reduced. Checks were completed on the environment by external contractors such as the fire system. Seventy five percent of staff had up to date fire training. There were policies and procedures in the event of an emergency and fire evacuation. Each person had an individual evacuation plan to ensure their needs were recorded and could be met in emergencies.

Good

Is the service effective?

Our findings

People's relatives told us staff appeared to know people well and had the skills to meet people's needs.

The locality manager told us new staff completed an induction which incorporated the care certificate. The care certificate is the minimum standards that should be covered as part of the induction training of new care workers. The care certificate is based upon 16 standards health and social care workers need to demonstrate knowledge and competency in. Competency checks were carried out on staff in relation to medicines. Documents verified this. This ensured as far as possible staff were carrying out the correct procedure when administering medicines.

Staff had received appropriate training to meet people's care and support needs. The registered manager confirmed training was provided through face to face classroom based approaches as well as e-learning. This is training staff would complete online. Records showed most staff were up to date with the provider's required training. Where staff required refresher training this had been booked. The staff we spoke with felt they had received sufficient training to enable them to do their job effectively. One staff member told us they received "More than enough."

Staff had received regular supervision. These were recorded and kept in staff files. Staff told us these were useful as they gave both the supervisor and the staff member an opportunity to talk about issues that may be affecting the staff member or the people living in the home. The supervisory role was carried out by the registered manager and the support lead. Annual appraisals were also held for staff. One staff member told us "We still have to achieve our goals and get things done and we do." Plans were in place to introduce a link worker meeting. A staff member whose role included the coordination of information about a person was known as a link worker. The meeting would give the link the opportunity to discuss with senior staff the care being provided to the person they were link worker for. Any changes in care would be recorded in the person's care plan and this would be discussed at the team meeting. This demonstrated how staff were supported to provide consistent care.

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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We saw from the training records that 75 % of staff had received or had planned training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Each person had assessments regarding their capacity to make decisions and where DoLS applications were required, these were made. The registered manager and staff demonstrated an understanding of the DoLS procedures.

It was evident from talking with staff, our observations and from care records that people were involved in day to day decisions such as what to wear, what they would like to eat and what activities they would like to participate in. Staff were able to provide us with detailed accounts of peoples' daily routines as well as their likes and dislikes.

Care records included information about any special arrangements for meal times and dietary needs. Where people had special dietary needs, there was evidence that the relevant professionals were involved in menu planning. For example, one person needed support to manage their weight. Records showed a dietitian had been involved and had given advice on how this could be achieved.

Each week the home held a menu planning meeting with people. This included discussions and pictures of meals that people liked. It was found that people's concentration did not allow for the meeting to last too long. So this had now been shortened. Staff were aware of people's preferences, and used this information to support menu planning. Taster meals were provided and recently people had tried polenta. Themed days included related meals, for example Chinese food when celebrating Chinese New Year. One relative told us "The food is very good, they get a varied diet. It is excellent." Another said "I have been there when they have been cooking all sorts of things like shepherd's pie and casseroles. I have thought, I wish I was tucking into that."

People had access to a GP, speech and language therapist and other health professionals. The outcomes following appointments were recorded and were also reflected within care files.

The property had a homely feel to it. Rooms had been personalised with photographs of people. Bedrooms accommodated the equipment people needed but had remained comfortable, clean and reflected people's likes. Access was available for people in wheelchairs, and the service had its own minibus van to facilitate outings for people.

Good

Is the service caring?

Our findings

People's relatives told us they thought the staff were caring. Comments included "I think on a day to day basis they are more like his family than I am." "They [staff] are all very good, you couldn't find fault with any of them. They are all caring people." "We are particularly happy with one of the carers, I think she understands [person] very well and he likes her, she is very efficient."

Staff were kind, considerate and respectful towards people. It was apparent they knew people well and provided them with appropriate support. Positive relationships had developed between staff and people living in the home. We saw smiling faces and laughter when staff joked with people. People's relatives felt the staff knew people's needs well and were able to respond accordingly.

From our observations we could see staff were respectful towards people, and documents about people were written in a considerate way. For example in one care plan it stated "Staff should knock on [person's] door and wait for a few seconds before entering the room. Staff should say good morning to [person] and check if he is awake. [Person] sometimes takes a few moments before opening his eyes. Give [person] time to respond to your presence before proceeding with the following tasks." When we spoke with staff they were able to describe how they protected people's privacy and dignity and how they showed people respect. They understood the importance of these elements of care. They described how they would cover people up when carrying out personal care, and by not disclosing personal information about people. One staff member told us "I treat people the way I like to be treated."

People appeared well cared for and their preferences in relation to the support people received was clearly recorded. Relatives we spoke with provided positive feedback about the staff team and their ability to care and support people. Comments included "Very pleased indeed, we have no worries." "Without a doubt they have full awareness of what he needs. I have absolutely no concerns about his welfare." "I think it is absolutely marvellous how he is treated. Not one [staff member] can I find fault with."

Care records contained the information staff needed about people's significant relationships including maintaining contact with family. Relatives told us they were able to visit when they wanted to. One person's relative was transported to and from the home, to enable them to visit the person. Others told us of their arrangements and how they were kept up to date with any changes in people's health needs or other relevant information.

Funeral plans including people's preferences were being developed for people. In order that people's views were understood and recorded, activities such as choosing flowers and music were being investigated. People were encouraged to smell different flowers and their preferences were noted. They were also encouraged to listen to hymns or music so that staff could determine what their preferred choice might be.

Requires Improvement

Is the service responsive?

Our findings

People's relatives told us they believed people were offered the opportunity to participate in regular activities. One comment stated "He has a better life than I do."

However, we had concerns about the amount of regular activities and stimulation on offer to people. During the first day of the inspection we observed a person was assisted to be positioned in front of the TV after their breakfast. They had little interaction from staff until lunch time; they did not appear to be watching the TV. After lunch they were taken to their room for a rest. We looked at their daily records, to see what activities they had participated in over a 16 day period in the previous month. We noted they had been involved in activities outside the home on one occasion. For the other 15 days they had participated in activities within the home, including listening to music, watching TV, hand massages and having their nails filed. On the second day of the inspection the person was supported to go to the cinema. We spoke to staff about activities in the home. They told us they did not always have enough staff and not enough time. We saw in people's daily records that some activities had been cancelled due to staff shortages. They told us they did what they could within the limitations of staffing and maintaining the health needs of people. This did not always protect people from the risk of social isolation and lack of stimulation. We spoke to the registered manager who told us they were working to improve the frequency and the nature of activities on offer to people. Activities included sensory sessions at an adult learning centre, aromatherapy, shopping, and outings to places of interest.

We recommend the service seek to review the deployment of staff available to support people with meaningful activities.

People appeared to be comfortable living in the home, with staff they were familiar with and an environment that was safe. Each person had a care plan. Care plans outlined people's needs and how staff were expected to meet those needs. Any changes to people's care plans was documented in the communication book and shared through staff meetings and handover meetings.

The daily notes contained information such as people's emotional state, what activities people had engaged in, their nutritional intake and any appointments they may have attended. Records related to their sleep at night were also documented. This meant the staff working the next shift were aware of how people were and care could be flexible.

Changes to people's needs were identified and were reviewed monthly or sooner if required. Where appropriate their relatives and health and social care professionals where involved. Relatives informed us they were invited to participate in annual reviews and felt their opinions were taken into account.

Reports and guidance had been produced to ensure that unforeseen incidents affecting people would be well responded to. For example, if a person required an emergency admission to hospital, each care file contained a document named "All about me." The purpose of the document was to help the staff in hospital to get to know the person. It contained basic contact details, medication and daily needs of the person.

Systems were in place to manage complaints. The provider had a complaints policy and procedure in place. People's relatives told us they knew how to complain but had not had to do so. If they had concerns or issues they would discuss these with the registered manager. Staff knew how to deal with complaints. There had been no complaints made since the change of provider in July 2016.

Good

Is the service well-led?

Our findings

There was a registered manager working at the home. The registered manager had been in post for eight months at the time of the inspection. They managed two homes one of which was The Old Forge. They shared their time between the two services. Staff spoke positively about management. Staff told us they felt they could discuss any concerns they had with the registered manager. They told us the registered manager was accessible.

The registered manager told us since they had started one of the key challenges was "Getting the paperwork into a good place." They told us information needed to be in the right place and getting it up to date was important. They praised the reliability and competence of the support lead. Although they were office based they spent time observing the care being provided and in this way they could determine the daily culture of the home. Where standards were not maintained they took appropriate action to address this.

The staff described the registered manager as being office based. They focussed their attention on getting documents up to date and support plans in place. They told us they felt supported by the registered manager. Relatives told us the management were visible and had a good rapport with people living in the home. One relative told us they had had a number of conversations with the registered manager about the care provided to their loved one, the registered manager had responded positively and had listened to their opinions.

Staff told us there was an open culture within the home and the registered manager listened to them. Staff said team meetings took place monthly and gave staff an opportunity to voice their opinions. One staff member told us the introduction of the link worker meetings with the registered manager and the support lead would be really helpful to both the staff and to the people living in the home.

There were audit processes in place at The Old Forge. Documents showed care plans had been audited and improvements had been made. Finance audits were competed weekly and checked monthly by the registered or locality manager. Infection control audits were completed these also checked sufficient stocks were in place of items necessary to maintain a hygienic environment such as hand gel and soap. A monthly peer audit took place this involved a visiting manager from another service auditing areas such as health and safety, medicines and fire safety amongst others. We saw some action had been taken, but the date for completion was after the inspection. This was the first of its type to be held at The Old Forge.

Staff told us they had been sent a feedback form from the provider. They told us they had not worked for them long enough to give constructive feedback. The registered manger told us the provider had designed a pictorial questionnaire to send to people who used their services and their relatives. This had not been implemented at the time of the inspection. The feedback we received from people's relatives and staff included "I enjoy the job. I enjoy the input I have and the good feedback from the [people] I treat them as individuals and they appear to like me." "I enjoy working in care." "I think they [staff] are very good I don't think you would find anything better," "I am very happy with the care they provide." "Very pleased indeed I have no worries."

A health care professional who visited the home regularly told us the care people received was "Very good." They had never had any concerns about the staff or how care was provided. They described people as always clean and the staff were always calm when supporting people. They assisted people when receiving health care and the staff appeared competent. They commented that staff always asked questions and showed an interest in the health care being provided. They told us all referrals were appropriate and they felt the home was organised and well managed.

There was a contingency plan in place to ensure the service could continue to be provided in the event of an unexpected emergency. Consideration had been given to alternative accommodation if the home inaccessible. This ensured as far as possible people would be kept safe and comfortable.

The provider has a legal duty to report certain events that affect the well-being of a person or affects the whole service. These had been sent to us to keep us informed of incidents in the home.