Care Quality Commission

Community Integrated Care

Strothers Road

Inspection report

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Date of inspection visit: 27 November 2014
Date of publication: 29/01/2015

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 27 November 2014. This was an unannounced inspection. This means the provider did not know we would be inspecting. A second, announced day of inspection took place on 1December 2014. We last inspected Strothers Road on 9 May 2014 where we told the provider to make improvements with regard to regulation 20 (records). The provider submitted an action plan which stated they would meet all legal requirements by 30 July 2014. During this inspection we found improvements had been made.

Strothers Road is a care home without nursing and provides accommodation and personal care for up to four people. The service is primarily for people with a learning disability. At the time of the inspection four people were living at the home. Due to the complex needs of people living at the home not everyone was able to share their views about the service but we did spend time with people.

There were sufficient staff employed to meet people's needs and the home employed their own bank staff to cover any staff absences. Staff knew the people they supported well and used person centred thinking tools to ensure everyone was supported in an individual way.

The communication needs of each individual was clearly understood and staff used pictorial aids such as 'now and next' boards to involve people in decision-making and

Summary of findings

choice. Now and next boards use pictures to support people with communication needs to understand what is happening now and what is going to happen next. Staff were committed to ensuring people's rights were respected and offered people the time and reassurance they needed to enable them to communicate their needs and wants.

Staff were appropriately trained and had a good understanding of safeguarding, mental capacity and deprivation of liberty safeguards.

Medicines were stored, administered and managed safely. Only staff trained and assessed as competent administered people's medicines and recorded was robust. People had individualised profiles for their medicines which included pictorial information and descriptions of why people had been prescribed the medicines. Audits were completed regularly.

The service liaised with other healthcare professionals including dietitians and had a good understanding of the impact diet has on health and well-being. The service actively sought advice with regards to health, including diet, and followed advice appropriately. A community nurse told us she was very impressed with the professionalism and effective communication of the staff team. No one we spoke with had concerns about the home and said they felt the registered manager was approachable if they did need to discuss anything.

People had individual activity planners based on their likes and dislikes. Learning logs were used so staff could record what worked well about activities, what people enjoyed and what people didn't enjoy so much. People were actively involved in deciding how they spent their time and pictorial aids were available for people who needed support with communication.

A registered manager was in post at the time of the inspection. 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were enough well trained, knowledgeable and experienced staff to meet people's needs.

Staff were knowledgeable about safeguarding and people's rights and told us they knew how to report any concerns.

Robust emergency plans were in place and there were on- call procedures in place for management support outside of routine working hours.

Medicines were stored, administered and recorded in a safe manner.

Is the service effective?

Good

The service was effective. Staff were positive and told us they felt well supported. Team meetings were regular and staff were encouraged to share their views and make suggestions.

People were offered choice according to their communication needs and had access to food and drinks as they wanted.

The registered manager was knowledgeable about Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and had sought appropriate authorisations as needed.

Is the service caring?

Good

The service was caring. We observed positive relationships between staff, people who used the service and relatives.

Staff learnt how to communicate with people and were eager to share this with us so we could also communicate with people, for example by clapping to say hello to someone.

A community nurse said she was very impressed with how mindful staff were of people's needs.

Is the service responsive?

Good

The service was responsive. We saw that person centred thinking tools were used to get to know people's histories and preferences.

Care records gave a detailed account of how to support people whilst respecting their rights and choices. Learning logs were used to record what was working and what wasn't working.

Individual activity plans were in place for people based on their likes and dislikes.

Is the service well-led?

Good

The service was well-led. Everyone we spoke with was positive about the home and had no concerns.

Staff and relatives said the registered manager was supportive and had an open door policy.

Robust quality assurance systems and audits were in place and completed by the regional manager. The audits identified any action that needed to be taken, who should take it and by when.

Strothers 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 27 November 2014 and was unannounced. A second day of inspection took place on 1 December 2014 and was announced. The inspection was completed by one inspector.

Before the inspection, we reviewed the information we held about the home, including the notifications we had received from the service about safeguarding and deprivation of liberty applications. Following the inspection, we contacted the local authority safeguarding team, the commissioning team and one community nurse.

At the time of the inspection four people were living at the home. Due to their complex needs not all people were able to share their views about the service but we did spend time with people. We spoke with the registered manager, two senior care workers, three care workers and two relatives.

We looked at three people's care records and three people's medication records, staff handover was observed and five staff files were reviewed. Staff supervision log and the training records were reviewed as well as records in relation to the management of the service. We looked around the building and were shown around individual flats by some of the people who lived there.

Good

Is the service safe?

Our findings

People felt the service was safe. One relative told us, "Everything is fine, we are happy with the care, we visit regularly and keep them on their toes."

We saw there was a safeguarding policy and flowchart available for staff to follow which detailed the action to take if abuse was suspected. One staff member told us, "We've done safeguarding training. If we think someone's been abused we need to keep the person safe and report it, if it was about a senior we go higher, and go even higher if we need to." We looked at the safeguarding log and noted it included alerts and notifications but didn't detail any action taken. When asked the registered manager told us, "The safeguarding team don't have their own alert form so I send them our own. I speak to them about alerts but nothing has been picked up at strategy level, I'm just told to let them know the outcome." A member of the local authority safeguarding team told us, "We have no concerns."

Both person-centred and environmental risk assessments were in place. Person centred risk assessments cover peoples individual needs. Risk indicators were clearly identified and provided detailed information on how to manage the risk. Where people's behaviour might present a risk to themselves or others risk assessments had been developed which were based on their individual needs. These risk assessments had been completed by behaviour specialists, relatives and people who knew the person well. We noted that reviews were scheduled according to a risk scoring tool. If the risk was identified as high it clearly stated that support was not to be delivered until the potential risk was reduced. A staff member told us, "We review after a change of circumstance or an incident."

Health files included risk assessments associated with people's health and well-being such as medication and dentistry. Environmental risk assessments included infection control, slips, trips and falls, fire, electrical and gas appliances. There were also risk assessments about the safety of staff including lone working, personal security, stress, challenging behaviour and isolation. These risk assessments were reviewed on a six monthly basis.

The environment was clean and tidy and each flat had a homely feel which was very individual to the person or people living there.

There was an emergency response file near the main door and in the office. This included the on- call procedure and rota, pen pictures of people, their emergency contacts and up to date lists of prescribed medication. Pen pictures give a concise summary of peoples support needs. The file also included the fire procedure and evacuation plans as well as plans in the event of electricity failure, floods, assault, and missing persons. People's individual files also included emergency planning arrangements. This meant potential risks to people were assessed and managed to maintain their safety.

Accident and incident reporting was completed by a computer system so senior managers could review the information, and request further information such as action taken. A whistle-blowing poster was on display for staff. Staff commented, "We know about the whistle-blowing phone line and how to whistle-blow" and "We can speak to the manager about any concerns but if they didn't listen I would take it higher."

We observed a handover session between staff at the start of the shift where information was both verbal and written. One of the senior care workers chaired and discussed the well-being of each person including any activities they had completed and had planned and personal care. They shared that one person had fallen so first aid had been administered and the person was monitored. Staff asked questions and clarified details and were allocated roles for their shift. This meant there were good communication arrangements for staff so they were made aware of each person's needs.

There were sufficient staff to support people's needs at this service. Staff told us, "There's always enough staff to support people" and "support levels meet people's needs". The registered manager told us, "It's difficult to get the right staff but I won't use agency, I don't believe in it. We have our own bank staff who we use, it's much better for people." Staff told us, and care records confirmed that some activities required a certain number of staff, for example some people needed two staff to support them in the community. Staff said these needs were always met.

Staff told us, "There's three waking night staff, one upstairs and two downstairs" and went on to say "could have support from other staff [waking night staff] but no procedure to alert someone, we can normally see triggers and we know what to do but it may change over time, just a door bell or something would do." The registered

Good

Is the service safe?

manager confirmed that there were two waking nights downstairs. Upstairs staff would come down or downstairs staff would hear. They help each other out. Staff told us they had support at night from the management, "The on call rota is on the wall for out of hours support, the managers take it in turns, we just ring the number. We can also ring staff from here, no one minds." There was also a Regional Manager on call should more senior support and guidance be needed.

We viewed the rota and noted that, other than on a rare occasion, there was always a senior care worker on duty between 7.30am and 10pm. The registered manager said she was also managing another service so she generally spent three days a week at Strothers Road and the senior care workers used their hours flexibly to either support people or complete administrative tasks. All staff worked early, late and waking nights and the registered manager told us this was so staff "know everyone well and can contribute to team meetings and discussions about people's support". The registered manager told us, "Rotas are going to be personalised so everyone we support will have their own core team and rota." Some people already had core teams and pictorial rotas let them know who would be supporting them.

The provider made sure only suitable staff were employed and staff files contained application forms and references as well as interview assessment sheets.

The arrangements for the management of people's medicines were safe. Medicines were stored and administered safely and regular audits were completed by senior care workers. One staff member told us, "Only staff who are trained and competent administer medication." We saw that every person had an individual medicines file which included a photo of the person, a medicines profile and a medicines routine. All information was individualised and included detail of how to support the person, a pictorial description of the medicine the person took and an explanation of why it was prescribed. Protocols for as and when needed medicines were in place and had been written by the prescribing GP. Staff told us they understood these procedures and it was noted that these medicines were not routinely administered.

Medication administration records (MARs) clearly stated if medicines weren't kept in blister packs and included administration instructions and details on when a second dose of medicines could be administered. There was also detail of the maximum dose that could be administered in any 24 hours period.

All medicine administrations were clearly recorded as was the receipt and return of medicines. A Controlled Drug administration protocol was in place and a controlled drug book was used. Controlled drugs are medicines which can be misused and therefore stricter legal controls apply to prevent them being obtained illegally, or causing harm.

Good

Is the service effective?

Our findings

People were supported by staff with the necessary skills, experience and knowledge. Staff told us "We get induction, shadowing and mentoring on the floor" and "we get plenty of time to read support plans and files".

The registered manager told us there had been "no new starters recently but we do have an induction workbook and schedule for when staff do start". The induction workbook included specific detail about people's communication needs and specific training staff needed to complete before supporting people on an individual basis. The induction workbook also included key policy information such as confidentiality, whistle-blowing and complaints.

Staff told us, and records confirmed that training was provided in several formats, ranging from competency workbooks, to on-line Common Induction Standards assessments and classroom-based training. Examples included medication training, moving and handling, safeguarding, emergency first aid, food safety, infection control, health and safety and autism awareness. Staff also attended Mental Capacity Act training which was delivered by the local authority. All staff received training in MAPA (Management of Actual and Potential Aggression) and the training records included refresher dates for all staff. The registered manager told us, "Staff do not use physical restraint, there's no need. We might use the two person escort but nothing more."

Staff told us they had regular team meetings and individual meetings for each person's core team every other month. Minutes of these meetings were available for staff who couldn't attend and actions from the last meeting were always reviewed. Each person supported was discussed and support plans, dietary needs and choice were always on the agenda. Staff were able to raise items for discussion such as the shopping and the rota and it was noted that maintenance and health and safety were standing agenda items. The registered manager told us, "Staff work all shifts, including earlies, lates and nights so they are able to attend meetings and contribute to discussions about people's support needs."

Staff told us they felt "well supported" and received supervision "every three months or so but if there's major issues we can ask for one." We reviewed the supervision log and noted that at the time of the inspection staff, unless on sick leave, had received three supervisions since April 2014. The registered manager told us the target was six supervisions a year but supervisions were not held routinely on a bi-monthly basis which would have made sure the target was met. Supervisions were conducted by the registered manager and the three senior care workers. The registered manager told us that she assessed competency and went through the format and the process with senior care workers before they chaired supervisions as there was no formal supervision training.

We asked about annual appraisals and a staff member told us, "I've not had one – not sure if they are phasing them out." We asked the registered manager about this who said "They aren't being phased out. The paperwork is being changed so they'll be done on the new form." The registered manager said "Last appraisals were about a year ago, the new paperwork should be available in the new year" they added "During the first year in post there's no appraisal just supervisions and the 6 monthly review." Staff told us they could speak to the manager or senior as they needed to and received feedback on performance in supervisions.

We found that the provider was following the requirements of Deprivations of Liberty Safeguards (DoLS). The Mental Capacity Act (MCA) DoLS require providers to submit applications to a 'Supervisory Body' for authority to do so. For example, one person had a DoLS authorisation in place, a multi-disciplinary capacity assessment had taken place, and a Relevant Persons Representative (RPR) had been appointed. A RPR is a person who is independent of the care home and who is appointed to maintain contact with the person using the service to represent and support them in all matters relating to their deprivation of liberty safeguards. This meant the provider was complying with the conditions applied to the authorisation.

We noted that a capacity assessment had been completed for dentistry for one person and a best interest decision had been recorded. Capacity assessments were also in place for finances for people and we saw evidence of appointeeships and how these should be managed. This meant any major financial decisions on behalf of people were made through multi-disciplinary best interest decisions. Staff told us they had completed training in the

Good

Is the service effective?

MCA and DoLS. A staff member told us, "Mental capacity means giving people choice in a way that they can make their own decisions, people have rights to choose for themselves."

We spoke with a community nurse who told us, "It's very positive; staff have very good working relationships and are positive about behavioural presentations and working together to support people." They also told us, "They communicate effectively and are good at sharing ideas."

The service used the pro-active behavioural management model. This helped to establish emotional bonding between staff and people through the use of verbal and physical interaction. This supports people to develop meaningful and trusting relationships. Staff told us, "You see the person first. [name] is great, we love working with them." Following incidents of challenging behaviour staff completed records of why the incident happened and had a debrief sessions about it with senior staff. "We can move, have a break if we need one but changes are introduced slowly over time. People are very accepting of change and it can reduce behaviours if done well, like the back door being locked at night, its reduced behaviour and it's been accepted really well."

We observed that people had full access to food and drinks and had individual facilities to support this. Staff told us, "People choose what they want to eat. We always give a choice but in a way they understand so we might do it like mince and dumplings or fish and chips." All staff complete training in food and nutrition and we observed staff completing individual shopping lists with people they were supporting.

Following the last inspection an action plan was completed by the registered manager which stated pictorial menu boards were being introduced. It was noted that these were not yet in place. The registered manager said, "We are developing them. We've asked a speech and language therapist to get involved but we're hoping to use a Widget system." (Widget are a company who specialise in using pictures as a means to make information more accessible for people.)

Care records included health action plans which named the other professionals who were involved in the person's care. We saw evidence that staff had sought advice from a dietitian with regard to diet and its potential impact on challenging behaviour. It was good practice that although advice had been received about a gluten free diet, DoLS had also been considered as this would have severely restricted the person's diet. The outcome was to slowly introduce healthier options and additional fresh fruit and vegetables. The staff team had attended specific training workshops delivered by professionals in order to support them with specific behavioural strategies. This meant the staff team understood how to support people and were consistent in their approach which provided routine and predictability for people.

Healthcare was included in support planning, we saw an individualised care plan around wearing glasses which included where the person kept their glasses, where to record information, what to do if the person declined to wear them, that is, to "provide encouragement but respect my wishes, document it and try again later". One person's health record included the involvement of their GP to rule out any physical health needs but also engaged with the Intensive Support Team to develop support strategies. We saw a meal time information sheet and recording with regard to dietary advice and saw that the care plan included information from the GP and dietitian.

People had their own flats which were decorated to meet their individual needs and preferences. We saw evidence of detailed multi-agency planning around adapting a person's kitchen area to meet their needs and staff were working with another person to introduce a sensory room into their flat. This meant environmental changes and adaptations were being made in order to meet people's needs.

Good

Is the service caring?

Our findings

A relative told us, “We are happy with the care, things are going well. The care is the main thing.” Staff spoke about the people they supported with knowledge, kindness and respect. They were able to share people’s histories and their likes and dislikes. Staff explained specific engagement and communication methods to us so when we met people we were able to communicate with people, for example that one person would clap to say hello. We observed staff engaging in this way in a reassuring, positive and natural way.

A community nurse told us, “Staff are very professional and welcoming, they are effective communicators and good at sharing ideas. I was very impressed; they were keen to support my visits but were very mindful of the client’s needs.”

Staff were patient with people and they offered support and encouragement in a relaxed way giving them the time they needed to process information and engage in the conversation. We saw that staff were respectful, addressed people by name and actively engaged and supported people to make their own decisions. Where people had limited verbal communication pictorial aids were in place to support active involvement. For example, one gentleman told his staff what activity he would like to do before lunch by using pictures and a ‘now and next’ board. A ‘now and next’ board can be used so people understand what activity they are doing now and what activity will follow.

Care records included person centred thinking tools which captured people’s memories, their relationship circles, hobbies and interests, likes and dislikes. A staff member told us, “We know people well, we really like the people we support.”

People had one page profiles which explained what people liked and admired about the person, what is important to the person and how best to support the person. It was noted that staff also had one page profiles. One page profiles provide a summary of what others like and admire about the person; what is important to the person from their own perspective and a description of what is important for the person, for example how best to support them. The purpose is to give a summary so others can get to know the person quickly, so they can consider what is important to and for the person and develop relationships that make a difference.

Care plans and risk assessment documentation had a place to record ‘how I am involved in my care’ but these were blank. We saw an audit had commented that there was work to do in this area. It was evident that staff used communication aids such as ‘now and next’ boards, intensive interaction and picture exchange systems to involve people in decision making and care planning but this needed to be documented.

We saw evidence that when people needed support to make decisions an advocate was involved. Staff explained that they knew this advocate had previously supported the person and so had been able to involve them again as they felt the existing relationship would support decision-making further. This was in respect of a major decision about kitchen adaptations. Staff had used specific picture cards related to the kitchen in order to ensure the person they were supporting was provided with as much information as possible and could be actively involved in the decision- making process.

The service had signed up to the Dignity Challenge and one of the people who used the service attended dignity forums held by the organisation where he “had his say”. The Dignity Challenge sets out clear expectations of what people can expect from a service that respects dignity.

People’s right to confidentiality were respected and all sensitive and private information was kept in locked filing cabinets. The senior staff or registered manager on duty kept the keys to filing cabinets with them at all times. The improvements the provider told us they would make following the last inspection had been met.

Good

Is the service responsive?

Our findings

Staff were knowledgeable about the people they supported. One staff member told us, "We genuinely like the people we support and want the best for them." Staff were able to describe the needs of the people they supported and explained how best to meet their needs, for example by explaining how to present choices to people in a way that they would understand.

Person centred thinking tools were used throughout care records and included information on people's histories and preferences, their relationship circle and memories. Care records also included one page profiles, information passports which detail information about a person's communication needs, activities people enjoyed and documents for recording what worked and what didn't work about activities. Person centred thinking tools support staff to understand and get to know the person and not just understand the tasks that the person needs support with.

There were detailed communication passports which detailed how people communicate with their behaviour, these are particularly useful when people do not communicate with words. For example they explained how to start and finish interactions by clapping hello and goodbye; how to offer people choice through using picture exchange communication systems (PECS). The passports also included explanations of people's behaviour. For example, when I do [this] it means [that]. Staff used a variety of pictorial aids to communication such as now and next boards; pictorial rotas; objects of reference. Staff were open and receptive to this and acknowledged peoples decision's positively responding appropriately.

Care records included individual activity planners based on people's likes and dislikes and learning logs so staff could record what worked well about activities, what people enjoyed and what people didn't enjoy so much. It was noted that although every person had their own activity planner there were also group activities people were supported to attend. For example on the day of the inspection people went out together to the Christmas Fayre. This meant people could form friendships and develop relationships and shared interests.

Risk assessments and care plans contained specific detail on how to support in an individual way. Care plans were regularly reviewed but reviews often stated "no change". By not detailing the reason for no change it could mean the support is currently working for the person or that not all areas of support have been considered during the review or that the person does not currently need active support in this area.

People's care records included scheduled annual reviews of needs. Individual review package was completed 6 monthly and included home life, choice, health needs. During this review any further action was identified which included community presence, safety awareness, hobbies and interests. However there was no record of who was involved in this review. Key-worker checklists were completed on a monthly basis and used pictorial representations to show progress against individual outcomes such as making a positive contribution, being healthy, staying safe, enjoying and achieving.

Care plans were reviewed depending on risk. The registered manager and staff confirmed that there was a scheduled programme of reviews but if there was an incident or change in circumstances that would trigger a re-assessment. One relative told us, "Staff always keep in touch. We have a meeting planned with the staff and the social worker and the health professionals to make sure everything's going well."

The service kept a file of compliments, complaints and concerns which included a pictorial complaints policy and a flow chart which included timeframes for action but there were no recorded concerns or complaints. When the registered manager was asked about this she said, "There have been complaints but they were investigated by people outside of this service. I should add them to the log with a record of who has investigated and what the outcome was." One relative we spoke with told us they had "no complaints, things are going quite well".

There was evidence that people had been invited to 'know your views' sessions but there was no information on any lessons learnt or changes made in response to these sessions. These sessions were held by the provider to give people the opportunity to share feedback, thoughts and opinions on the service being provided. When asked how they sought feedback on the service, the manager told us "We do surveys of staff, people supported and relatives but this hasn't happened this year.

Good

Is the service well-led?

Our findings

At the time of the inspection the service had a registered manager who had been in post since June 2014 but who had worked for the company for many years. There was a clear staff structure which included three senior carers, the registered manager, who also manages another service and a regional manager. The atmosphere in the home was relaxed and it was noted that all staff were open and supportive of each other and clearly had positive working relationships with each other including the senior staff and the registered manager.

It was evident from staff conversations the quality of life of people who lived at the home was the main priority for everyone and the team were working together to ensure people were supported appropriately. Staff discussed activities for people and how to engage people in developing adaptations to the environment. Relationships with relatives were positive and proactive, staff openly discussed people's needs with relatives and sought their opinions.

Staff and relatives told us managers were approachable and supportive, that there was an open door policy with management and they can ask anything they like. Staff said they "really enjoy working here" and the registered manager told us "staff retention isn't an issue, there's been some turnover due to changes and disciplinary procedures but there's a very robust recruitment process". She also commented, "There's the organisation's re-structure in January which we'll now be part of and consultation starts in January." The registered manager went on to say, "Some people will leave because of this and it'll be difficult to manage staff's motivation levels but we'll get more information once the consultation starts properly."

We saw the registered manager was very visible and observed they had supportive and trusting relationships with the staff team. Care staff felt comfortable and confident coming into the office as needed as the door was always open. The registered manager told us she was well supported by the regional manager and we saw that they also maintained regular visits to the home.

A variety of robust quality assurance checks were in place and we saw that the regional manager checked support plans, health and safety and completed medicines audits. They recorded comments on action that needed to be taken, who should take it and when it should be completed by. The regional manager site visits also included audits of complaints, accident and incident reporting, fire log books and action taken with regard to any outstanding training.

We noted that the CQC action plan submitted following the last inspection had been reviewed frequently and dates had been added once tasks had been completed.

Clinical governance reports were also completed on a monthly basis which covered any hospital admissions, weight loss, pressure sores and CQC notifications.

There was clear evidence that the service operated a culture of openness and transparency, staff were encouraged to and felt able to contribute and make suggestions for improvements, for example about the rota. One staff member told us, "We have regular meetings about [person supported] so we can say if any changes are needed. It's to discuss ongoing support and to make a contribution." They also said, "We are encouraged to get involved and make suggestions, it sometimes falls on flat ears though." All staff were working together to provide a high quality personalised service for people with complex needs.