Polesworth Group Homes Limited

Highfield

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 8th December 2015 and was announced.

Highfield is a purpose built bungalow designed to support five people with a learning disability. The service also provides domiciliary care across eight supported living locations, to people with a learning disability in their own homes, some of whom require 24-hour care.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were comfortable with staff and relatives were confident people were safe living in the home. Staff received training in how to safeguard people, and had access to the provider's safeguarding policies and procedures if they had any concerns. Staff understood what action they should take in order to protect people from abuse. Systems were used to identify and minimise risks to people's safety. These systems were flexible so people could take risks if they were able to do so and build their independence.

People were supported with their medicines by staff that were trained and assessed as competent to give medicines safely. Medicines were given in a timely way and as prescribed. Regular checks of medicines helped ensure any issues were identified and action could be taken as a result. There were enough staff to meet people's needs.

The provider conducted pre employment checks prior to staff starting work to ensure their suitability to support people who lived in the home. Staff told us they had not been able to work until checks had been completed.

Some people were considered to lack capacity to make decisions. We found that assessments of capacity for these people had not always been completed, and DOLS applications had not been made as required. However, staff and the registered manager had a good understanding of the Mental Capacity Act, and the need to seek informed consent from people wherever possible.

People told us staff were respectful and treated them with dignity and respect. We also saw this in interactions between people at our inspection visit, and it was also reflected in records kept. People were supported to make choices about their day to day lives. For example, they could choose what to eat and drink and when, and were supported to maintain any activities, interests and relationships that were important to them.

People had access to health professionals whenever necessary, and we saw that the care and support provided in the home was in line with what had been recommended. People's care records were written in a

way which helped staff to deliver personalised care, which focussed on the achievement of outcomes. Staff tried to ensure people were fully involved in how their care and support was delivered, and people were able to decide how they wanted their needs to be met.

Relatives told us they were able to raise any concerns with the registered manager, and they would be listened to and responded to effectively, and in a timely way. Staff told us the management team were approachable and responsive to their ideas and suggestions. There were systems to monitor the quality of the support provided in the home, and recommended actions were clearly documented and acted upon. This was achieved through unannounced provider's visits.

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.

People's needs had been assessed and risks to their safety appropriately identified. Staff were aware of safeguarding procedures and knew what action to take if they suspected abuse. People received their medicines safely and as prescribed from trained and competent staff. There were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity to make day to day decisions, this was not always assessed. Neither had DoLS applications been made as required.
Staff understood the need to get consent from people on how their needs should be met, and where people lacked capacity they had involved others appropriately.
People were supported by staff that were competent and trained to meet their needs effectively. People were offered a choice of meals and drinks that met their dietary needs, and were able and encouraged to help prepare their own meals. People received timely support from appropriate health care professionals.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were supported with kindness, dignity and respect. Staff were patient and attentive to people's individual needs and staff had a good knowledge and understanding of people's likes, dislikes and preferences. Staff showed respect for people's privacy.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support which had been planned with their involvement and which was regularly

reviewed. Care was focussed on what people wanted to achieve, and sought to build on people's strengths and help them to do so.
People knew how to raise complaints and were supported to do so.

Is the service well-led?

Good

The service was well led.

People felt able to approach the management team and felt they were listened to when they did so. Staff felt well supported in their roles and there was a culture of openness. There were systems in place for the provider to assure themselves of the quality of service being provided. Where issues had been identified, action had been taken to address them.

Highfield

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 8 December 2015 and was announced. We told the provider in advance so they had time to arrange for us to speak with people who used the service. The inspection was conducted by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service. We looked at information received from local authority commissioners and statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We reviewed the information in the provider's information return (PIR). This is a form we asked the provider to send to us before we visited. The PIR asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to review the information as part of our evidence when conducting our inspection.

During our inspection visit, we spoke with three people who lived at the bungalow, and two people who received care and support in their own homes. Prior to the inspection visit, we spoke by telephone to eight people who received care and support in their own homes. Some people being supported by the service were unable to speak with us, so we also observed interactions between staff and people in the home. We spoke with two relatives during our visit. We also spoke to the registered manager, the assistant manager and four care staff.

We reviewed four people's care plans from the residential service, and one person's care plan from the domiciliary care service, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated, including medicine records, staff recruitment

records, the provider's quality assurance audits and records of complaints.

Good

Is the service safe?

Our findings

People told us they felt safe. One person told us, "I feel safe here. When I'm worried about anything I always tell the staff and they help me." Another told us, "I feel safe in the house. Lock the door at night, you don't know who is around the corner." When asked what they would do if they did not feel safe one person told us, "I would speak to the staff of course." We spent time observing the interactions between the people living in the home and the staff supporting them. We saw that people were relaxed and comfortable around staff, and that they responded well when staff approached them.

People were protected from harm and abuse. Staff had received training in how to safeguard people and to help them understand their responsibilities. There were policies and procedures for them to follow should they be concerned that abuse had happened. One staff member told us, "I would report it straight to [registered manager]." There was information on display, including contact details of the local safeguarding team, so staff knew who to contact. Staff were clear that they would escalate concerns if no action were taken. One staff member told us, "If I needed to I would go to the chief exec then the board of governors. We have all the directors' phone numbers."

Risks relating to people's care needs had been identified and acted on. Risks had been assessed according to people's individual needs and abilities and action plans were written where risks were identified. Risk assessments were clearly written, and were regularly reviewed, with more frequent reviews when changes had been identified, for example in response to changes in people's behaviour. This helped staff support people in a way that minimised risk but also promoted independence. Staff knew about people's needs and risks associated with their care, and were able to tell us about these in detail.

Records showed risk assessments were reviewed annually. The registered manager told us staff were responsible for alerting managers to changes in people's needs and any incidents and accidents that had occurred which meant risk assessments needed updating.

Other risks, such as those linked to the premises, or activities that took place at the service, were also assessed and actions agreed to minimise the risks. Routine safety checks were completed for the premises, these included gas checks and checks on electrical items. Records showed that when staff had reported potential risks, these had been dealt with appropriately. Maintenance work on the home was undertaken when required.

Staff knew what arrangements were in place in the event of a fire, and were able to tell us the emergency procedures. The fire risk assessment included personal emergency evacuation plans for each person who lived in the home. Fire safety equipment was tested regularly, and the effectiveness of fire drills was assessed and recorded. There were contingency plans to keep people safe if people were temporarily unable to use the building.

People told us there were enough staff to meet their needs. One told us, "They [staff] are always there if I want anything." The registered manager told us staffing was based on the needs of people living in the

home. During our visit we saw staff were available to meet people's needs when required. Staff told us there were enough staff to meet people's needs. One member of supported living staff told us, "There is always help at the end of the phone if you need it."

The provider's recruitment process ensured risks to people's safety were minimised. The registered manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. Staff told us they had to wait for these checks and references to come through before they started working in the home.

People told us they received their medicines when they needed them. One person said, "The staff are trained to help me, the medication is always on time." The assistant manager told us all new staff undertook training to administer medicines safely. Training included shadowing experienced senior staff and being observed in practice over the next twelve weeks. Staff's competence in medicines administration was then checked every year.

People's individual medicines administration records (MAR) included information about the medicines they were taking and what they were taking them for. Known risks associated with particular medicines were recorded, along with clear directions for staff on how best to administer them.

Medicines were stored safely, and were administered as prescribed. We saw that where people took medicines on an 'as required' (PRN) basis, plans were in place for staff to follow. For example, where 'as required' medicines had been prescribed to manage someone's behaviour, the plans focussed on how staff should take practical steps to support people before administering medicines as a last resort.

Medicines were checked twice daily to ensure stocks of medicines left following administration were as they should be. MAR sheets were checked monthly to ensure they had been completed correctly. These checks were used to provide assurance that medicines were managed and administered as prescribed.

Requires Improvement

Is the service effective?

Our findings

Relatives all agreed staff were well trained and knew how to support people effectively. One relative told us, "They do all the courses. I've heard them talking about it. Yes, they are well-trained." Staff used their skills, training and knowledge of the people who lived in the home to support them effectively. For example, staff were able to communicate with people in ways they understood.

Staff told us they completed an induction when they first started working at the service, which included face to face and online training, working alongside experienced staff and being observed in practice before they worked independently. We saw that induction included completing 15 standards as set out in the 'Care Certificate.' The Care Certificate assesses staff against a specific set of standards and staff have to demonstrate they have the skills, knowledge and behaviours to ensure that they provide compassionate and high quality care and support. The registered manager confirmed all staff had an induction. They told us even if a new member of staff had experience of working in a care service, they would look at a minimum of three weeks mentoring so they could be observed and ensure they had the right attitude.

Staff told us training was good quality and helped them support people effectively. One staff member told us, "I have just re-done medicines training. It was very good. It's amazing how much changes, so it was very informative." Another told us, "All the training is thorough."
Staff told us training was delivered face to face and that they preferred it this way. One told us, "After training [Registered Manager] asks how we are putting it into practice."

A training record was held by the registered manager of the home, which outlined training each member of staff had undertaken and when. The provider organisation had guidance in place which outlined what training people in particular jobs should complete. The registered manager told us they would ensure this guidance was followed, and would also monitor what other training staff needed. They told us this was in response to the changing needs of people being supported, as well as discussions with staff and day to day observations of their practice.

Staff had undertaken specialist training from the provider organisation to help them support people. For example, staff had been trained on how to effectively support people who presented behaviour that challenged other people, and how to support people to manage specific health conditions.

Staff told us they attended regular one to one supervision meetings, which gave them the opportunity to talk about their practice, raise any issues and ask for guidance from the registered manager. Staff told us this helped them to develop their skills and to become more confident with their roles and responsibilities. One staff member told us, "Supervisions here happen every six weeks to eight weeks."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DOLS).

Care records showed that people's ability to make decisions had been assessed. For example, some people had been assessed as needing support to cross roads safely or with managing their money. Where this was the case, plans were in place so staff knew how people should be supported. These plans focussed on how staff should support people in the least restrictive way possible. However, there were no documented mental capacity assessments seen to demonstrate the person's ability to make decisions based on these activities. Neither was there any record of best interests meetings being held for people living in the bungalow who lacked capacity. We discussed this with the registered manager who agreed the way capacity was assessed by the provider could be improved. They showed us a MCA assessment tool that the provider had developed recently, and agreed they would start using this for people lacking capacity.

Staff we spoke with understood and applied the principles of the MCA. One told us, "Capacity for people here can fluctuate, sometimes it is better than others. We go to [registered manager] with any big decisions." Another told us, "It is about people and who can make a decision in their best interests." Staff also knew about DoLS. One told us, "It is looking at what might be a deprivation of liberty. Not allowing people to do things if you think they can't make their own decisions." Again, staff were clear that they would speak with registered manager with such issues.

The registered manager understood the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). They were working closely with the Local Authority DoLS team in relation to restrictions for people in one of the supported living locations. However, no DoLS applications had been made for people being supported in the bungalow. Some of these people lacked capacity to decide where they lived, and were not free to leave the building alone. The registered manager and staff told us if people did try to leave the building alone, they would try to discourage them from doing so. If people insisted on going out alone, they told us a member of staff would go with them to supervise them. We discussed this with the registered manager, who agreed this meant people who lacked capacity to decide where to live, were not free to leave, and were under continuous supervison. They assured us they would contact the Local Authority and submit DoLS applications.

Risks to people's nutrition and hydration were minimised. Staff knew about people's individual food and drink requirements and needs. Care records showed staff were following recommendations made by health professionals. The registered manager told us they monitored fluid intake for those who needed it. We saw fluid charts were completed and up to date, and staff told us they knew how and when to complete them.

Lunch time was calm, relaxed and friendly and there was good clear communication between staff and people. Staff sat and ate with people which encouraged and supported them to socialise. People talked about their day, and what they would be doing later. Some people who were able to communicate humorously shared jokes with staff. Food was freshly cooked and smelt and looked appetising. People were able to choose alternatives if they did not want what was on offer and there was a choice of drinks. Staff told us they often cooked three or four different options in response to what people said they wanted to eat. One member of staff told us, "We have tried having a set menu but it became too regimented and it didn't feel right so we don't do that now."

Staff checked people were as comfortable as possible so they could enjoy their meal time experience. During lunch, one person said they felt like they were slipping in their chair. Staff were quick to respond and helped the person get comfortable so they could carry on eating. People who were able to eat

independently did so, while others who needed encouragement and support received it from staff. Staff explained people usually had a hot meal in the evening, but this had been changed to lunch time today, so people could attend an event later that day if they wanted to.

People told us they were supported to access support and advice from other health professionals on a routine basis, and when sudden or unexpected changes in their health occurred. One person told us, "I have a good relationship with the GP, staff phone up for an appointment and go with me." The registered manager told us they worked with an "Acute Liaison Nurse" at the local hospital to co-ordinate care between the two providers and facilitate better communication with other health professionals and care staff. People also had "hospital passports" which contained important information for other health professionals that the person might otherwise not have remembered to share. People had "Health Action Plans" in place so it was clear how good health could be maintained, and how health conditions should be monitored.

Good

Is the service caring?

Our findings

People told us the staff were caring. One person told us, "Staff are gentle always." One relative told us, "[Staff] are very very good. They relate to [name]. They converse with [name]. They are there to listen. [Name] is happy. If [name] is happy then I am happy. It boils down to the care." Another relative told us, "If ever I have to be cared for I hope I come somewhere like this."

A member of care staff told us, "We are a good staff team. The people we support are like our second family." We saw people were comfortable with staff, and were supported in a kind and caring way, which encouraged friendship. People were happy to laugh and chat with staff and were encouraged to maintain their independence. Staff told us the provider's values included a caring ethos, which was understood and promoted by the registered manager. One member of staff said, "That's one thing I can't knock this company for. People always have the best food, they go out when they want. They all seem happy."

People had been consulted on how their care should be delivered, and on changes to the people supporting them. For example, people had been asked to give consent (where they were able to do so) to a member of staff being their keyworker. People's care and support had been reviewed regularly, and records showed how staff had supported people to be involved in this. Staff used pictures and symbols to help people understand what they were being asked in relation to their care.

Relatives told us there were no restrictions on when they could visit the home. One relative told us, "We can come and visit whenever we want." People also went out with their relatives. This was important to people, who wanted to maintain family relationships.

Staff promoted dignity and respect for the people they supported. One member of staff told us, "We always explain what we are doing. We keep people relaxed and calm when we are helping them with their personal care." A second member of care staff said, "You just have to think about what you would like done to you if you were in that position."

The registered manager's office was at the bottom of the garden so it was away from the home environment. The registered manager told us this was a deliberate decision in order to encourage a homely environment, and to support people's privacy. Staff working at the home, but also at the domiciliary service, accessed the office via a side gate so they did not need to walk through the home.

Good

Is the service responsive?

Our findings

People told us staff knew what was important to them and respected their choices. One person told us, "Staff are nice to me, [name] has my wish list we are working together." Another told us, "I go to bed between 9:30 and 9:45. In the week I get up at 7am but at weekends I have a lie in 7.30 to 7.45. Yes I am an early bird."

Care plans explained people's individual likes and dislikes and how they preferred to be supported. Care plans were detailed and described the individuals' goals, the steps they wanted to take to achieve their goals and how staff should support them to take each step. The aim for each person was to promote their independence. Staff told us they had helped to put together people's care plans and so had read and understood them. Staff demonstrated they had good knowledge of people's individual needs and were able to tell us how people should be supported.

Relatives told us they were involved in developing and reviewing people's care plans. One told us, "We have a review meeting tomorrow. [Registered Manager] will help us go through it."
The registered manager had a detailed knowledge of people who lived in the home, their history, needs, likes, dislikes and preferences. This meant they were able to share with new staff and to advise all staff appropriately where issues were raised regarding people's care.

Care plans included detailed information on when people might become anxious or agitated, and helped guide staff on how this could be managed. For example, where people's behaviour could be challenging to staff, there were clear management plans in place which focussed on supporting people sensitively.

Relatives told us staff supported people according to their needs and responded effectively as their needs and abilities changed. One told us, "[Name] isn't on half the medication [name] used to be." They added, "[Name] is a different person. They have changed [name] round." Another relative told us, "Staff know people's preferences." Staff told us there was an information book where they could record information to be handed over to staff coming onto the next shift. This helped staff understand any issues or concerns before they started work and supported them in providing continuity of care.

People told us they were supported to maintain their independence where they were able to. One told us, "I go out a lot. I have been to college today and I go and do exercise too, as well as craft." They added, "Staff do the shopping but they ask me if I want to go with them." Another told us, "I go for walks, Costa. I go to college for healthy eating and maths lessons. I go out every Thursday to the Church Hall." People also told us they were supported to see their friends and people who were important to them. One told us, "I see my friend twice a week. She's my mate."

Staff were responsive to people's needs to maintain their interests and activities. People were out at college and on family visits during the inspection visit. Staff were on shift at times when people needed to be dropped off and collected from activities of their choosing and when people were at home.

Relatives told us they had little cause to complain, but that they knew how to do so and when they did they received an effective and timely response. The registered manager had not received any complaints in the past 12 months. There was information on display about what people could expect and how to complain if they were not happy with anything. The information was in 'easy read' format to help people to understand their rights. There were policies and procedures in place for staff to follow to ensure complaints were dealt with effectively.

Good

Is the service well-led?

Our findings

Relatives and staff told us the registered manager was effective in their role and was approachable. Staff told us it could be challenging when supporting people at the service, but they met regularly with the registered manager for guidance. One member of staff told us, "The support from [registered manager] has been brilliant." Another member of staff said, "[Registered manager] is approachable and listens. So is the assistant manager." Relatives said the registered manager was approachable and responded quickly and effectively when they raised concerns.

Staff told us they followed the registered manager's example in creating a "homely' atmosphere. One staff member who worked in a supported living setting told us, "It is a relaxed, happy environment." Another staff member told us, "Staff get on well, people are happy and healthy. Everything gels together." Staff told us the registered manager and the provider helped to make their jobs more rewarding, which meant they were more able to support people at the service. One staff member told us, "I want to be working for the company until I retire." Another told us, "It's quite fulfilling really."

The registered manager was supported by an assistant manager, who supervised staff and oversaw four of the supported living locations. The registered manager told us they were also well supported by the provider and had regular opportunities to discuss how the service was developing and their own needs as a manager.

Staff told us they had the opportunity to share their views at staff meetings. Staff told us they were listened to and that made them more likely to share their views. They told us issues were discussed, actions were agreed and progress on actions was fed back by the registered manager. One told us, "The meetings can be useful if you have any concerns."

People were invited to complete a questionnaire every year, which the provider used to assess the quality of the care provided. We saw that questionnaires included simple questions with pictures and symbols to help people understand what they were being asked. The registered manager told us staff went through these with people, but if anyone indicated they were anything other than happy with an element of their care, the registered manager followed up with people to explore ways in which the service could improve. People and relatives were also given the opportunity to meet with others in the provider organisation. This gave them a chance to talk to someone other than the registered manager if they wanted to. Relatives also completed the provider's questionnaires. Records of the most recent survey in summer 2015 included an action plan based on the themes raised. For example, one action was for managers to talk to staff to ensure they had realistic expectations of what people could do for themselves, following some concerns raised by relatives that sometimes staff expected too much of people.

The service was managed effectively so it was able to respond to people's changing needs. The provider organisation analysed its staff groups annually in order to help ensure they had the right mix and numbers of staff. For example, they looked at staff who had started and left the organisation (including an analysis of any information people had given on why they had left), and the ages of the staff in order to identify any

trends so that action could be taken. The registered manager told us they had recently reviewed and changed how they supported people to work towards achieving good outcomes following work with the Local Authority.

The registered manager understood their legal responsibility for submitting statutory notifications to us, such as incidents that affected the service or people who used the service and they had notified us appropriately throughout the previous 12 months.

The registered manager monitored and audited the quality and safety of the service. Incidents and accidents relating to individual people were recorded centrally and analysed by the registered manager. They identified trends and recommended actions both for individual people and for the service as a whole. For example, action had been taken to review risk assessments for people as a result.

Records showed that unannounced provider visits were undertaken by directors on a monthly basis, to check that the service was run safely and effectively. Where issues were identified, actions were recommended and a record was kept of when and how these were to be completed and by whom.