Downing (Alton) Limited

Jasmine House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Jasmine House is a residential home situated in the town of Alton, Hampshire. It provides care for up to five young adults who may have either a learning or physical disability and other complex needs. At the time we inspected there were two young adults living permanently at the service and one person having a respite break. The service is located on a quiet residential road, close to local amenities. The service has five bedrooms, two situated on the ground floor and three on the first. Stairs and a passenger lift provide access from the ground floor to the first floor. Each bedroom has an en suite shower or wet room.

At the last inspection in November 2014, the service was rated good. This inspection found that the service remained good.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. The previous registered manager had recently stepped down from this role and a recruitment process was underway. In the interim the provider's operation manager was overseeing the service and provided support for the inspection. Downing Care (Alton) Ltd, the provider, operates three other services locally and specialises in providing services for adults with learning disabilities, with or without physical disabilities, and/or additional complex needs.

People told us they felt safe living at Jasmine House and were supported by kind and caring staff. Staff understood how to recognise and respond to abuse. There were sufficient numbers of experienced staff to meet people's needs.

People's medicines were managed safely. People had risk assessments and risk reduction measures were in place to help keep people safe.

People were encouraged to express their choices and these were respected. The leadership team understood the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People were supported to have enough to eat and drink and their dietary needs were met. Staff worked effectively with a range of other healthcare professionals to help ensure people's health care needs were met.

Staff had a good knowledge and understanding of the people they were supporting. Staff were taking action to support people to access activities, follow their interests and where appropriate to access work opportunities.

People, relatives and staff spoke positively about the leadership of the service and of the provider. There was

a positive and person centred culture within the home. Some of the management functions such as providing regular supervision and undertaking some audits had slipped, but the operations manager told us they would ensure action was taken to address this.

Care records were person centred and helped staff provide care which was in keeping with people's needs and wishes, however in some places, the records relating to people's care and support could be more accurate and clearly reflect the care people received.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains rated as good.	**Good**
Is the service effective? The service remains rated as good.	**Good**
Is the service caring? The service was previously rated as outstanding and is now rated as good.	**Good**
Is the service responsive? The service remains rated as good.	**Good**
Is the service well-led? The service remains rated as good.	**Good**

Jasmine House

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 unannounced comprehensive inspection took place on 2 March 2017 and was carried out by one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During our inspection we spoke with both of the people living permanently at the service and observed aspects of their care and support. We spoke with the provider's operation manager, the previous registered manager and two members of care staff. We reviewed two people's care records, staff training records, recruitment files for two staff and other records relating to the management of the home such as audits and meeting minutes. After our visit we spoke with two people's relatives to obtain their reviews on the quality of care and obtained feedback from three health and social care professionals.

The last inspection of this service was in November 2014 when no concerns were found.

Good

Is the service safe?

Our findings

People told us they felt safe living at Jasmine House. One person said, "I really do feel quite safe". Assessments were undertaken to identify risks to people's wellbeing and were completed using a severity and likelihood matrix and listing of control measures which assisted in reducing the risks to the person. For example, people had risk assessments in relation to moving and handling, the risk of developing pressure sores or becoming malnourished. The control measures included the use of pressure relieving equipment, staff training, assistance with repositioning and a good diet. One person's risk assessment regarding dehydration included information about the signs which might suggest the person was becoming dehydrated. Staff were provided with person centred guidance about how risks or unsafe practices should be avoided. For example, one person's care plan stated that staff needed to listen to the person carefully during moving and handling tasks as the person was able to give good directions that would help prevent discomfort. Staff were reminded never to lift the person inappropriately. We have recommended that guidance regarding one person's specific dietary needs be made more readily available in the kitchen. The operations director confirmed this would be actioned.

Care plans described whether people understood certain risks associated with their needs. For example, one care plan read, 'I am able to fully understand most risks unless unwell with an infection, I need to learn about life's risks independently, I need to make my own mistakes…I may even choose to ignore and not act on prompts, I am aware of my decision, I do understand the consequences'. We spoke with this person, who confirmed that staff did not support them in an overly risk adverse manner, but respected their choices. The staff we spoke with had a good understanding of people's risks and how to support them to maintain good health and stay safe. A social care professional told us that staff and the management team were dedicated to supporting people's needs around risk in line with their capacity to understand the implications of their choices.

The provider had completed a range of environmental risk assessments which, for example, planned for the risks associated with slips, trips and falls, lone working and legionella. Regular checks were undertaken of the fire alarm system, fire equipment and exits. A fire drill had taken place in January 2017 and another was shortly planned for the night staff. Checks were made of the gas, electricity, water temperatures, first aid kits and the safety of the homes mini bus. A fire risk assessment had been completed in October 2016. No actions were required as a result of this. People had personal emergency evacuation plans (PEEPS) which detailed the assistance they would require for safe evacuation of their home and a business continuity plan was in place and set out the arrangements for ensuring the service was maintained in light of foreseeable emergencies.

Staff who administered medicines had completed training and underwent annual competency assessments. Medicines were kept safely in a locked cabinet in a medicines room. The temperature of the cabinets used for storing medicines was monitored daily. Storing medicines within recommended temperatures is important as this ensures they are safe to use and remain effective. There were protocols in place for the use of 'as required' or PRN medicines. These included information about the strength of the drug and the maximum dose to be given in 24 hours. We reviewed three people's medicines administration

record (MAR). These contained sufficient information to ensure the safe administration of medicines.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. At each supervision staff were asked if they had any concerns about people using the service. The organisation had appropriate policies and procedures and information was available on the local multi-agency procedures for reporting abuse. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. Staff told us they were aware of how to report concerns about poor practice which is often known as whistleblowing. They were confident that the leadership would act on any concerns they might have. A social care professional told us, "If there have been any concerns about an individual at Jasmine House, it has been reported promptly".

Staffing levels were under review to help ensure they remained appropriate to meet people's needs. During the day the current staffing levels were two support workers. At night there was one waking night staff member. Shifts were planned to ensure there was the correct skill and experience mix to meet people's needs. For example, each shift had a member of staff able to drive the mini bus and staff trained to administer medicines. The staff team had all been employed within the service for some time and this helped to ensure that people received continuity of care, however, it was a small staff team and if a support worker was unwell or on annual leave, it was not always possible for the remaining staff to cover their shifts which meant agency staff were required. This was not a regular occurrence, but when it did happen, it meant that people were being supported by staff with whom they had not yet developed a close relationship which they found difficult. A relative told us that they felt an additional member of staff would be beneficial particularly at weekends to allow their family member more access to external activities. The operations manager told us they were aware of these concerns and it was evident that they were taking action to recruit an additional staff member to the team to provide additional flexibility within the staff team allowing people's needs to be met in a more responsive manner. Staff told us the staffing levels were adequate and enabled people's needs to be met in a safe manner and a social care professional said, "In my dealings with [the home] they have only had a small number of residents but with appropriate numbers of staff to meet their needs".

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks which were repeated every three years. Staff underwent a competency based interview which tested their skills and knowledge in relation to key areas. These measures helped to ensure that only suitable staff were employed to support people at the service.

Good

Is the service effective?

Our findings

People told us they were happy with the care they received. They agreed that staff were well trained and understood their needs and how to meet these. One person told us, "They know me well, the night staff are good too". Relatives also told us that staff provided effective care. One relative said, "Most of the staff are very good at the care side and [the person's] keyworker is particularly good at communicating with [the person] at their level and understanding. I think they all try very hard to meet [the person's] emotional and practical needs". Another relative told us they were very impressed with the care provided and added, "They [the staff] know what is right and do it. We are almost as comfortable when [the person] is there as we are when they are at home; it is a great relief to us".

Health and social care professionals were positive about the skills and knowledge of the staff at Jasmine House. One health care professional said, "I think deal with the person's needs very well, they are very keen to do the right thing, I have explained things to them and they have taken this on board". Another healthcare professional said, "I have had a number of patients who have lived at Jasmine House and have always felt they have been looked after in exemplary fashion. Patients are treated with skill and expertise".

People were supported by staff who had appropriate skills and experience to deliver care their care the expected standard. All of the staff currently employed had been working at the service for some time, however, we were able to see that when they first started within the service that been provided with an induction which included learning about the needs of people using the service, their needs, risks and daily routines. The induction also provided an opportunity for new staff to familiarise themselves with the home's aims, objectives and key policies and procedures such as the safeguarding and whistleblowing policies. Moving forward we were told that new staff would be supported to complete the Care Certificate. The Care Certificate sets out explicitly the competencies and standards of care that new care workers are expected to demonstrate.

Staff also completed a range of essential training which was a mixture of face to face and e-learning. Training provided included manual handling, administering medicines, first aid, food safety, health and safety, fire training, MCA 2005, risk assessment, infection control and safeguarding people. Staff also had additional training relevant to the needs of people using the service. For example, staff had completed training in epilepsy, person centred care and choking prevention awareness. Staff were observed and assessed as competent in a number of key areas such as providing personal care, the use of moving and handling procedures and the administration of medicines. Each staff member held either a level 2 or 3 nationally recognised qualification in health and social care. Staff were positive about the training available and told us it helped them to perform their role effectively and was relevant to the needs of people using the service. Staff felt well supported in their role and said they were able to seek advice or support from the operations director or the on call manager at any time whilst a new manager was being recruited. We noted however that over the last six months, the frequency with which staff were receiving supervision had declined. We spoke with the operations director who told us they would ensure that moving forward supervision took place on a regular basis. We were able to see that staff were currently in the process of having an annual appraisal.

People's rights were protected because the leadership team and staff were aware of the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). The MCA 2005 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 living at the service were able to express their wishes and choices and staff respected these. People had signed consent forms to agree to their care and support plans. To check whether people were able to make more complex decisions about their care, staff had, when required, completed and documented mental capacity assessments. A staff member told us, "We always think about their capacity to make decisions".

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where potentially restrictive care practices were in place, the people currently using the service had capacity to agree these, therefore they did not require a DoLS to be in place. However, the operations director was aware of when an application might be needed and the process to follow to request this.

People's dietary requirements and their food likes and dislikes were known by staff and respected and people confirmed they received the food they needed and preferred. This was also confirmed by a relative who told us, "Yes, [the person] has a say in their food and is aware that they need a special diet. The staff encourage this on a daily basis". The menus were planned by people on a weekly basis and they were involved in shopping and preparing their food. The menu for the week of our inspection included a number of ready prepared or processed foods. We spoke with staff about this, they told us "They [people] buy their own foods, they decide, we try to encourage healthy stuff too".

Where necessary staff worked effectively with a range of other healthcare professionals to help ensure that people's physical and mental health care needs were met. This included GP's, physiotherapists, occupational therapists and community nurses. Staff had been trained by a healthcare professional to deliver catheter care for one person and in the use of a specialist walking frame used to develop a person's walking gait. People were supported to attend dental and optician appointments and had hospital and dental passports. These are documents that assist people with disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital. Health action plans (HAP) were also in place. A HAP holds information about an individual's health needs, the professionals who are involved to support those needs and hospital and other relevant appointments. Due to their knowledge of people, their normal routines and demeanour, staff told us they were able to pick up any changes in a person's well-being and respond appropriately by ensuring referrals were made to relevant health care professionals. This was confirmed by the relatives we spoke with.

Good

Is the service caring?

Our findings

People told us they were cared for by kind and caring staff who knew them well and with whom they had a good relationship. One person said, "The staff are very nice always kind and caring". Relatives were positive about the caring attitude of staff. One relative told us, "The staff are absolutely fantastic, absolutely kind and caring". Another said the staff were "Very caring and person centred". A health care professional commented that staff had developed good relationships with the people they were looking after and another told us people were treated were "Great dignity and respect". All of the feedback received by the service indicated that people and those close to them felt the service was caring. For example, one relative had written, "There are no words that can express my gratitude and thanks to you for the love and care given. I had 100% confidence in the care".

Our observations indicated that staff showed people kindness and patience and provided care in a calm and quiet manner. We saw a staff member interacting with one person; they were using musical instruments to provide a sensory experience which the person was clearly enjoying. The staff member spoke with the person fondly and in a caring manner.

People told us they felt listened to and that staff respected their choices and wishes, encouraging them to be involved and engaged in making decisions about the care and support provided. One person told us, "I tell them if something is not right and they change it". This was echoed by a relative who told us, "Yes, the staff have [the person's] best interests at heart and are open to feedback and suggestions from me and professionals, [the person] is listened to by the staff there". We observed staff encouraging people to make choices about what they would like to do and what they wanted to eat. This respect for people being in control of decisions about their care and support was reflected throughout their care plans. For example, we read in one person's care plan, 'I have capacity to tell and give instructions to my carers on how I would like to move and transfer'. An example of this was being in control of the hoist controls when being assisted with transfers. Our observations indicated that staff acted in accordance with people's wishes and respected their decisions.

Both of the people using the service had family who were very involved in their lives. The relatives both told us staff kept them fully involved about their family's members care and support which they valued. People were also supported to stay in contact with friends and this contributed to the quality of their life. For example, one person had expressed a wish for a friend who lived some distance away to come to their birthday tea. To enable this to happen, staff had made arrangements to collect the friend and return them home afterwards. This had meant a great deal to both the person and their friend. Another person told us that staff had adjusted their shifts to enable them to attend their work Christmas celebration. Again, they told us they had valued this. People's rooms were personalised and decorated in a manner of their choosing.

Staff supported people in a way that maintained their independence. For example, people were encouraged to get involved in daily chores such as preparing their meals and shopping. Care plans clearly noted the tasks that people could manage independently and those with which they needed help. For example, one

person's care plan described how they needed help with their medicines and cleaning their teeth. People told us they were cared for with dignity and respect and that staff were mindful of their need for privacy. We observed that people could spend time alone in their bedrooms or in quieter areas of the home if this was their preference.

Arrangements were being made to work with people and their relatives to develop end of life care plans which gave the person, as far as possible the opportunity to plan and make choices about how and where they would like their care to be managed in their final days and what they would like to happen after their death.

Good

Is the service responsive?

Our findings

Relatives felt involved in their family members care. They felt that the staff kept them informed and updated them quickly about any changes in people's needs. One relative said, "we are always the first to know". Relatives did not have any complaints and said if they had any concerns the leadership team worked hard to resolve them. Health and social care professionals told us the service provided care which was responsive to people's individual needs, for example, one social care professional told us staff "Demonstrated a very person centred approach taking into consideration the person's specific health, care and support needs…I have always found the staff knowledgeable to the individual's needs, they provide a dedicated, kind and caring approach tailored to the individuals likes and dislikes".

People's needs were assessed before they moved into the home. The information provided helped to ensure staff would be able to support and care for the person appropriately and served as the basis for developing the fuller person centred plan. We viewed two people's support plans. These contained information about them as a person and their life before coming to live at the service. The plans provided information about people's preferred daily routines, their needs and how they communicated. For example, care plans recorded information such as, 'How I say no' and 'Things I would like help staff to help me with'. Information was available about the goals people would like help in achieving. One person had only been living at Jasmine House for a short period of time. Staff told us the person's care plans would be refined and updated as they had learnt more about the person's specific needs, likes, dislikes and preferences. The focus throughout the care plans viewed was how staff could support people's choices, preferences and support them to retain control over their care. This supported staff to deliver responsive care. The staff we spoke with were able to give us examples of people's likes and dislikes and needs which demonstrated they knew them well.
Staff used hand held tablets to record daily records which noted the care that had been provided. For example, the records showed whether people had eaten well or drank sufficient fluids. A communication book was used to share information effectively, such as whether people had healthcare appointments they needed to keep. There was also a daily handover which helped to ensure staff all remained informed about any changes in people's needs.

People were able and encouraged to undertake tasks such as laundry, cleaning their rooms and helping with shopping and with cooking their meals. They were also encouraged to follow their own interests and to pursue work opportunities, for example, staff supported one person to attend their employment each weekday, bringing them back each lunchtime for their meal. A social care professional working with this person told us they felt this was evidence of staff "Going the extra mile". Another person told us, "The staff are nice, I can do what I want, [staff member] is my key worker, we go in the mini bus to the shops, but I likes arts and crafts best". A relative, however, did comment that they felt that the quality of in house activities was an area where some improvements could be made. We spoke with the operations director about this. They explained that this person was still settling into the service and staff were supporting them to explore the leisure and work opportunities available locally so that a more detailed weekly programme of activities could be developed that was in line with their personal interests and aspirations. The options being explored included, art and craft classes, drama classes and horse riding lessons. They were confident they

would soon have a structured programme of relevant and meaningful activities in place to enable the person to resident to participate in community based and in-house activities of their choice.

The operations director met with people regularly and there was evidence they took account of people's views about how their care might be improved. For example we saw action was being taken to revise the staffing arrangements in order that the working day could be extended to take into account a person's wishes about how their evening routine was managed. We spoke with the person concerned. They confirmed that the provider was trying to make adjustments to meet their needs and they were confident progress would be made. A relative told us "The operations manager is actively looking at activities for [the person] and listening to my thoughts and [the person's] wishes". Questionnaires had in the past been used to seek people's views about the quality of their care and of the environment. The operations manager planned to revise the questionnaire to ensure it was more appropriate to the needs of people currently using the service. They also planned to ask people if they would like to have a regular 'residents' meeting as these did not currently take place within the service. It was hoped that these would provide further opportunities for people to spend some time together and make suggestions about how the service might improve.

People were confident that could raise any concerns they might have. One person told us, "I would go to [staff members] they would do something". The provider had a complaints procedure in place that was accessible to people. Records showed that the provider had not had any complaints in the last 12 months.

Good

Is the service well-led?

Our findings

People and their relatives were satisfied with the current management arrangements. One person told us, "[The operations director] knows what she is doing". A social care professional told us, "I have always had robust and positive interaction with the management team when I have visited. They know their residents and own staff very well".

The service did not currently have a registered manager and over the last six months there had been a number of management changes. Whilst a new registered manager was being recruited, the operations director was visiting the service most days to oversee the care being provided and to support the staff team. Feedback from staff was positive. Despite a period of change, they told us they felt well supported by the provider. One staff member said, [the operations director] is always with us, or calling to see if we need anything, we feel well supported". Staff told us morale amongst the staff team was good. They felt confident going to the operations director with any concerns or ideas. They all felt she would listen and take action if they could. Staff meetings were held on a regular basis and were used to discuss matters relating to the needs of people using the service, staffing matters and learning from incidents and accidents. The operations director was full of praise for the staff team who she said had "Stepped up to the challenge" of adapting to supporting people with physical disabilities. They told us the staff team "Support one another incredibly…I have a huge amount of trust in them, they are good people with good values".

Staff demonstrated they had a good understanding of people's needs, but we did note that some of the records relating to people's care could be more accurate and clearly reflect the care people received. For example, the records relating to one person's nutritional needs were not consistent, one person's care plan stated they were turned every two hours at night when this was not the case and one person who suffered from seizures had an escalation plan in place for the use of emergency medicines, but they did not have a seizure care plan which provided information about the type of seizures they experienced. Some of the records relating to the management of medicines were not being maintained in line with the provider's policies and procedures. For example, we found that one person had a stock of four 'if required' medicines but there was no medicines administration record for these. This meant that stock was not accounted for and was not included in the medicines checks and audits. There was no record to demonstrate that the use of homely remedies for one person had been approved by their GP. Since the inspection, the operations director has confirmed that all of the above issues have been addressed.

Systems were in place to monitor the quality of care being provided. Checks were made of people's money and medicines. The provider had invested in a new web application which involved staff using hand held tablets to record the care provided to each person throughout the day. Charts and reports could be produced to demonstrate that aspects of people's care such as fluid intake and catheter care had been completed. Alerts highlighted whether care tasks had not been completed or were overdue. This system allowed the operations director to have an overview from wherever they were of whether people at Jasmine House were receiving their care as planned. They acknowledged that this did not confirm the quality of care being provided, but they were confident that from their discussions with people and staff that people were receiving a good quality of care. This was confirmed by our discussions with people.

Incidents were documented and reviewed by the leadership team to help improve people's care. The provider visited the service on weekly basis and undertook a more formal audit once a quarter which involved talking with people, staff and reviewing records. A health and safety audit was completed on a quarterly basis and an action plan produced as a result of these. Many of the required actions from the last audit had been completed. The operations director sent us confirmation following the inspection that the remaining actions had either been addressed or would be completed within the week. Other audits had, however, not always been taking place as planned due to management changes within the service. The operations director told us the audits would be recommenced immediately however, they were confident that their presence within the service most days enabled people, their relatives and staff to readily raise any concerns about the quality of care being provided. There was also evidence that any shortfalls or areas where improvements could be made were acted upon. For example, a relative told us, "[the operations director] and I speak regularly about things and discuss any improvements or concerns I may have. These are always addressed appropriately".

The provider's core belief was that people should be supported to 'enjoy meaningful life experiences, to take risks and seek new opportunities and to develop positive social networks'. The operations director told us that in achieving these aims, it was important to "Deliver the best service we can, understand what they want, what they might not know they want". They told us that it was important for staff to be show respect to people and their choices. Our observations indicated that the leadership and staff team continued to practice in a manner that was in keeping with these aims and values. For example it was evident that staff promoted people's choices and encouraged them to have control over their care whilst at the same time offering suggestions or alternatives that might allow them to experience new opportunities such as foods or activities. The operations director had a vision for the future of the service. These future improvements included consulting with people about updating the internal environment and working with the current residents to identify suitable people to take up the current vacancies. The operations director hoped this would help to secure the future sustainability of the service and also provide more opportunities for the young people to interact and socialise with one another if they wished.