ABLE (Action for a Better Life)

Glanmor

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of this service was carried out on 12 March and 13 June 2016 and was unannounced. At the time of the visit seven people with mental health care needs were living at the service. The last inspection of this service was in May 2013 and all standards inspected were being met.

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

Medicine systems were not always safe. Protocols were developed for medicines to be administered "when required". The Medicine Administration Records (MAR) charts were not always appropriately completed. MAR charts were not always signed by staff when the medicines were administered and on other occasions the staff had signed the MAR charts but had not administered the medicines. This meant people were not having their medicines as prescribed and there was potential for confusion between staff.

Support plans were developed in line with people's preferences. The support plans included aspects of care people were able to manage for themselves, and the action plans gave staff guidance on the person's preference for their delivery of their care and treatment. However, support plans were not developed for people with mental health care needs. This meant staff may not be aware of the potential signs and actions needed for detecting any deterioration in a person's mental health.

People said they mostly felt safe living at the home. The staff knew the procedures for safeguarding vulnerable adults from abuse. This meant they were able to describe the types of abuse and the actions they need to take if they suspected abuse. A copy of the No Secrets guidance was available for staff working at the service for reference.

Risks were assessed and assessments developed on minimising potential risks. Staff were aware of the risks to people and the actions they must take to ensure people's safety and for them to take risk's safely.

People said the staff responded to their request and spent time with them. The staff rota in place showed there was lone working for part of the day and at night. An on call system was in place for staff to gain advice and support. . This meant that staff were able to gain advise and additional support should aggressive incidents towards staff occur when they were lone working.

Staff were supported to maintain and develop their skills. New staff had an induction to prepare them for their role and responsibilities. Training courses were available each month and staff said there was a variety of courses and the quality of the training was good.

People had capacity to make their own decisions. The staff used the most appropriate approach for people

who at times, used verbal aggression towards them.

People were supported by the staff to manage their ongoing health conditions. Staff consulted with people about arrangements for making appointments. This included the times of appointments and whether the staff were to accompany them on these visits.

Quality assurance arrangements in place ensured people's safety and well-being. The views of people were gathered and their feedback about the service was positive. Monthly visits from the area manager took place to monitor the quality of the service people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicine systems were not always safe. Staff were not signing medicine administration charts to show they had administered the medicines. On other occasions they had signed the records but not administered the medicines.

People told us they had the attention they needed from the staff. Sufficient levels of staff were deployed to meet people's needs.

The people we spoke with said they felt safe living at the service. Staff knew the procedures for safeguarding vulnerable adults from abuse.

Risks were assessed and staff showed a good understanding of the actions needed to minimise the risk to people.

Is the service effective?

Good

The service was effective.

People said they were able to make their own decisions. People were not subject to continuous supervision within and out the home. .

New staff received an induction to prepare them for their role and responsibilities. Staff said the training delivered increased their skills to meet people's changing needs.

Members of staff benefited from one to one meetings with their line manager.

People's dietary requirements were catered for at the home

Is the service caring?

Good

The service was caring.

People said the staff were caring and were made to feel they

mattered. We saw good interactions between people and staff. We observed staff using the most appropriate approach to explain the consequences to people's actions.

People told us their rights were respected; and they were free to leave the home without staff support. People had keys to the home and to their bedrooms.

The staff helped people to maintain links with family and friends

Is the service responsive?

Good

The service was responsive.

Support plans were developed to reflect how people wanted their care and treatment to be delivered. However, support plans were not developed for all of the people with mental health care needs.

People were supported by the staff to raise complaints.

People told us they participated in a variety of activities. One person said they attended clubs and at weekend they went to watch footballs games.

Is the service well-led?

Good

The service was well led.

Systems were in place to gather the views of people and their relatives and positive feedback was received about the service.

Members of staff worked well together to provide a person centred approach to meeting people's needs.

Quality assurance systems to monitor and assess the quality of care were in place and protected people from unsafe care and treatment.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 March and 13 June 2016 and was unannounced.

The inspection was completed by one inspector. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.' We also reviewed information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with three people, two staff and the registered manager. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for two people. We also looked at records about the management of the service.

Requires Improvement

Is the service safe?

Our findings

Systems to manage medicines were not always safe. Medication administration records (MAR) charts were not always signed by the staff to show the medicines had been administered. For example, on some occasions the MAR chart was signed to show the medicine was administered but we found the medicine in the monitored dosage system [storage device designed to simplify the administration of solid oral dose medication]. On other occasions the medicine was administered but the MAR chart was not signed. This meant people were not always receiving their medicines as prescribed and there was potential for confusion between staff.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Protocols were in place for the medicines prescribed to be taken "when required (PRN)." We saw for some people protocols for PRN pain relief, gave staff guidance on the purpose of the medicines and directions on administering the medicines, including the maximum dose to be administered in 24 hours and when to seek advice from the GP.

The people we spoke with said most of the time they felt safe living at the home. The reasons for not feeling safe all the time were not related to other people or the staff. Members of staff showed a good understanding of safeguarding of adult's abuse procedures. They knew the types of abuse and the actions they must take if they suspected abuse.

Risks were assessed and where risks were identified assessments had been developed to minimise the risk to people. Risk assessments were in place for people who at times misused alcohol, for people whose behaviour challenged others and for people at risk of malnutrition. For example, the risk assessment for misusing alcohol directed staff to discuss with the person the consequences of combining alcohol and medicines and the actions staff must take if the situation escalated to physical aggression.

Members of staff showed a good understanding of managing risk to people's health and to enable people to take risks safely. A member of staff explained that a soft diet was served to one person who previously had a healthy appetite but recently was losing weight. Another member of staff told us the action plan in place to support one person to leave the home without support from the staff.

People told us they had the staff responded to their request and where needed spent time with them. Staff said the team was small and where cover for vacant hours was needed, existing staff within the home and organisation were used. The staffing rota in place showed there was lone working at times throughout the day and at night. We saw the on-call procedures for staff to contact in the event of an emergency. This meant that staff were able to gain advise and additional support should aggressive incidents towards staff occur when they were lone working. The registered manager said new staff had been recruited and two staff were on duty at all times during the day. They said in extreme cases a second member of staff was able to sleep-in.

Good

Is the service effective?

Our findings

A member of staff said the organisation's induction included registration onto the 12 week care certificate. They said during their induction they shadowed more experienced staff while they "learnt how to work with people at the service". This member of staff said the shadow shifts helped them feel confident to work with people.

Another member of staff said the training provided by the organisations helped them fulfil their role and responsibilities. For example, fire safety, dignity and respect and sleep disorders. They said gaps in their training were discussed with their line manager and the appropriate training provided where there were shortfalls. The training programme of courses was available to staff every month throughout the year and included Health and Safety, personality disorders, infection control and diet and nutrition.

The supervision policy in place said the staff would have group supervisions during team meetings and on a one to one basis with individual staff. A member of staff said during their induction, one to one meetings were every eight weeks followed by three to four weekly.

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 be as least restrictive as possible.

People can only be deprived of their liberty so that they can 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). People living at the home were not subject to DoLS for continuous supervision.

People said they made their own decisions. One person said their preference was to stay at the home and have staff accompany them on shopping trips. Members of staff said people had capacity to make decisions. A member of staff gave us an example of when one person with capacity had made the decision not to keep an appointment for health screening.

Another person said they made their decisions but the staff managed the times when they had cigarettes. A member of staff explained that some people were supported to budget which included helping people to have sufficient supplies of cigarettes. They said some people's cigarettes were kept in the office and the person had agreed the times for cigarettes. For one person the signed "smoking" care plan dated 11 November 2013 and reviewed on 1 January 2016 indicated agreement with the action plan. For example, the person was to be "told to come back at the times agreed" should the person request a cigarette before the agreed times.

People with capacity to make decisions had signed agreements for specific actions. For example, cleaning

their bedrooms and taking their medicines. Medicine agreements described the expectation on the person to take their medicines as prescribed and the actions staff would take should the person refuse to take their medicines.

Members of staff said there were people who at times became verbally challenging. They said charts to identify triggers for specific behaviours were completed by the staff. A member of staff said when people became verbally challenging they were given space so as not to escalate the situation, and for staff to speak in lowered tones. Another member of staff said they separated people and advised them to "stay away "from each other when they became confrontational towards each other.

People's dietary requirements were met. The range of fresh, frozen and tinned foods at the home which ensured people were provided with adequate food and fluid to maintain good health. Menus on display included the name of the person that suggested the meals to be served. One person said they usually had toast for breakfast, sandwiches at lunchtime and a cooked meal in the evening.

People were supported with their ongoing health care needs. The people we asked told us they were accompanied on GP visits by the staff or by their relatives. One person said "I have a GP and the psychiatrist visits the home every six weeks. They explain the changes in medicines." A member of staff said "Some people will tell the staff they are unwell. Others will not recognise they are unwell. The staff observe people and take appropriate action". Another member of staff said people were asked if they wanted to be accompanied on their health appointments. They said before appointments were arranged people were asked for their preferred dates and times.

Good

Is the service caring?

Our findings

The people we asked said the staff were caring. One person said "The staff will help". Another person told us the staff reminded them about their agreement to participate in independent living skills routines.

Members of staff described the ways of working with people to make them feel they mattered. A member of staff said giving people choices, spending time and listening gave people a sense that they mattered. Another member of staff showed a good understanding on how best to approach people. They said some people responded to humour while others respond to negotiation.

We saw examples of good interaction between people and staff. We observed staff using the most appropriate approach to explain the consequences of people's actions. This member of staff discussed with the person the consequences of drinking alcohol. For example, "You need to keep it under control. Cut it down. You won't have your medicines if you have been drinking."

We saw staff respond appropriately to people who asked for cigarettes before the agreed times. Members of staff were respectful when they reminded people of their agreement and suggested the time they needed to return to the office for their cigarettes.

Support plans in place described the approach staff were to use to support each person. For one person we saw their life story was documented which included how the person spent their day and their preferred activities. A member of staff said support plans were written in language that people were able to understand.

People said the staff respected their rights. One person said they were independent and were provided with keys to the house and their bedroom. Members of staff gave us examples on how they respected people's rights. For example, ensuring people had keys to their bedrooms and to the home and respecting people who did not want to be disturbed when they were in their bedrooms.

People were told they were able to maintain contact with friends and family. One person said they had visitors and although they took place in the communal areas, they were able to use their bedrooms for additional privacy. Another person said they maintained links with their siblings and parent.

Good

Is the service responsive?

Our findings

The people we asked knew who to approach with concerns and complaints. For example, care coordinators or the staff. A member of staff described the procedure for making complaints. They said the nature of the complaint was discussed with the person and their desired outcome. This member of staff also told us people were helped to make formal complaints which may include assistance to write complaints letters.

The complaints procedure was on display in the office. The steps for making complaints were clearly described and included the external agencies that could be contacted if the complaint remained unresolved. However, the legislation referred to within the complaints procedure had been superseded. This meant the complaints procedure was not reviewed to ensure the correct legislation which applies to services registered with the Care Quality Commission was used.

Support plans were developed to reflect how people wanted their care and treatment to be delivered. Members of staff were aware of the actions needed when people were showing signs of deterioration in mental health. However, support plans were not developed for all the people with mental health care needs. A mental health support plans was in place for one person. The support plan detailed the symptoms of a deteriorating mental health, the events that may trigger any deterioration for example, changes to routines and the actions staff must take for example, spending time talking to the person and offering "when required" medicines.

People were aware that support plans were developed on how the staff were to meet their needs. One person said their support plans were "extensive," they "had read them and signed them." A member of staff said the registered manager took an overview of the support plans and the staff were expected to keep them up to date. Another member of staff said the expectation was on them to read the support plan although they had not read them all. They said more time was to be set for reading support plans.

Where risks were identified support plans were developed. For example, the risk assessment had identified an increased risk of paranoia if one person became "too isolated". The aim of the communication support plan was to support this person with socialising. The action plan was for the staff to encourage discussion on how they were feeling to discourage isolation and to ensure feedback from relatives was gained on potential signs of a deteriorating mental health.

The "eating and drinking" support plan for one person stated staff were to ensure the person was consulted on their menu choices as this person had refused to be served with a soft diet. A member of staff said for one month food diaries were completed to monitor this person's intake as they had lost weight. They said the person's care coordinator was contacted to discuss issues with this person. Staff recorded the meals eaten by the person such as roast lamb on Saturday.

The personal care support plan for one person described the agreements reached with the person, how the person wanted the staff to support them and manner staff were to use. For another person the support plan for personal care included their preferences with personal hygiene.

Staff said there was a handover from the staff on duty when shifts changed. A member of staff said there was "a lot of communication." They said at handovers oncoming staff were given information about the shift. This member of staff also said the day's events were documented and house diaries were used for appointments. The communication book was used to document events such as "when required" medicines were administered, the people who were not at the home and any visitors to the home. Initials were used to maintain confidentiality.

People told us they participated in a variety of activities. One person said they attended clubs and at weekend they went to watch footballs games. Another person said they participated in household chores, read and watched television. The third person described their programme of activities. A member of staff described the activities some people will participate in which include employment, joining groups and visits to the local shops. They said some people were supported by befrienders [volunteers, trained to provide support and companionship] to join in social groups to follow religious beliefs and to watch football games.

Good

Is the service well-led?

Our findings

The aims of the organisation included enabling people to exercise independence and as much self-determination, to be part of the local community and to access facilities. A member of staff said people were valued and there was a "personal approach, [staff were] honest with people and they were given choices". Another member of staff said "people have their characters, the care is friendly. We work in [people's] their home, they don't live in the workplace."

A registered manager was in post. The registered manager was not present during the inspection. Their comments were gained during telephone feedback on our findings. The registered manager said the key challenges were environmental, time management and training. They said providing specific office space was being considered for them to meet the demands of the role. A member of staff said the registered manager listened and "runs a good ship." Another member of staff said the registered manager appreciates when the staff go above their role expectations
Staff said the team was good and worked well together. A member of staff said the team was "good and there was a good blend of staff that have shared values". Another member of staff said the team was "stable" that worked well together.

Questionnaires were used to gather from people, their relatives and staff their views about the service. Four responses from people were received and generally people were positive about the standards of care and treatment.

Quality assurance arrangements included an evaluation of the service by area manager. Monthly visits to the service were conducted and reports on the findings and outcome of the visit were maintained at the service. We were provided with copies of the most recent visits to the service and this included people the area manger had consulted with and observations of the environment. Within the report the area manager described the actions to be taken for areas of risks to people. For example, one person not eating well was to be monitored for two weeks.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medication records were not always appropriately signed by the staff. Medication administration records (MAR) charts were not always signed when medicines were administered and on some occasions medicines were not administered but staff had signed to indicate that medications were administered.