Community Integrated Care

Penk Ridge 26

Inspection report

26 Penk Ridge
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19 February 2016

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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

This inspection took place on 17, 18 and 19 February 2016 and was unannounced.

26 Penk Ridge is a service managed by Community Integrated Care and provides accommodation and personal care for up to three young people with complex autism and behaviours that challenge.

26 Penk Ridge is located in a residential area, has four bedrooms, one of which is used for staff to sleep over night, a lounge/diner, kitchen, communal washroom facilities, one bathroom and an activity room. At the time of this inspection there were three young people living at the home. There were eight permanent staff, which included one senior support worker. The service also used bank staff that were employed by the provider and known to people living at the home.

People were safe at the service. Staff knew how to keep people safe from harm and had a good understanding of how to report safeguarding concerns. Safeguarding concerns were raised to the local authority and management plans had been put into place to protect people from the risk of harm. People's finances were managed safely.

Different types of risk assessments were in place for each person and risk management plans were implemented to ensure people and those around them were supported to stay safe. The service did not use restraint. Fire safety procedures were in place for the home and were followed to keep people safe.

There were sufficient staffing levels at the home, which were flexible to meet people's needs. Safe recruitment and medicine practices were followed.

Staff were experienced and knew people well. Staff received induction training in line with the Care Certificate when starting work at the home. Staff received regular supervision and one to one sessions.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how to put this into practice.

People were supported to have enough to eat and drink and meal times were flexible to meet people's needs. People regularly accessed healthcare services.

The service was caring and people experienced care that was compassionate. Staff treated people as individuals and encouraged them to do as much for themselves as possible. People's privacy and dignity was respected.

People received the care and support they needed, were listened to and had their choices respected. A variety of communication techniques were used to ensure people were engaged with and involved in making decisions about the support they wanted. People's needs were regularly assessed and reviewed.

Activities were personalised and meaningful.

People were given the information to tell them how to complain. Complaints had not been received about the service in the past 12 months.

There were clear visions and values in place and good leadership at the home. Quality audits were completed which supported the registered manager and senior managers to assess the overall quality of the home.

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

Staff knew how to keep people safe from harm and relatives felt people were safe. We observed people were happy and content with staff. There were enough staff on shift to meet people's needs and keep them safe.

Risk management plans were in place to manage people and risks and staff demonstrated a good understanding of protecting people.

Safe recruitment practice and medicine procedures were in place.

Is the service effective?

Good

The service was effective.

Staff received regular supervisions and training. Staff knew people well and could demonstrate an understanding of people's needs and how they liked to be supported.

Consent to care and treatment was always sought in line with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were in place.

People were supported to have enough to eat and drink and have access to healthcare services.

Is the service caring?

Good

The service was caring.

People experienced care that was caring and compassionate and staff treated people as individuals.

People were encouraged to do as much for themselves as possible whilst staff respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People received the care and support they needed, were listened to and had their choices respected. A variety of communication techniques were used to ensure people were engaged with and involved in making decisions about the support they wanted.

People's needs were regularly assessed and reviewed and they, their relatives and other health care professionals were involved in the reviews and assessment of their needs.

Activities were personalised and people were supported to carry out the activities they enjoyed.

People were given the information to tell them how to complain. Complaints had not been received about the service in the past 12 months.

Is the service well-led?

Good

The service was well led.

There were clear visions and values in place that staff were aware of and
they put these into practice when supporting people. Staff said management were "brilliant" and they felt supported to raise concerns about bad practice.

Quality audits were completed and safeguarding issues, incident reports and feedback on staff were also discussed and actions were put into place following these discussions.

Penk Ridge 26

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 17, 18 and 19 February 2016 and was unannounced. The inspection team consisted of an 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 reviewed the Provider Information Record before the inspection. We looked at notifications received by the provider. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with two people who lived at the home. The third person was staying with their relatives. The two people we spoke with were not always able to share with us their experiences of life at the home, due to their particular communication skills; therefore we also observed practice to see how they interacted with staff. We spoke with one relative, three support workers, one senior support worker, the service lead, who was the registered manager and the regional director.
We reviewed a range of records about people's care and support and how the service was managed which included support plans for three people and specific records relating to people's health, choices and risk assessments. We looked at medicine records for three people, daily reports of support including staff handover communication notes. We looked at information about what activities people liked to do and had planned to do, food choices and shopping lists, rotas, incident and safeguarding logs, complaints and compliments, health and safety records, cleaning rota's and service quality audits. We looked at recruitment and supervision records for four staff, training records for all eight members of permanent staff and minutes of staff meetings.

We asked the registered manager to send us information after the visit. This information was received.

The service was registered with the Commission in August 2013 and this was their first inspection.

Good

Is the service safe?

Our findings

People were happy and we observed they were comfortable and relaxed when being supported by staff. Relatives felt people were safe, treated as individuals and felt they could raise concerns about their relatives' care. One relative said, "[Relative name] is very safe there, I don't have any worries at all now. [Name] would not be in that home if I had any concerns at all."

Staff said they would keep people safe from harm by reporting any concerns to the registered manager. This included recognising unexplained bruising and marks or a change in behaviour. Staff had received training in safeguarding adults and had a good knowledge of the procedures they should follow if they had a concern. For example, one member of staff said, "I would report any concerns to the senior or manager, we also have a whistleblowing line we can contact at any time, failing that I would contact social services, the police and Care Quality Commission."

Safeguarding concerns raised were reported by management to the local safeguarding authority However, the Commission was not always notified. For example, two safeguarding concerns had been raised in March 2015, one on 6 March 2015 and another on 26 March 2015. Both concerns had been reported by management to the local safeguarding authority; however the Commission had only be notified of the safeguarding concern from the 26 March 2015. The registered manager stated they had not notified the Commission of the concern raised on 6 March 2015 as the local safeguarding authority had advised them that this concern did not constitute a safeguarding concern. However the regional director was aware that the Commission should be notified of all allegations of potential abuse and stated they would look into this matter. Management plans had been created following outcomes of safeguarding meetings and all staff were aware of the management plans in place for the people they supported.

Systems were in place to ensure that people's monies were managed safely. Mental capacity assessments had been completed for each person regarding their finances. People's money was kept in individual containers and in a locked safe in their rooms. When people went out and took money with them it was counted out and back in to their individual container and checked each day by staff. We observed this practice being carried out.

Risk assessments were completed for each person which identified risks to themselves and others. Risk management plans were implemented to ensure people and those around them were supported to stay safe. For example, one person's risk management plan identified they would become aggressive toward staff and others if their routine was interrupted. The plan identified that a chart had been put into place for the person to show staff when a routine had finished. We observed this person carrying out their routine during the inspection and observed positive interactions between the person and staff.

Risk assessments were in place for people who experienced behaviours that could be seen as challenging. All staff knew the signs and triggers to look for when a person experienced such behaviours and were confident they could manage the situation without the use of restraint. For example, one staff member told us the different types of behaviours people could display and how they would manage the situation, they

said, "Depends on the person's mood and body language, I take each incident on its own merits, stay calm and follow the person's guidelines of behaviour."

The registered manager and staff confirmed restraint was not used in the service as staff were trained in the Management of Actual or Potential Aggression (MAPA). This training would enable staff to safely disengage from situations that present risks to themselves, the person or others without the use of restraint.

During our inspection we observed fire safety procedures were displayed in the hallway. Fire exits were clearly marked and the pathway was clear to access them. All fire equipment had been tested regularly and in line with the provider's policy. We noticed a protective cover had been placed over one fire alarm and the senior support worker informed us this was due to one person living at the home removing tags from the extinguishers. There was a plan in place for a trained staff member to become a fire warden and they would be the designated lead responsible for ensuring fire safety procedures were carried out safely. The front door and inside door was locked with a key, there was a key for use in emergencies in a locked box with breakable glass by the front door.

There were enough staff on shift. Relatives confirmed this. Staff told us there were enough staff on shift as long as staff were not sick. Staff and management confirmed bank staff were used in the event of the service being short staffed due to planned or unplanned leave; however the majority of the time shifts were covered by permanent staff. This was confirmed by the staffing rotas. The service used Community Integrated Care supply of bank staff to cover shifts. These staff had undertaken the same recruitment process as permanent staff and were familiar with people living at the home. Staff confirmed when bank staff were used they were always known to the person and supported by a permanent member of staff to make sure they were aware of the person's updated needs.

There was a system in place to ensure there were enough staff at all times and the support was flexible to ensure people received the support they needed. The registered manager and regional director confirmed they divided the total number of support hours by the amount of permanent staff and an electronic rota was used to log all the support hours provided. Two staff members were present on each shift, however on occasions an additional staff member would be present because one person did not leave the home and required one to one support. One staff member slept overnight at the home. The service lead confirmed all three people required one to one support in the home and out in the community, sometimes two to one support was required in the community dependent on the activity and how the person was feeling. We observed one person being supported by two staff members to access the community on the first day of our inspection and one staff member remained at the home to support the other person. Set activities were built into the rota which were reflective of the personal interests of people and there was flexibility for people to be supported with daily activities.

Safe recruitment practices were followed. We looked at four staff members' recruitment files and saw the appropriate steps had been taken to ensure staff were suitable to work with people. All necessary checks, such as Disclosure and Barring Service checks (DBS) and work references had been undertaken. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

There were clear procedures for supporting people with their medicines. Relatives confirmed they did not have any concerns with how the home managed people's medicines. One said, "They manage it (medicines) very well." The medicines were kept in a locked cupboard in people's rooms and only staff that had been trained and confirmed as competent by the service lead were able to support people with their medicines. Staff members demonstrated a good understanding of safe storage, administration, management,

recording and disposing of medicines. People who required PRN (as required) medicine were given these medicines when they required them.

Checks were completed daily by staff that were trained to support people with their medicines. Weekly and daily medicine audits were also completed by the management team which included checking for gaps in Medication Administration Record (MAR) sheets and any medicine errors. One medicine error had been identified by the management team and incident reports had been completed which detailed the reason for the error and what action had been taken to remedy them and prevent re-occurrence.

Good

Is the service effective?

Our findings

Relatives were positive about the support people received. One relative told us staff were experienced and knew their relative well because they had been working at the home for a long time.

Staff received an induction when starting work at the home. This induction programme included the completion of required training and working with an experienced member of staff to watch and learn communication techniques and understand people's needs. Staff would also read people's support plans. New staff were subject to a three month probationary period in which their performance was reviewed at regular intervals. New starters had completed the Cavendish Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. The Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff had received regular supervision and one to one sessions from the senior support worker and the senior support worker had regular supervision and one to one sessions with the service lead. The supervision sessions gave staff the opportunity to discuss people and identify additional support for themselves. One to one sessions were used as an opportunity to discuss performance issues with staff and support them to improve. Staff confirmed they felt supported and could request any additional training that would help them meet the needs of people. The service lead had a training plan in place which identified when staff had completed training and when the training was due to be updated. The training plan also included details of staff who did not attend the training and the reason why and there were clear records to show that the training sessions had been rebooked and completed by staff.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how to put this into practice. For example, staff confirmed that people could consent to most decisions concerning their day to day support by using communication techniques individual to the person to help them make a decision. However staff confirmed that all three people living at the home could only access the community with support because of the risk to themselves and others. As a result locks had been placed on the front doors and back door to prevent people from leaving the home unsupported.

Mental capacity assessments had been completed when people were deemed to lack capacity and a decision needed to be made concerning a person's wellbeing or finances. Best interest decisions had been carried out and appropriate professionals, advocates and relatives had been consulted. We saw mental capacity assessments had been completed for people to support them with finances and medicines. A mental capacity assessment and DoLS application had been completed and authorised for all three people with regards to the locks on the doors.

People were supported to have enough to eat and drink and meal times were flexible to meet people's needs. Relatives and staff confirmed they felt people were given a choice and were involved in decisions about their meals. We observed people were given a choice of meal and could eat their meals at times that suited them. For example, over the course of our three day inspection we observed one person have breakfast and lunch at different times during the day dependent on what time they chose to get up in the morning. People would be supported to make their meals and write a shopping list each week to indicate what types of food they would like for their meals. We often heard people ask for a specific meal and this was given in line with their preferences. Drinks were offered regularly and staff supported people to make their own drinks.

People's plans documented what types of food they liked and disliked and whether they had any food allergies. We saw in one person's plan that they enjoyed eating healthy food and would take a healthy packed lunch with them to college. Staff confirmed this person was on a healthy eating plan due to health related concerns and this person was supported to choose healthy options from the supermarket and have them for their meals.

One person's support plan identified they could be at risk of malnutrition because of their condition. This person would use a lot of energy throughout the day by walking at a fast pace around the home as part of their routine. The routine would continue for as long as the person needed it to; however if the routine was interrupted the person would have to start the routine again. This could have an effect on if and when the person would eat and drink, as they would not start another routine until they had finished their previous routine. Plans were in place for staff to manage and support the person with having sufficient food and fluids throughout the day. We observed this practice.

People regularly accessed healthcare services. Relatives confirmed people accessed health care services. One said, "I know that [name] gets to see their GP when necessary as the home will call and tell me if they are not well and if they have had to call the doctor." People's activities for the week were recorded on a white board in the kitchen. We saw that one person was taken to the dentist on Monday 15 February 2016. Notes were present in people's support files which demonstrated when they were taken to; or visited by a health care professional. The visitors log showed regular visits from healthcare professionals such as speech and language therapists and occupational therapists.

Referrals had been made to other appropriate healthcare professionals when required such as learning disability nurses to update a person's epilepsy profile and intensive support teams to discuss a person's behaviour.

Good

Is the service caring?

Our findings

Relatives were positive about the care and support received by staff. One said, "The staff are very caring, they are always there for you."
We observed positive and caring interactions between members of staff and people. Staff spoke to people in a kind and respectful manner and people responded well to this interaction by smiling or responding verbally using words or happy sounds. One relative had commented in a survey that, "The staff of Penk Ridge are brilliant, very friendly and professional."

People felt at ease and comfortable with staff. For example one person would frequently laugh and have a friendly joke with staff members and felt comfortable to sit at the dining table drawing or completing a puzzle with them. Another person would respond to staff with a smile or sit next to staff on the sofa.

People were treated as an individual and encouraged to do as much for themselves as possible. Staff said this was the person's home and they always asked people what they wanted to do and how they wanted to be supported with their care. One said, "Offer assistance where people want it. Let them do what they can and support with what people find difficult." For example, we observed a person taking their clothes to the laundry with a member of staff, making some cakes and accessing the community with the activity of their choice and another person completing their daily routine without any interruptions from staff.

Staff would use different communication methods to support people to make a choice. Two people in the home could communicate verbally. One person did not communicate verbally and would use hand signals, facial expressions and body language to communicate with staff. The Picture Exchange Communication System (PECS) was also used as a communication tool to ensure this person was given the support to clearly communicate their needs and wishes. Relatives confirmed people were always involved in their care planning particularly making decisions about what they wanted to do and wear on a day to day basis.

We observed that people were free to move around the home, one person would go upstairs to their bedroom for a time out if the home became a bit too noisy for them and come back down stairs when they felt ready. We observed another person liked to sit on the sofa with their iPad.

Staff confirmed they would respect people's dignity and privacy by closing doors, knocking before entering the person's room and informing them what they are going to do before supporting them with personal care or other support tasks. One staff member said, "When I am supporting [name] with a bath, I will always inform other residents that the bath will be in use, so no one walks in. I ensure the person walks to the bathroom in their dressing gown and closes the bathroom door."
We heard staff asking if they could come in before entering a person's room.

Good

Is the service responsive?

Our findings

People's needs were regularly assessed and reviewed by staff and people together.

Staff knew about the people they were supporting. Staff gave us examples of how they supported people differently according to their needs. For example, one person liked rock climbing and trampoline and would be supported in the community with this activity at least three times a week. An additional support worker was employed to support this person with these activities and we observed this support worker visit the home and support the person out in the community. Another person attended college and stayed with their family on a regular basis. All people needed different levels of support with their personal care and staff demonstrated a good understanding of these needs.

All people had individual support folders which contained support and health plans and risk assessments. People's support plans were individualised and personalised. The support plans were very detailed and included a one page profile which included what was important to the person, what do people like and admire about the person and how best the person can be supported. For example, one person's one page profile stated they required regular communication from staff to tell them about changes in the home, such as opening and locking doors and whether visitors would be coming to the home. This was to help support the person from becoming anxious and displaying behaviours that could challenge. We observed on regular occasions staff informing the person of what they were doing and staff would make sure the person was informed of the times the inspector would be visiting the property over the three day inspection of the home. As a result the person remained happy, calm and relaxed throughout the inspection process and did not display any signs of behaviour that could be challenging.

The service lead and staff confirmed families and other professionals were involved in gathering information about people and records confirmed this. Regular observations of people's behaviours and interactions were used to develop the support plans and risk assessments over time. Reviews of care plans were completed. The service lead told us they had implemented a key worker role which included reviewing people's support plans. Staff we spoke with confirmed this had been discussed with them and they were aware of the responsibility of this role.

People were able to communicate by speaking or making sounds and noises or by pointing to an object, person or picture and using body language. Different communication techniques and tools were used with different people to encourage them to openly communicate their thoughts, feelings, likes and dislikes, choices and decisions. Communication books and handovers between shifts were used to communicate any information amongst staff about each person for that day, such as healthcare appointments, activities and additional requests for staff to review peoples' care plans and risk assessments.

Activities were personalised and people were supported to carry out the activities they enjoyed. One person attended college, stayed with their parents regularly and took part in outdoor activities to help keep them healthy and active. Another person liked going to the gym and was supported in the community by an additional support worker who was known to them. This person also liked to play on their iPad in the lounge

and we observed this activity. A third person did not like to go out in the community because this made them anxious. A support plan was in place to help encourage this person to take part in meaningful activities within the home at times that would suit their routine. For example, this person's support plan identified they would more likely engage in activities at certain times of the day and if they were given two choices of activities. The support plan indicated that staff should give the person 15 minutes to respond and the person should start the activity. We observed this person drawing and completing a puzzle with staff after staff used this technique. The home had an activities room which was full off games, sensory equipment and a number of different types of puzzles.

The service lead stated they were reviewing the current style of support plans as a new initiate called 'The Golden Thread' was being implemented in the service. The aim of the Golden Thread was to support the provider to become a 'deeply' person – centred organisation with the principles of personalisation sewn into the fabric of the organisation. The new support plans would introduce goal and outcome setting and support would be tailored to support people to take control of their lives and the support they received. The service lead stated that this has been launched within the service and the first of the support plans is being reviewed.

Relatives confirmed they had never needed to make a complaint about the service. However they felt confident to express concerns and if they had any issues they knew who to complain to and would be confident that the concern would be dealt with. The service lead said they had received two complaints since being in post but complaints had not been received in the past 12 months. The complaints folder documented that two complaints had been received into the service since they registered with the Commission in August 2013. These complaints had been dealt with and resolved in line with the provider's policy. There had been no recorded complaints about the service in the past 12 months.

We saw the complaints procedure and folder was displayed in each person's room informing them on how to make a complaint. The complaint procedure was written in an appropriate format, which included pictures. Staff and the service lead were confident that people knew how to make a complaint.

Good

Is the service well-led?

Our findings

There was a registered manager in place, who was known as the service lead but they were on annual leave when the inspection was taking place. However the service lead did meet with us on the second day of the inspection. One relative said, "It [the service] seems to be well managed; we've never had any problems."

The service lead had a good knowledge of people's needs and personalities and interacted well with them. They demonstrated a good understanding of their role and responsibilities and were proactive in identifying development needs for themselves and the service. For example, the service lead was planning to complete a level 5 Diploma in management.

The service lead said they had an open door policy and were approachable to staff. However the service lead also managed two other homes and was only present at the service two days a week. There was a senior support worker who was present at the service most days and staff felt well supported by both the senior support worker and the service lead. One staff member said of the management and leadership of the service, "Brilliant, I've always had 100% support." Staff meetings took place at regular intervals which gave staff and the service lead the opportunity to discuss customer focus, workforce, quality, culture, change and any other business.
The service lead was supported by a regional manager, who was not based at the home. There was an out of hours on call system run by the provider in place for both service lead and staff if they needed additional support.

There was a clear vision and a set of values that involved putting people first. The service lead said the organisation had rebranded last year and introduced a value statement which was, "People, Passion, Potential." The service lead said this also included equality, diversity and promoting independence. They said, "This is people's home and staff are aware that everything they did must be about the person." Staff were aware of the visions and values of the home and put these into practice when supporting people. We observed these values being put into practice at the home during our inspection.

Staff were supported to question practice and they demonstrated an understanding of what to do if they felt their concerns were not being listened to by management. Staff said they would speak with the police, local authority and Commission. Staff stated they had every confidence in the service lead and senior support worker to deal with any concerns.

There was a system in place to analyse, identify and learn from incidents, and safeguarding referrals. Members of staff told us they would report concerns to the service lead or out of hour's regional managers and follow this up in writing. Incidents and safeguarding referrals had been raised to the local authorities. Management plans had been developed to help learn from incidents that had taken place and manage people's behaviour that may challenge others.
A number of audits had been completed to assess the quality of the home. Service Quality Assessment Tools (SQAT) had been completed by the service lead in March 2015 and were required to be completed annually. The service lead and regional director confirmed a new SQAT would be completed in March 2016. The SQAT

helped identify areas of improvement for the service in the following areas; support planning, risk assessment, nutrition and healthcare, communication and decision making, health and safety, medication management, environment, safeguarding, leadership, staffing and training and quality and complaints. Once completed an action plan is developed highlighting the areas that require improving, who is responsible for implementing the improvements and the timescales. This information is then sent to the regional managers who will visit the location and sign off the SQAT once the action plan has been met.