Norwood

Blenheim Avenue

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

This inspection took place on 12 April 2016 and was announced. We gave the registered manager 24 hours' notice prior to the inspection. This was because the service was small and we needed to ensure that they were available during our inspection.

Blenheim Avenue provides supported living and community based domiciliary care services, particularly to support people with learning disabilities from the Jewish community to live as independently as possible.

At the time of the inspection the service was providing support to 20 people who live in their own home. This location covers a number of accommodations across Redbridge using both Blenheim and Southwood office hub for staff to work from. Supported living is where people live in their own home and receive care and/or support in order to promote their independence.

There was a registered manager in post and they were present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service has a registered manager in place and a team leader who has overall day to day responsibility for the service.

People felt safe using the service. They were protected from the risk of abuse because the staff were trained in safeguarding adults and the provider had systems in place to minimise the risk of abuse.

People were supported by staff who were kind and caring and knew them well. People were treated with dignity and respect by staff who understood their needs well. Staff received the training and support they needed to carry out their role.

Staff had a good understanding of risks associated with people's care needs and knew how to support them to be independent.

There were enough staff to support people safely. The organisation had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Medicines were stored and administered safely. People were supported to take their medicines by staff as prescribed. People were supported to have their healthcare needs met.

The team leader and staff understood the principles of the Mental Capacity Act 2005 (MCA) and supported people in line with these principles.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs.

Care records contained evidence of visits to and from external health care specialists.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

The service had links with community services and other local organisation. The service had a positive culture that was person-centred, open and inclusive. The provider had a robust quality assurance system in place. People who used the service, family members and staff were regularly consulted about the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were protected from abuse and avoidable harm because the provider had effective systems in place to protect people.

Risks to people were assessed. Staff understood how to keep people safe.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective. People were supported by staff who had received appropriate training to help them carry out their role.

People were supported to access a variety of healthcare services to maintain their health and wellbeing.

People's human rights were protected because staff were aware of their responsibilities regarding the Mental Capacity Act.

Is the service caring?

Good

The service was caring. The staff approach was one of enabling people to achieve and be as independent as possible.

We observed staff had an easy rapport with people and they trusted and confided in staff.

People were supported to maintain their dignity and were treated with kindness and respect by the staff.

Is the service responsive?

Good

The service was responsive. Care was delivered in a way that met people's individual needs and preferences.

People were supported to take part in activities that they enjoyed and were important to them.

Systems were in place to ensure that concerns and complaints

were taken seriously and acted upon.

Is the service well-led?

Good

The service was well-led. There were effective service improvement plans in place.

The quality assurance systems in place meant the service was continually reviewed including safeguarding concerns, accidents and incidents, and complaints and concerns.

The organisation had a clear set of values that included person centred approaches, which were understood and promoted by all staff.

Blenheim Avenue

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 announced inspection took place on 12 April 2016. 24 hours' notice of the inspection was given because the service is small and we needed to ensure that the manager and team leader were present during the inspection. The inspection was conducted by one adult social care inspector.

Before the inspection, we asked the provider to complete 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. They returned the PIR and we took this into account when we made the judgements in this report. We also reviewed all of the information we held, including feedback from people who use the service and their relatives and notifications of events affecting the service that the provider must send us.

During our visit we spoke with four people who used the service, two relatives and one advocate. We spoke with three care workers, the registered manager and the team leader.

We reviewed three people's personal care and support records and looked at two staff personnel records. We checked records relating to the management of the service such as audits, staff training and supervision records, staff rotas and complaints records.

Good

Is the service safe?

Our findings

People told us they felt "safe" when supported by the staff and at the service. Family members told us their relatives were "very safe" and "I don't have any concerns."

Staff had been trained in safeguarding adults and were aware of their duty to report any concerns to their team leader. One staff member said, "I would tell the team leader if I had any concerns." Staff told us that safeguarding people was on their team meeting agenda and were aware that they could raise/ discuss any issues with the team leader and the registered manager. We saw that safeguarding incidents had been appropriately investigated and referred to the relevant agencies, including notifications being sent to CQC.

A whistle blowing policy was in place and staff were aware of this and knew the process to follow if they had any concerns. Whistleblowing is a means of staff raising concerns about the service they work at.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff in order to make sure they were suitable to work with people who used the service. This included Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passport, driving licence and birth certificate.

There were enough staff to meet the needs of the people who used the service. We discussed staffing levels with the team leader and looked at staff rotas. Staffing levels were based on the contact hours for each person who used the service and as some people were more independent than others, this varied across the service. We also saw a copy of the management on call rota. Any staff absences were covered by the service's own permanent and bank staff who knew the people who use the service, for continuity of care. Staff, people who used the service and family members did not raise any concerns regarding staffing levels.

Risks to people were assessed and plans were in place to minimise them. People were assessed in areas such as safety, cooking, behaviours, travel and finance. Where other particular risks arose, these were also assessed. Staff knew how to support people in a variety of situations including managing health conditions such as epilepsy and diabetes, diet and nutrition, bathing and accessing community facilities. For example, staff had done extensive work with a person who had diabetes around making appropriate food choices on a daily basis when buying and preparing food and when eating out. One person said, "I know about risks, like not talking to strangers, being careful when crossing the road, plugs and kettles in the kitchen." Risk assessments were reviewed every two months or more frequently if needed so that people were enabled to remain independent and protected from risk of harm or injury.

Staff knew how to report accident or incidents so that these could be managed effectively. Records showed that staff and people who used the service had completed fire safety and first aid training. There were plans in place in case of an emergency, such as fire. People explained the process stating what they had to do. They explained that they would call for help if there was fire and pointed out where they would gather outside.

Appropriate arrangements were in place for the administration and storage of medicines. Assessments and relevant risk assessment were carried out to decide whether a person was able to self-administer medicines. Where required, people were supported by staff (who had completed medicine administration training) to take their medicines. Each person kept their medicines and medicine administration records in their own room in lockable cupboards. Protocols were in place to ensure staff were provided with the information they needed so that medicines were administered safely to people. Appropriate records were maintained to ensure that people had received their medicines.

The team leader carried out audits to ensure staff safely supported people to take their medicines. They were correctly ordered, stock checks, medicine expiry dates and administration records. New staff received a medicines competency assessment to ensure medicines procedures were being followed and that medicines were being administered safely.

Good

Is the service effective?

Our findings

People said they were, "Very happy with the staff" and "There is always someone around to help us." Family members told us, "They are very good."

People were supported by a consistent staff team who had the necessary skills and knowledge to meet their assessed needs. We looked at the provider's training matrix and staff training records. Statutory training included safeguarding adults, privacy and dignity, first aid, food hygiene, moving and handling people, equality and diversity and the Jewish way of life.

Staff told us they had an induction when they started working at the service and had worked alongside more experienced staff before they began to work independently. They said that the induction and further training had provided them with the knowledge they needed to meet people's needs safely and effectively.

Staff were able to meet people's specific religious and cultural needs (meeting the needs of people from the Jewish community) as a result of the training provided by the organisation. The team leader told us all new staff were also enrolled on the Care Certificate training. The Care Certificate is a standardised approach to training for new staff working in health and social care.

People were supported by staff who received effective support and guidance from the managerial team. Staff told us that they received good support from their team leader. This was for both day-to-day guidance and individual supervision (one-to-one meetings with their line manager to discuss work practice and any issues affecting people who used the service). Systems were in place to share up to date information with staff including staff meetings, visits to the office or via the telephone.

We looked at how the service was meeting the requirements of the Mental Capacity Act 2005 (MCA). The 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. We checked whether the service was working within the principles of the MCA.

Systems were in place to ensure that people's legal and human rights were protected. Staff had received MCA training and were aware of people's rights to make decisions about their lives. People who used the service had the capacity to make decisions about the level of support they received and were encouraged by the staff and supported to do this. We saw that people had signed their care plans and other documents indicating their knowledge of and agreement with these. The team leader was aware of how to obtain a best interests decision when needed.

Consent had been obtained from people who used the service for the administration of medicines, receiving personal care and support, sharing of information and management of money and correspondence.

Staff had attended food hygiene training but were not directly involved in meeting people's nutritional needs. However, they provided advice and support to people around planning menus, shopping and meal preparation. For example, healthy food and nutrition advice was provided to a person who had diabetes.

People who used the service had access to healthcare services and received on going healthcare support from staff. They attended health care appointments with people if needed and provided information about any health concerns, including advice and support about epilepsy, diabetes and behaviour management. Records were kept of GP, dentist, optician and hospital appointments. There was a record of important information about the person to be given to hospital staff when attending appointments or on admission to hospital.

Good

Is the service caring?

Our findings

People who used the service and family members were complimentary about the standard of care at Blenheim Avenue. Family members told us "I have no concerns about the care [my relative] receives" and "I know there will always be someone there to support [my relative] when I am not here."

People were well presented and looked comfortable with staff. We saw staff talked to people in a polite and respectful manner. People confirmed that staff listened to them. We saw staff knocking before entering people's flats and doors were closed behind them to respect people's privacy. The team leader asked people if they wished to talk to us about living at Blenheim Avenue and if we could look at their records. They all agreed to this request.

We saw that staff treated people with respect and took steps to maintain their dignity. The team leader and staff told us that treating people with respect and dignity formed the basis of all the training provided to staff. This informed staff that people who used the service had a right to be treated with dignity, be treated courteously and as individuals, be listened to and be as independent as possible.

Staff knew how to support people and understood their individual needs. People told us of household tasks that they undertook, for example, cooking, cleaning, laundry, checking water temperatures and fire safety checks. They travelled independently to undertake activities. This meant that staff supported people to be independent and people were encouraged to care for themselves where possible.

We saw that equality and diversity was promoted with staff and discussed at meetings and development planning sessions. People's religious and cultural needs were met with staff having received specific training about 'The Jewish way of Life' in order to meet their specific needs. However, whilst the service upheld Jewish cultural values, people could make decisions about how involved in this they wished to be. One person told us of attending and celebrating specific Jewish events but chose not to attend the Synagogue regularly. These choices were documented within their care plan. A relative told us, "The staff always know when there is a Jewish festival and encourage [my relative] to celebrate it."

Plans were in place to record people's end of life care preferences. Details included what the person would like, who they would want there and what they would like to happen.

People were enabled to make informed decisions about their lives. We saw that easy-read information was available to help people understand key documents such as care plans and a recent survey about the quality of the service.

Good

Is the service responsive?

Our findings

People were complimentary about the service they received. They told us, "Very happy" and "Yes, I like it here. The staff are always here to help us if we need them."

Care planning was person centred. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to them. Each person had a care plan in place for a number of different areas, including activities, domestic skills, finance, healthcare, medicines, personal care, relationships and social networks. Care plans also highlighted what staff would need to do if a person was becoming anxious or showing behaviours that challenge.

Information about the person's life history contained things that were important to them, such as particular events or family information. This allowed staff to familiarise themselves with that person's personal preferences. Care plans were reviewed annually but updated whenever there was a change in a person's needs. For example, one person's 'health' care plan had been updated following a visit to their doctor regarding concerns about their diabetes. Their risk assessment had also been updated following recent concerns about their ability to handle their finances independently. This was done so that staff were aware of people's current needs and preferences.

Once a care plan was reviewed this was discussed again with the person and at staff meetings to make sure everyone agreed with the change and were aware of it. Daily notes recorded how a person had been that day or night, any appointments they had or were to attend and any updates.

Each person had their own keyworker. Key workers supported people to get involved with the community, made sure they had everything they needed such as clothes and toiletries. People we spoke with were able to identify their key worker and spoke positively about them.

Staff told us how they promoted independence and built people's self-esteem. For example, they assisted and encouraged one person who worked at a major department store and another who worked at a charity shop. Assistive technology was used to enable people to live as independently as possible. For example, one person was reminded that it was time to take their medicines by the use of a phone alarm. Staff were alerted by the same system if the person failed to take their medicine, which would require a response from them. Another person was enabled to keep in contact with their parent and sibling by installing their photographs on the system so they recognised their faces to make the call. Others used a tablet computer to plan menus and make shopping lists.

People accessed activities of their choice. Different activities took place such as independent living and social skills, leisure and social events and hobbies and interests. This included taking part in social events linked to the community club they belonged to and also a wide range of leisure and social activities. People told us about how staff had supported them to attend a local adult education college. One person told us, "I go to [the college] to do English and maths, I love it." They also told us that they had been involved in staff recruitment and had been asked to make suggestions about suitable questions to ask during the interview.

They had enjoyed their involvement in the process.

Staff told us that they recognised the importance of social contact. They supported people to maintain friendships and relationships. They helped people to visit family members and supported them to take part in family events. We found that staff were person centred in their approach and all the planning was based around the likes, needs, interests and their knowledge of the people they were supporting.

A relative told us, "They are very helpful and always there if we need them and not just for [my relative] but for me as well. They help [my relative] to stay independent in the flat, to keep it tidy and also with cleaning and ironing."

There was a policy in place for managing complaints. There was a pictorial complaints procedure available and "Something to say" cards to express any concerns. People were aware of these. The complaints policy set out what would constitute a complaint, how it would be investigated and the relevant time frames for doing so. It also contained information about external bodies that people could talk to if they were dissatisfied with the service's response. An advocate who represented a person who used the service spoke very highly of the staff and the team leader saying "The staff and the team leader always listened, are open to suggestions and know how to deal with the challenges in a person centred way."

One person told us that they would speak to staff if they were not happy about something. A relative told us, "I couldn't fault them. I have absolutely no concerns. They are really good and keep me informed and involved with [my relative's] care." Relatives told us that they would raise their concerns with the team leader if they needed to but had not needed to raise any concerns.

Records showed that there was a system for recording and investigating complaints and to identify any emerging trends. This information was passed onto senior managers within the organisation to scrutinise and to make improvements.

Good

Is the service well-led?

Our findings

All of the people we spoke with and their relatives told us that the service was well run and that the team leader and registered manager were "always approachable and very professional." An advocate told us, "Very impressed with the team leader and staff. They always listened to me and kept me updated."

Audits were regularly undertaken to assess and monitor the quality of the service. We saw that weekly and monthly audits were carried out by both staff and the team leader. For example, staff carried out a weekly medicines audit on stock levels. The team leader also completed a series of audits once a month. These audits covered areas such the 'experience of the service user', care plans, medicine management, health and safety and the environment.

The adult services manager has operational oversight and carried out a quarterly audit and the project manager carried out an annual audit and compliance check. All audits produced an action plan with dates of when remedial action had to be completed by and who was responsible. The action plans were checked before the start of the next month's audit. This meant that the registered provider was analysing information about the quality and safety of the service.

The registered provider sought and acted on feedback from people who used the service, staff and professionals. The quality assurance surveys we saw were all complimentary of the staff and the service delivery. In reply to a question about any changes required, a relative commented, "Norwood support staff do a wonderful job of supporting [my relative] and I have no complaints about their service whatsoever."

Staff told us they felt supported by the team leader. One member of staff said, "[The team leader] is very approachable and very supportive." Another said, "You can go to [the team leader] if you have any issues and they deal with it straight away."

Staff confirmed that they were kept updated about any changes to the service during monthly staff meetings. They had an opportunity to contribute to the agenda and felt listened to.

The service had a clear vision and set of values that included honesty, involvement, compassion, dignity, independence, respect, equality and safety. These were understood and consistently put into practice by the registered manager and the staff. The service had a positive culture that was person-centred and empowering. The team leader told us "We all know really well all the people who use the service and they are at the centre of everything we do."

The team leader completed returns for the provider in relation to key areas including incidents and safeguarding. Representatives from other parts of the organisation also visited the service to monitor, check and review the service and to ensure good standards of care were delivered. The law requires providers send notifications of changes, events or incidents at the home to the Care Quality Commission and they had complied with this regulation.

The team leader informed us that people were members of a user group forum that was involved with shaping the future of the organisation and advice on policy. One of the people we spoke with told us that they were involved with the group.

All the people who used the service had a tenancy agreement in place. People's homes were owned by a landlord separate to the care provider. The team leader told us that they had regular contact with the landlord and would raise any issues that needed to be addressed with them.