MacIntyre Care

Asquith 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

The visit took place on the 28th of January 2016 and was unannounced.

Asquith House provides accommodation and care for six adults with a learning disability. It is set in a residential area of Chester, close to local amenities and the city centre. All six bedrooms are single and five of them have en-suite showers and toilets. There is one communal shower/bathroom/toilet on the first floor and a toilet on the ground floor. There is a lounge and a dining room on the ground floor. The garden at the back of the home provides a well maintained area.

The service had a registered manager 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. The registered manager was on sick leave during our visit yet the registered provider had appointed an interim front line manager from within the staff team to run the service in the Registered Manager's absence. The interim manager was present during our visit.

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People who used the service told us that they were happy living at Asquith House, felt safe and considered that staff cared about them. This was reinforced by observation of the care practice provided to two people who were present during our visit.

Staff explained to us what they would do to keep people safe and how they protected their rights. Staff had been provided with training and showed an understanding about safeguarding adults from abuse, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff practice was focussed completely on the needs of people and this was delivered in a friendly yet dignified manner. People had full access to other medical services as well as advocacy when required.

There were opportunities for people to take part in group activities but they were also encouraged to develop personal interests and this was evident throughout the building and through individual discussions.

Staff protected people from the risks associated with poor nutrition and hydration as they encouraged people to eat and choose a balanced diet. Staff ensured that people were able to eat independently but with discreet supervision to ensure that this was done safely.

Records that we looked at were comprehensive and kept up to date. Support plans contained detailed information on each person and how their care and support was to be delivered. The information was regularly reviewed with the person who used the service and significant others. Care plans were presented in

a format that was appropriate to the communication needs of each person. This meant that people received personalised care in line with their wishes and preferences.

People were supported by staff who were well trained and regularly supervised. The service was run by a registered manager and registered provider who were open and transparent in their practice, responsive to the views of staff and people alike and monitored the quality of care in an objective and transparent manner.

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 who used the service told us that they felt safe living at Asquith House.

Staff demonstrated a commitment and a good understanding of protecting people from harm.

The premises were clean, hygienic and well maintained.

People were protected by the review of risk that they faced in their daily lives.

Medcines management was safe and promoted the well being of people who lived there

Is the service effective?

Good

The service was effective.

Staff received the training and supervision they required to meet the needs of people.

Communication between team members was good and fostered positive teamwork which provided a good outcome for people who used the service.

The rights of people are protected through the provider's knowledge of the mental capacity act and other safeguards

Is the service caring?

Good

The service was caring

People told us that they felt that the staff team cared about them and listened to them.

People were involved in the running of the service and in making decisions about their own lives

The privacy and dignity was maintained through staff practice.

Is the service responsive?

Good

The service was responsive.

Care plans were very person centred, detailed and relevant to the needs of each person.

People are able to pursue their own preferred activities with staff support.

Information on how to make a complaint was in an appropriate format and demonstrated a wish for the registered provider to listen to and act upon complaints made.

Is the service well-led?

Good

The service was well led.

People who used the service were happy with the support they received which suggested that the management of the service was focussed on meeting their needs with positive outcomes for them.

The staff team considered that the interim manager and registered provider were supportive and responsive to the needs of people.

The management of the service and the registered provider demonstrated a clear understanding of the requirements made of a registered service.

Asquith 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 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 the 28th of January 2016 and was unannounced. The inspection team consisted of one adult social care inspector.
We last inspected the service on 11th of June 2014. At that time the registered provider had met all of our standards.

Before our visit, we reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at four care plans and other records such as staff recruitment files, training records, policies and procedures and complaints files. We had requested a Provider Information Return (PIR) . A PIR is a document which enabled the registered provider to comment on how the service was operating in line with the five questions we ask of any service. The registered provider had received our request to complete this yet the deadline for return had not arrived. The interim manager confirmed that they were working through this at that time.This contained information on how the registered provider maintained a good standard of care.

We checked to see if a Healthwatch visit had taken place. Healthwatch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of care provided. No visit had yet been undertaken by Healthwatch to Asquith House.

Prior to the inspection we contacted a number of organisations for their views on the service. These included the local authority commissioners, the safeguarding unit and the community learning disability team. All were positive about the service.

During the inspection we spoke with two people who used the service. People were able to provide us with comments relating to the support they received. We spoke to three members of staff; one of which was the interim manager. We looked at the records of all people who used the service and also records relating to the management of the service. These included quality audits, training records, and records relating to the recruitment and support of staff. We conducted a full tour of the premises. This was done to ensure that standards of hygiene and decoration were being maintained. We provided information to visitors on how they could have their say about the service and requested the views of the local learning disability team. No comments were received at the time of this report, although any subsequent feedback will be used as part of our on-going inspection process.

Good

Is the service safe?

Our findings

People told us that they felt safe and happy living at Asquith House. One person told us about their medication and how they preferred the staff team to deal with this. They told us that they always received their medication when they needed it and that this was never missed. People told us that they liked the decoration n the building and that this was always clean and homely in appearance.

Staff demonstrated a good understanding of the types of abuse that people could experience and the action they needed to take in order to report any concerns. Staff confirmed that they had received training in this and that they had access to relevant procedures. Staff felt confident that if they did report any concerns, that these would be taken seriously by the management team and that action would be taken to protect people. Staff were aware of other agencies they could contact if they had concerns about the registered provider.

We reviewed our records relating to the service and found that no concerns had been received in relation to the registered provider. The local safeguarding team also told us that they had no concerns.

We looked at risk assessments relating to all people who lived at Asquith House. These were up to date and included how people could be kept safe from risks faced in their everyday lives. Individual assessments had been devised to ensure that people could be free of financial abuse as well as threats to their personal safety while out in the local community. One person we spoke with used the local community independently and risk assessments reflected this. Other assessments were in place relating to those risks faced by people from health conditions that they had. In addition to this, assessments were in place indicating risks posed to people from the environment. Again these had been updated. The registered provider had ensured that electrical and gas systems were safe and that portable and firefighting equipment had been periodically checked. Plans were in place for each person indicating how evacuation could be safely achieved in the event of emergencies. The interim manager was able to provide us with further evidence of regular drills, for example, fire evacuations to ensure that people and staff were familiar with what they needed to do.
The premises were clean and hygienic with no offensive odours. Staff had access to personal protective equipment such as gloves and aprons if needed as well as cleaning products. Information was in place for staff to ensure that the service was hygienically maintained. The service had recently received a visit from the infection control team yet this related more to food hygiene arrangements.
The building was well maintained and decorated in a homely manner through. The service had been redecorated since our last visit and the lounge and bedrooms were particularly well presented rooms. The interim manager said that responses to emergency repairs was swift and general for other repairs, these were responded to I a timely fashion. Steps had been taken to personalise hallway areas with stencils on walls which included photographs of the people who lived there.

Accidents and incidents were recorded and analysed to identify any patterns or trends. These formed part of the audit system to determine the quality of the support provided.

We spoke to two members of staff. Both confirmed that they considered that they had enough staff on duty during each shift to meet the needs of the people living at Asquith House. The service had a full complement

of staff and the rota indicated that staffing levels were safely maintained. No staff from outside of the organisation had been recruited. We spoke to one member of staff who had been transferred from another service operated by the registered provider. They told us that they had had the chance to meet people living at Asquith House through a "meet and greet" scheme and had received an appropriate induction in respect of the layout of the building. The member of staff had already had an idea of the values of the registered provider given that they had worked for them albeit in another service. The "meet and greet" event enabled new staff to meet with people who used the service and for them to comment on how this member of staff could assist in supporting them. The interim manager told us that this was in place for new staff within the organisation although this had not had to be used given that there had been no new staff recruited from outside of the organisation.

We looked at how medicines protected the health of individuals. One person told us that they were given medicines by the staff team. We saw that risk assessments had been devised to ensure that this was the safest course of action and the individual was happy with this. All medication was stored in individual locked cupboards in people's bedrooms. We looked at medicines for two people. We found that medication was appropriately stored and cupboards locked when not in use. A monitored dosage system was used. Records suggested that medicines were appropriately signed for although the interim manager stated that they had to remind staff to sign when medications had been received and was seeking to address this. We noted that received medicines were not always signed for with the number received yet this had been identified and address by the interim manager. Disposal records were in place indicating a safe system for removing those medicines that were no longer needed.

We spoke to two members of staff about medication. All care staff manage medication. They told us that they received training and in addition to this received an annual competency check to make sure that they did this safely. We were able to tally stocks of medication with those medicines that were held in each medication cabinet. Where medication is prescribed when needed (known as PRN), a protocol was in place for reference when this should be taken. This applied to medication such as painkillers to medicines that should be used in the event of a prolonged epileptic episode.

Good

Is the service effective?

Our findings

People told us that they liked the staff team and through that they knew how to best support them. People were complimentary of the food provided and stated ways in which they helped with food planning and preparation in a safe manner as possible. People told us that they felt that staff were able to communicate with them in a positive way.

Each person had had a communication assessment available. These were up to date. Staff were able to confirm that all people were able to communicate with them although one person, despite having little or no verbal communication, had good understanding of what was said to them and staff used non-verbal cues from this person to gain an understanding of their preferences. One person had good verbal communication and was able to give an account of their routines and lifestyle. Another person used sign language as well as speech to make their needs known. We were able to gain the views of this person by using sign language. A 'sign of the day' was on display in the kitchen area and staff sought to reinforce each sign per day for this person. We were able to observe the support people received and it was clear that they were able to make their needs known to staff.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the management team. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivations of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

Care staff demonstrated a good understanding of the MCA and associated safeguards. They told us about which people living at Asquith House had restrictions in place and how these had enhanced their quality of life and safety. The interim manager was able to give a more detailed overview of how the MCA operated within the service. This included evidence of applications for restrictions and authorisations that had been granted. The interim manager was mindful of when these would expire and demonstrated their co-operation with authorities in order to review these. We saw evidence that one safeguarding was due for expiry in the near future yet evidence was in place suggesting that a health professional had visited as part of this process. Information was available within the service for staff reference indicating the general principles of the MCA. Staff told us that they had received training in this and this was confirmed through training records.

Staff told us that they had received training in a number of topics. These included mandatory health and safety topics as well as safeguarding and training which was linked to the needs of individuals. Some people had a significant health need that had to be monitored and interventions made in an emergency. Training and protocols enabled these interventions to be effective. Another person had developed a health need and staff were able to tell us how training had assisted in ensuring that this person could have their needs met. All training was included on a training matrix so that any due training could be identified and refresher

training arranged. Training certificates confirmed the sessions that people had attended.
Staff told us that they received supervision and that the aim was to have this once a month. They told us that any important issues to them could be dealt with outside of the supervision framework and that they did not have to wait for supervision to take place for these to be raised. Staff told us that supervision was useful and that it was a two way process between them and the supervisor. Appraisals took place annually. These enabled staff to gain an indication of how their performance was and any future needs they had to enhance this performance. A supervision and appraisal schedule was on prominent display. The interim manager explained how they in turn received supervisions and appraisals from a representative of the registered provider.

Care plans suggested that there was no need for restraint to be used on individuals. Care plans did suggest that there was some potential for challenging behaviours. This had been included in a risk assessment where applicable. Steps were in place for staff to intervene in a way which enabled such incidents to be dealt with by talking to people and to achieve this in a reassuring manner.
People told us that they like the food provided and that they could always have an alternative if they wanted to. Care plans indicated that nobody had any specific dietary needs but people did have like and dislikes. People were able to eat independently yet attention was paid by staff to ensuring that people did not choke on their meals. During our visit, one person as having breakfast and they were able to choose what they wanted. People were encouraged to assist with preparing their meals or drinks yet attention was paid to their physical safety. People were able to assist in getting the weekly shop and devising menus. We asked staff whether they considered anyone to be nutritionally at risk. Independently staff told us that while no one was at severe risk, they were monitoring the weight of one person to make sure that they were within safe guidelines. Refrigerators and freezers were well stocked and hot drinks were available to people on request.
Our tour of the premises noted that there were no adaptations in situ for people. This reflected care plans that concluded that people were independently mobile and as a result no lifting equipment or hoists were needed at that time. We did note that in some instances, the decoration of one bedroom door had been tailored to assist with the needs of one person

Good

Is the service caring?

Our findings

People we spoke with liked the staff team and felt that they looked after them. They told us that they were treated in a kind and friendly manner and were able to spend time on their own if they wanted without staff interference.

The support we observed during out visit supported that view. People were supported in a friendly manner with attention paid to making sure that their needs and preferences were in place. People were given genuine choice about issues such as meals or what they wanted to do that day.
People were provided with the opportunity to be involved in their support and also in the running of the service. Meetings were held with people on a regular basis. In addition to this we saw people being told what was going on in the service and given information verbally about. People were also given information they needed in pictorial form appropriate to their communication needs. The registered provider had adopted an approach known as 'Great Interactions'. This was a method used by the staff team to examine the way they interacted with people and to reflect on such interactions. Giving people information was a key part of this process.
People told us that they were generally well and received support from other medical agencies when needed. A system was in place known as a 'anticipatory care calendar' This was used for those people who could not readily express how they were feeling from a health point of view and this system enabled staff to make a judgement through observation. One person had had an accident which had affected their mobility for some time. This person was able to tell us how they had been assisted by the staff team in a positive way and was returning to full health. All people were registered with a general practitioner and there was evidence of ongoing routine appointments to monitor people's health as well as appointments in response to health issues as they arose. The registered provider had developed a health passport for individuals. This provided medical professionals with a summary of the needs of people such as their communication needs and how best to support them during a hospital stay.
One person had developed a health need that significantly affected their daily life. We saw through documentation and discussions with staff that a community nurse had become involved with this person to offer advice and to start this person on a health pathway to take their condition into account.
Only one person had an advocate involved in their day to day life. This person had become involved given that this person had limited communication and that the registered provider had sought to ensure that their rights were protected and key decisions made with the assistance of an independent person. The interim manager was seeking to increase the role of advocates for other people since they recognised that this involvement ensured that people had their rights protected and that the service was as transparent as possible when dealing with people's finances, for example.
We witnessed people being supported in a manner which preserved their dignity and privacy. People were always included in conversations about those issues that affected them directly. Our observations found that people were always given a meaningful choice about activities they wished to pursue and the focus on the individual suggested that their dignity was preserved at all times. We did not see any evidence of institutionalised practice which would have meant that individual dignity would not be promoted.
Interactions with people were respectful although a degree of light hearted banter had developed between the staff team and people. When entering people's bedrooms, we saw staff knocked on the door before they

were invited in. One person was asked if it was possible for us to view their bedroom. This request was granted with the person accompanying us to assist. People were able to go to their bedrooms if they wished. One person spent time in the lounge but then went off to their bedroom. This was respected. The person also left their door open so that they could relax in their room but felt reassured that they could be seen by the staff team if they needed support.

Our observations noted that the independence of people is taken into account. One person had had an accident which had impacted on their mobility in the short term. Despite this, the person was able to mobilise around the building with a walking aid and no staff support was required to do this. The same person gave us an account of their interests within the wider community and how ordinarily they had been able to do voluntary work in a community facility that reflected their interests. These interests were pursued independently yet in line with risk assessments.

Another person preferred to remain in the building during our stay yet they were independent in choosing what they wished to do. They took pride in the appearance and cleanliness of their bedroom and were able to independently maintain this with some staff support.

Good

Is the service responsive?

Our findings

People we spoke with did not comment specifically on the responsiveness of the registered provider yet were able to express positive comments about the staff team. They told us that the staff always sought to help them if they needed it and to provide information when possible.

We looked at three care plans. Care plans were very personalised and provided a detailed account of every aspect of the person's daily lives. Given the amount of detail, the staff team had sought to summarise these needs into a short summary for people to assist with their communication needs. This included a summary of positive aspects such as 'what is important to me' as well as the use of pictures and symbols to communicate the contents of care plans to each person. All care plans had been reviewed and had included the person themselves and people important to them in that process. We spoke to one person about their interests and lifestyle and their care plan accurately reflected these. One person had come to live at Asquith House since our last visit. We saw that assessment information was available outlining all aspects of the person's daily life. The person had come from another service operated by the registered provider yet despite this the assessment did not take this into account yet focussed on the person themselves.

Three people were not present during our visit. These people used a local day service during the week. The other two people had chosen not to attend this and preferred involving themselves in the running of the house or pursuing their own activities. Activities undertaken by people are recorded and are guided by the wishes of each person. People were able to use public transport or the services' own minibus. The proximity of the building to Chester city centre also promoted activities.

A complaints procedure was available. This was available in a format which was appropriate to the communication needs of people. We asked people if they had needed to make a complaint and none had had to. They told us that they thought the staff would listen to any concerns they had. Complaints records were maintained but no complaints had been recorded since our last visit. We looked at our records and found that no complaint shad been made about the service since our last visit.

Good

Is the service well-led?

Our findings

People we spoke with said that they liked the staff and that they were helpful and supportive to them. These comments included the interim manager of the service. They confirmed that the service always asked their views about how they were being supported.

The registered manager was not available on the day of our visit and had undergone a period of absence from the service. In the meantime an interim manager had been identified and recruited from within the service. We spoke to the interim manager about their role. They demonstrated a good understanding of the responsibilities of acting as the registered manager and was able to explain the system of notifications and other issues relating to the registration of the service. Our records showed that the registered manager and registered provider always informed us of any issues in line with their registration. These included notifications relating to the use of Deprivation of Liberty Safeguards and notice of the registered manager's absence. A certificate of registration was available. The registered provider had been requested by us to submit a provider information return (PIR). The PIR gave the service the opportunity to comment on those care practices that answered our five questions as well as identifying those areas that they considered needed improvement. The deadline for its return had not yet arrived and the interim manager confirmed that they were working through the PIR at present.

We spoke to two members of staff. They told us that they considered that the management of the service was approachable and willing to support them in all aspects of their role. They told us that the registered provider had a philosophy of care that was positive for the lives of the people who they supported and this was in line with their own values.

There was evidence that the quality of the service was assessed by the registered provider on a regular basis. Staff confirmed that they had the opportunity to contribute to a staff survey on an annual basis and that broadly the registered provider sought to act on their views. We saw evidence of surveys sent to people who used the service and their families. Again the results of these were incorporated into an action plan which was reviewed to ensure that any necessary improvements were acted upon. The survey for people who used the service was presented in a format appropriate to their communication needs. The interim manager told us that steps were taken to ensure that were support was needed for people to complete these surveys, that independent people familiar to each person was asked to provide this.

A robust system was in place for the auditing of systems within the service. The registered provider had its own compliance team who would check the quality of care and systems within the service periodically and report on them. In turn there was a requirement for the interim manager to undertake their own audits of aspects of the service. These included infection control audits, health and safety audits as well as checks to ensure that training and supervisions were up to date. The interim manager explained that the service had recently received a food hygiene inspection and that they were currently responding to outcomes.

Outcomes from this visit were positive. In addition to this, the service had received a visit from the local authority commissioning team. We spoke to the commissioning team who told us that they were satisfied with the quality of support provided to people living there.

We found that all records maintained at the service were up to date. Records were also securely stored when not in use.