Peninsula Autism Services & Support Limited

Ridgecott

Inspection report

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Ridgeway
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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?	Requires improvement
Is the service well-led?	Good

Overall summary

The inspection took place on the 23 and 24 June 2015 and was unannounced.

Ridgecott provides care and accommodation for up to ten people. On the day of the inspection there were ten people living in the home. Ridgecott provides care for people with a learning disability and associated conditions such as Autism and Aspergers.

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.

Relatives and other agencies spoke highly of the care provided at Ridgecott. Comments included,

"[…] is so happy at Ridgecott, […] see's staff as her family, and they welcome me and keep me well informed and included", and "It seems like a lovely place to work, residents and staff are always happy".

Staff had a good understanding of people's needs and support plans included clear information about how

Summary of findings

people chose and preferred to be supported. We observed many examples of people being supported to make choices and have control over their care and lifestyle. For example, we saw people choosing what they wanted to eat and when they wanted to get up. We also observed staff responding promptly when people became anxious and asking for people's consent before supporting people with medicines and personal care.

People's needs and support had not in all cases been assessed and planned in a person centred way. Some of the arrangements intended to protect people and keep them safe, such as key pads on the entrance to the kitchen and some communal areas may have limited people's opportunity to develop their skills and independence.

Staffing levels had been organised in a way to keep people safe. All of the staff we spoke to said there were enough staff available to keep people safe. Although staff worked hard to spend time with people and support people to partake in activities there were not always enough staff available to respond to individual requests to go out or partake in a certain activity.

People were protected by staff who knew how to recognise signs of possible abuse. Staff were able to talk confidently about the action they would take if they identified potential abuse had taken place.

People had their medicines managed safely. People received their medicines on time and in a way they chose and preferred. People's health and well-being was paramount, and systems were in place so staff could recognise changes in people's health and take prompt action when required. The food in the home was of a high standard and catered for people's special dietary needs and preferences.

People were supported by safe and robust recruitment practices. People were involved in the recruitment process and their views were taken into account when appointing new staff. Staff undertook training, which was specific to the needs of people they supported.

Care and support focussed on each person's individual needs, their likes, dislikes and routines important to them. When people were unable to consent to their care or support, discussions took place to ensure decisions were made in the person's best interest. When people's needs changed staff reacted promptly involving other health and social care professionals if needed.

Staff felt well supported by their colleagues and management. They were supported and encouraged to question practice and were inspired and motivated to provide a good quality service. The registered manager had an active role in the home and lines of accountability and responsibilities were clearly communicated.

There were effective quality assurance systems in place. Incidents were appropriately recorded and analysed. Learning from incidents and concerns raised had been used to help drive continuous improvement across the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Safe recruitment practices were followed and there were sufficient staffing levels to keep people safe.

Staff recognised people's rights to make choices and take risks.

Staff had a good understanding of how to report any signs of abuse or poor practice.

People were protected by safe and appropriate systems for handling and administering medicines.

Good

Is the service effective?
The service was effective.

People received care and support by staff that were well trained and supported within their role.

Staff had received appropriate training in the Mental Capacity Act and associated Deprivation of Liberty Safeguards. Management and staff displayed a good understanding of the requirements of the act, which had been followed in practice.

People were supported to have their health and nutritional needs met.

Good

Is the service caring?
The service was caring.

Staff had a good knowledge of people they supported and had formed positive, trusting relationships.

People were kept informed and actively involved in decisions about their care.

People's privacy and dignity was respected and promoted.

People had access to external support if they needed people to support them or act on their behalf.

Relatives and friends were considered important and were welcomed into the home.

Good

Is the service responsive?
The service was not in all cases responsive.

People's needs and support had not in all cases been assessed and planned in a person- centred way. Some of the arrangements intended to protect people and keep them safe may have limited people's opportunity to develop their skills and independence.

Requires improvement

Summary of findings

People's opportunities to partake in activities were at times limited and were not in all cases planned in a person centred way that met people's specific needs and wishes.

Systems were in place to help ensure information about people's needs were accurate and up to date.

People were supported to maintain relationships with people who mattered to them.

People were supported to raise any concerns or complaints about the service. Complaints were taken seriously and responded to appropriately.

Is the service well-led?

Good

The service was well led.

Where possible people were involved in discussions about the service and their views were valued.

Staff understood their roles and responsibilities and were supported by an open and inclusive management team

Staff were motivated and inspired to develop and provide quality care.

Quality assurance systems drove improvement and raised standards of care.

Ridgecott

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.

The inspection took place on the 23 and 24 June 2015 and was unannounced. The inspection was undertaken by two adult social care inspectors.

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 for example,what the service does well and improvements they plan to make. We also reviewed information we held about the service. This included previous reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with 7 people who lived at Ridgecott, two relatives, the registered manager and 9 members of staff. We also spoke to an advocate, a district nurse and a specialist mental health worker who had supported people at the home.

Most of the people who lived at Ridgcott had minimal verbal communication and were therefore unable to tell us about their experiences living in the home. To help us gather information about people's experiences we spent time in the communal parts of the home observing people as they went about their day and observing the care and support being provided to them.

We looked at the care records of 5 people living in the home. These records included support plans, risk assessments, health records and daily monitoring forms. We also looked at 4 staff files, which included information about recruitment, training and staff support.

We looked at records relating to the running of the service. This included policies and procedures, quality audits and incident reports.

Good

Is the service safe?

Our findings

Staff told us there were sufficient numbers of staff on duty to keep people safe. Two people had been assessed as requiring 1:1 staffing levels throughout the day and when they went out to keep them safe and to meet their needs. We saw these staffing arrangements were in place. All of the other people required some support from staff with specific daily tasks, and supervision at all times when they went out. All the staff we spoke to said staffing levels were sufficient to keep people safe.

Staff recognised people's rights to make choices and to take everyday risks. Some records confirmed that when risks had been identified management plans had been put in place to promote the person's well-being and independence whilst also keeping them safe. For example one person had known behaviours from a previous placement, which could result in significant damage to their personal belongings. The staff had taken these known behaviours and risks into account and had developed a behaviour support plan with the individual to help them value their belongings within their new environment. The registered manager said this risk management plan had resulted in a reduction in behaviours and significant improvement in the person's well-being and independence. We saw a risk assessment for one person had identified risks of falls due to deterioration in their mobility. A plan had been agreed to support the person to move to a room on the ground floor as a way of reducing the risks and maintaining their independence as long as possible.

One person had an intercom system to access their self-contained flat within the service. The person concerned used the intercom to contact staff when they needed support or if they wanted to leave the flat. Records confirmed that this arrangement had been agreed as part of a multi-agency process to meet the person's needs and to keep them safe. Staff were able to describe clearly how they supported this person and responded promptly when the person communicated with them using the intercom system. However, the arrangements for checking on this person throughout the day and night had not been documented as part of the person's plan of care. The absence of this information could mean that the person's safety was compromised if they were unable to contact staff or leave their room independently. This was discussed with the registered manager at the time of the inspection and we were told that these guidelines would be written as a matter of priority.

People were protected by staff who knew how to recognise signs of possible abuse. Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. Training records showed that staff completed safeguarding training regularly and staff accurately talked us through the appropriate action they would take if they identified potential abuse had taken place. Staff knew who to contact externally should they feel their concerns had not been dealt with appropriately by the service. Staff told us safeguarding issues were discussed regularly within team and handover meetings. Regular audits had been undertaken in relation to staff knowledge about safeguarding as well as any recorded safeguarding incidents in the service. A recent audit had highlighted gaps in some recording of incidents. These gaps had been discussed with staff and addressed to help further ensure appropriate action was taken when dealing with any reported or suspected safeguarding concerns.

People's needs were considered in the event of an emergency situation such as a fire. People had personal evacuation plans in place. These plans helped to ensure people's individual needs were known to staff and to emergency services, so they could be supported and evacuated from the building in the correct way. Regular health and safety checks had been undertaken and the service had contracts with external agencies to help ensure any equipment including vehicles were maintained, safe and fit for purpose. Accidents and incidents had been clearly documented and records audited so that any patterns or future learning could be considered and addressed. A major incident contingency plan was in place and available for staff to access in an emergency.

Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service.

People's medicines were managed safely and given to them as prescribed. Although some people had their own medicines cabinets for storage there was also a separate room within the home where medicines could be stored and prepared safely. Controlled drugs were safely stored

Good

Is the service safe?

and cold storage was available when required to ensure the quality of medicines were maintained. People's care records had detailed information regarding their medicines and how they needed and preferred these to be administered. For example one person had been assessed as being at risk of choking so medicines had been requested in liquid form. Medicines administration records (MAR) and controlled drugs records were in place and had been clearly and correctly completed. A clear system was in place when medicines arrived in the home and when they were administered to reduce the risks of any errors. Staff were appropriately trained and confirmed they understood the importance of safe administration of medicines. They made sure people received their medicines at the correct time and records confirmed this.

Designated staff had the responsibility of overseeing medicines and undertook regular audits and staff competency checks. Information was clearly available for staff about people who required, as needed (PRN) medicines. These protocols helped ensure staff understood the reasons for these medicines and when and how they should be given. The administration of homely medicines and medicines in the form of creams were also recorded as part of the person's medicines records. Clear guidelines were available for staff about what they needed to do in the event of a medicines error. We saw that appropriate action had been taken following a medicines error and this had included additional training for the staff concerned, and reviews of records relating to the administration of medicines in the home.

Good

Is the service effective?

Our findings

Staff confirmed they undertook a thorough induction programme and on-going training to develop their knowledge and skills.This gave staff the information they needed to do their job effectively. Newly appointed staff shadowed other experienced members of staff until they and the service felt they were competent in their role.

Staff were encouraged by the organisation to undertake regular training and had support when required from other professionals in relation to people's specific care needs. For example staff had undertaken training in relation to one person with mental health needs and another person living with dementia. The registered manager told us they encouraged staff to develop their skills through further training. They had asked several staff members to become qualified to train the staff team in First Aid, the Mental Capacity Act, Deprivation of Liberty Safeguards and Manual Handling. They commented that this increased individual's skills but also gave the team greater expertise to use when supporting people.

Staff told us the registered manager and deputy manager were very supportive and provided regular supervision, which the staff found useful. Staff files contained comprehensive supervision notes. Staff confirmed they could discuss any issues with the management and they were open to new ideas suggested by the staff team. Staff also had an annual appraisal of their work, which encouraged them to discuss and reflect on their practice. We saw competency assessments had been completed for different areas of care, such as medicines management. These checks helped ensure that staff had the correct skills and up-to-date training to meet people's on-going and changing needs.

People where appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS provide legal protection for vulnerable people who are, or may become deprived of their liberty. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Care records and the provider information return (PIR) showed that DoLS applications had been made for some people and evidenced the correct procedures had been followed. The registered manager and other senior staff had a good knowledge of their responsibilities under the legislation. A clear record had been made of any DoLS applications, when they had been authorised by the local authority and when they were due to be reviewed.

Staff demonstrated a good understanding of the main principles of the Mental Capacity Act (MCA). Support plans included assessments of people's capacity in relation to different areas of their care and lifestyle and highlighted when people were able to make decisions or if best interest meetings would be needed to support them. For example the capacity and support plan for one person stated that their ability to make decisions for themselves fluctuated dependent on their mental health. The plan stated that due to this the staff needed to assess this person's capacity at all times so that choice would be encouraged and support provided when required. Daily records confirmed that people were supported to make everyday decisions about such things as when they wanted to get up and what they wanted to eat and drink. However, when people lacked the capacity to make more complex decisions, meetings had taken place with family and other relevant agencies to help ensure decisions were made in the person's best interest. We saw that communication aids such as pictures and symbols were used to support these choices when people were unable to express their choices verbally. For example best interest meetings had been held in relation to one person's health care needs and their limited capacity to understand the need for a hospital admission and treatment.

People's consent was sought before care and support was provided. For example we observed staff supporting one person to take their medicines. We saw that staff asked the person if they agreed to have their medicines administered and provided the person with information about what they were doing when they requested it.

Staff were supported to understand and manage people's behaviours in an appropriate and lawful manner. Behaviour management plans were in place for some people to help staff understand the behaviour people may present, recognise the triggers and signs and understand the action they would need to take to manage the behaviours in a way that was appropriate and lawful.

People were supported to have a sufficient and well-balanced diet. The cook demonstrated a good knowledge

Good

Is the service effective?

of the dietary needs likes and dislikes of each person. They asked people on a daily basis if they wanted to eat what was on the menu that day and also asked for their opinions when planning the weekly menu. Staff understood any risks associated with eating and guidelines were in place in relation to choking hazards and other special dietary needs.

People's health needs were met. People were supported to maintain good health and when required had access to healthcare services. One person who disliked visits to the dentist had been supported by staff to overcome their fear. Staff had supported them to visit the dentist and just sit in the dentist's chair. This had helped them get used to the environment before any treatment. Support plans included information about people's past and current healthcare needs and staff were familiar with this information. People were supported to attend routine health checks and a record was kept of all appointments. Routine checks had picked up some health changes for one person. As a result staff had been able to support the person concerned to have these health needs dealt with in a timely and prompt manner.

Good

Is the service caring?

Our findings

People had limited verbal communication and it was difficult for them to tell us if they felt well cared for by the service and staff. We spent time with people seeing how they spent their day and observed the care and support being provided. We saw people being treated with care by the staff team. Relatives told us that the staff were kind and treated people with respect and dignity.

We observed the atmosphere in the home was warm and welcoming. The interactions between people and staff were positive. We heard and saw people laughing and smiling and people looked comfortable and relaxed in their home.

We saw staff showed concern for people's well-being and responded promptly when people showed signs of becoming anxious or distressed. Staff recognised when one person had started to show signs of anxiety due to the number of visitors in the home. We saw staff reassuring this person and providing distractions to help them feel more comfortable and relaxed. Staff recognised when another person communicated they were cold due to a draft from an open door. The staff member responded promptly by closing the door and checking the person felt warm and comfortable. We heard one person tell a member of staff that their hands felt sore. The staff member immediately stopped what they were doing and offered to rub the person's hands for them to help take away the sore feeling.

People were supported by staff that had a good knowledge of them and knew them well. Staff were able to tell us about people's likes and dislikes, which matched what was recorded in people's care records. Staff told us they had time to get to know people and were able to sit and spend time with people as well as attending to other tasks. Comments included "We are encouraged to spend time with people. If I was in the middle of doing something and someone asked me to sit with them I would do straight away".

Staff listened to people's views and gave people information in a way they needed and could understand. We heard staff responding promptly and clearly to people's questions and requests. One person asked about their medicines and when they would be taking it. The staff provided clear information, which clearly helped the person understand what was happening and feel less anxious. We saw information had been placed around the home to let people know about the day. For example a large notice board in the main sitting room had photographs of staff on duty as well as photos and symbols to show people the menu for the meals that day. Staff said they held regular 'Your voice' meetings, which allowed people, time to discuss any issues concerning the home or their care. People who chose not to attend these meetings or who were unable to participate verbally were supported by their keyworker to consider the issues that had been discussed.

People's privacy and dignity was respected. Staff told us they always ensured doors and curtains were closed when assisting people with personal care and made sure they found somewhere private to discuss confidential matters. We saw privacy and dignity issues had been discussed in a recent staff meeting. People who used the service had also been reminded during a 'Your Voice' meeting of the importance of staff speaking nicely to them and what they needed to do if this did not happen. The meeting had stressed to people the importance of them feeling important and respected.

People had the opportunity to access support from outside the home if they needed people to speak on their behalf. Two people had regular support from an independent advocate and this was considered by staff to be an important part of their support team. We saw that advocacy support had been requested for one person to assist with some issues they had been having in relation to their support plan. Staff said the advocacy support had ensured the person's wishes had been fully understood and had helped the person take a lead in planning their care. Feedback from advocacy services included, "The service is more than accommodating. They include […] in all their care and are very flexible. Staff are very caring".

Staff recognised the importance of people's family and friends. Relatives told us they were welcomed in the home and able to visit without any restrictions. Comments included "The staff always support me to make contact, this can be visits, phone calls or emails. They keep me well informed".

Requires improvement

Is the service responsive?

Our findings

People's needs and support had not in all cases been assessed and planned in a person- centred way. Some of the arrangements intended to protect people and make them safe may have limited people's opportunity to develop their skills and independence. For example, some parts of the home such as the communal dining area and main kitchen could only be accessed by staff using a key fob to open the door. Staff said they thought these locks were in place due to the potential risks for some people if they accessed these parts of the home without staff. Staff did say that people were able to access the kitchen and dining area with staff support. However, individual support plans did not describe these specific risks to individuals or how people would be supported by staff to use these facilities in a way that would promote and enhance their independence.

People had opportunities to partake in activities and to access facilities in the local community. However, staffing levels meant some people's opportunities were at times limited and were not always specific to their needs and wishes.

Some activities were organised and planned on a regular basis such as a weekly music group and an evening social event. Staff support and transport was available and people were able to choose if they joined in these activities. Some people were involved in activities, which were specific to their needs and personal interests. For example one person had a regular work placement and others liked to go out for walks and to favourite eating places. However, we observed some people sat in the communal lounge asking to do an activity or go out. Although staff clearly did their best to meet these specific requests they had to ask people to wait if another person also needed support or if there was no other staff member present. Staff said staffing levels did not always allow them to meet people's individual care needs particularly in relation to activities and taking people out. Comments included "People often have to wait, particularly if people have appointments" and "We take people out in groups or just for a short walk so that we can get back and take someone else" and "I think people are safe, but more staff would help us provide more person centred care". Daily monitoring forms contained minimal information about what people had done each day and did not always reflect the information in people's activity timetables. For example, one monitoring form stated that the person sat in the lounge watching television all day, although their timetable had stated they would be partaking in a bingo session. Staff had not in all cases recorded what activities had been offered to the person concerned. The absence of this information meant it was difficult to monitor if people's needs in relation to activities and community involvement were being met.

People were supported by staff who knew them well and understood their needs and personal wishes. Staff were able to give us clear and detailed information about people's daily routines and how they needed and preferred to be supported. Relatives and other agencies said the staff and management responded promptly and appropriately to any important issues or changes in people's health or support needs. They said when communicating with the manager about a person they would get an almost immediate response and any changes were implemented, "This means the person's care remains appropriate for their needs".

Care records contained detailed information about people's health and social care needs. Support plans included people's specific wishes about how they chose and preferred to be supported. For example, the support plan for one person stated they preferred a bath to having a shower. Arrangements had been made so this person could use a shower room on the ground floor for their personal care needs. Another plan stated how one person would communicate with staff when they wanted support and times when they wanted to be left on their own. Staff understood these guidelines and followed the person's choices and wishes about the care and support they received.

Staff were responsive to people's communication needs. People had the opportunity to communicate using picture cards. These were seen around the home and staff described how these were used for people to choose meals and activities and to get other needs met.

There was a clear process in place to review people's support arrangements to ensure information was accurate and up to date. Handover meetings took place at the start of each shift so information about any issues or changes in people's needs would be known and acted on promptly. Each person had a designated key –worker who had responsibility for working alongside people to help them with issues relating to their care and lifestyle. Keyworker

Requires improvement

Is the service responsive?

meetings took place each month and people were supported to discuss any issues and identify goals for the future. In addition to key-worker meetings relatives and other agencies are invited to attend annual reviews so that the person's support needs can be fully discussed and amended if required. The registered manager said that although these meetings were planned they could take place at any time if needs changed. For example, a review had taken place for one person due to significant changes in their health. As a result the support plan had changed to include additional support from staff at particular times of the day. This change helped ensure the person's needs were met whilst ensuring their well-being and independence was maintained.

People were supported and encouraged to maintain relationships with people that mattered to them. Relatives told us they were kept well informed and made to feel very welcome by staff and management. Staff supported one person to have regular contact with a relative who lived in a different part of the country. They supported the person to speak to their relative on the phone and kept them updated by email about any important issues.

The service had a policy and procedure in place for dealing with any concerns or complaints. The service had received one complaint in the 12 months prior to the inspection. Records confirmed this was dealt with in line with the services policy. Appropriate actions had been taken to deal with the complaint and the complainant was informed of the outcome. Staff told us they used keyworker meetings to ask people if they have any complaints and to encourage them to speak to anyone they felt comfortable with if they had any concerns.

Good

Is the service well-led?

Our findings

Feedback from other agencies and relatives about the management and running of the service was very positive. Comments included "The manager is always very helpful and keeps me well informed" and "People always seem very happy, it seems like a lovely place to work".

The registered manager said people were encouraged to be involved in issues concerning the home and their care. They said this was supported in a range of different ways due to people's diverse needs and limited verbal communication. Some people were able to attend 'Your Voice' meetings to discuss issues about the home and other aspects of people's care and lifestyle. Consideration had also been given about how people could be involved who had limited or no verbal communication. Staff said some people used pictures and others depended on staff to understand their behaviours and body language. For example, one person needed to be asked questions in a very specific way in order for them to understand and respond. People were asked what was important to them about the staff team and what should be asked during the interviews for new staff. People's views had been listened and used as part of the recruitment process.

The registered manager took an active role within the home. There were clear lines of accountability and responsibility within the management structure and tasks were delegated to help ensure the smooth and efficient running of the service. Comments from staff included, "The manager is always supportive, will always talk to us and help us out. We have a good relationship "and "The management are approachable and transparent. They explain clearly the things that they want doing or don't want doing". The registered manager maintained their own professional development by attending local care forums and by completing training to develop their management skills and their ability to support people's needs. This had included recent sensory and dementia training.

Information was used to aid learning and drive improvement across the service. We saw incident forms had been completed in good detail and included a form for staff to consider any learning or practice issues.

Staff meetings were held to provide an opportunity for open communication. The registered manager said all staff were expected to attend these meetings and were encouraged to discuss and question their practice. Staff were given the opportunity to complete an employment engagement survey to enable and empower staff to develop and support improvement.

There was an effective quality assurance system in place to drive continuous improvement within the service. The registered manager and staff team completed a range of quality assurance audits to monitor the standard of services provided. This included, reviewing care records, medicines, and the environment and health and safety systems. Accident and incident records were analysed to look for any trends developing and whether preventative action needed to be taken. For example, one person's support plan had been discussed following a number of incidents. It had been decided that the incidents highlighted a need to change the way the person's staff support was organised. As a result of this change the person concerned gained greater control of their lifestyle, which reduced the risks of incidents occurring in the future. Systems were in place to respond to safeguarding alerts and complaints. These were analysed to see whether improvements could be made to improve people's experiences of care.

In addition to internal audits the registered provider also undertook unannounced spot checks and audits within the home. This had included a health and safety audit and full service review in February 2015. Action plans had been completed with dates for the registered manager to address any areas of concern or need for improvement. The service had also been visited by the Plymouth City Council Quality Team who had undertaken a review of the quality of care provided to people funded by the local authority. We saw the review had been positive and the provider had addressed any areas for improvement as agreed within their action plan.

This section is primarily information for the provider

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.