Independence Homes Limited

Independence Homes Limited - 37 Foxley Lane

Inspection report

37 Foxley Lane
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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?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

We visited Independence Homes Limited – Foxley Lane on 18 and 21 November 2016. The inspection was unannounced.

The service provides specialist residential care for up to eight people living with epilepsy and other neurological or physical needs. At the time of our inspection there were seven people with complex needs using the service.

The service had a registered manager. 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 of people using the service and staff told us people were safe. Staff had completed safeguarding training and understood their personal responsibilities. Handovers between shifts ensured staff were aware of what had been happening and how people were. Staff were always in close proximity to people in communal areas. The service had provided a safe environment for people using the service. Equipment used by the service was modern, well maintained and relevant to people's needs. Risk assessments reflected people's needs, preferences and goals and supported staff to provide safe and appropriate care. There were sufficient numbers of suitably trained and qualified staff to meet people's complex needs.

Staff were supported with extensive training and regular supervision meetings. The service was working within the principles of the mental Capacity Act. We found relatives where appropriate were involved in the planning of people's care and support. People's nutritional requirements were met through a varied diet and the availability of drinks and snacks at all times. The service ensured people's healthcare needs were met and staff were given further support by access to a specialist epilepsy nurse and an epilepsy specialist who were available to provide advice at any time.

Relatives and healthcare professionals spoke positively about the service and staff. We observed and listened to people and staff. Staff communicated well and people responded positively. Relatives of people were involved in the ongoing planning of care and support. People's preferences were taken into account when providing care and support and their choices respected. Staff treated people with dignity and respected their privacy.

Detailed preparations and assessments took place before people moved into the service to ensure everything was in place to meet their complex needs. The care provided was person centred and responsive to people's needs. Care records, including person centred plans and delivery plans were written using person centred language. The service provided specialist care for people living with epilepsy and enabled staff to do so through extensive training and the availability of clinical advice and support. The service ensured they were up to date with recognised good practice and liaised closely with healthcare

professionals. The service had access to two vans enabling them to support people to attend appointments and providing opportunities for activities. Activities played an important part in people's lives and staff had the confidence and experience to take people out on planned and unplanned activities. The provider had processes in place to obtain feedback and ideas from the relatives of people using the service and using that information where deemed appropriate to improve service provision.

Staff and relatives spoke positively about the management team at the service. They felt confident they could raise any concerns or issues. Staff meetings were held once a month. The service had a system of reviews, checks, visits and audits to assess, monitor and improve service provision.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff understood their responsibilities around safeguarding adults. Care was provided in a safe environment and equipment was appropriately maintained. Risk assessments contributed to safe and appropriate care. There were enough suitable staff to meet people's needs.

Is the service effective?

Good

The service was effective. Staff were well trained to carry out their role. People's nutritional and healthcare needs were met.

Is the service caring?

Good

The service was caring. Relatives and professionals spoke positively about staff and the service. Relatives were involved in planning people's care and support. People's preferences, privacy and dignity were respected by staff.

Is the service responsive?

Outstanding ☆

The service was exceptionally responsive. Transition processes for people moving into the service were comprehensive and lengthy to ensure all appropriate preparations had been made to meet their complex needs and preferences. This enabled specialist equipment and training to be put in place whilst staff made a number of visits to observe how care was being provided. People were provided with person centred, specialist care. There were various activities for people using the service and staff encouraged and supported people to take advantage of them. The provider obtained feedback from relatives of people using the service.

Is the service well-led?

Good

The service was well-led. Managers were viewed positively by staff and relatives. Systems were in place to monitor, assess and improve service provision.

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Detailed findings

Background to this inspection

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

This inspection took place on 18 and 21 November 2016 and was unannounced.

The inspection was carried out by an adult social care inspector and a specialist advisor with expertise in neurological conditions including epilepsy.

Before the inspection, the provider completed a Provider Information Return (PIR).The PIR is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We also reviewed information we held about the service. This included any information we had received including, complaints, previous inspection reports, safeguarding alerts and notifications that the provider had sent to CQC. Notifications are information about important events which the service is required to tell us about by law.

During the inspection we spoke with six members of staff, a visiting relative and a healthcare professional. As people using the service could not tell us about their experiences we spent time observing and listening to how staff provided care and people's responses. We examined a random selection of records relevant to the carrying out of the regulated activity. This included the care records for six people and medicines records for three people. We specifically selected three people with the most complex needs and case tracked their care records; observed their care and spoke to the staff providing their support; and, we looked at the structures and processes in place underpinning that care and support.

After the inspection we spoke with four relatives and one social care professional.

Good

Is the service safe?

Our findings

Relatives of people using the service told us people were safe at the service. Staff ensured people they cared for were protected from avoidable harm and the risks of abuse. The provider ensured staff had completed safeguarding training and understood their personal responsibilities. Staff understood how to report allegations of harm and abuse and were aware of whistle blowing procedures. One member of staff told us the importance of safeguarding was emphasised during their induction.

Handovers took place between staff at changeover times. This meant staff starting their shift were advised about people's moods and behaviours and were aware of any health concerns. We found people were checked at regular intervals throughout the day and night. Motion sensors in people's rooms and occupancy mats on beds warned staff when anything unusual was happening. Motions sensors were used to detect seizures and significant changes in breathing. Occupancy mats alerted staff to people not being in bed and possibly needing support. When people were not in immediate sight of staff this combination of checks and alarms ensured seizures and other incidents were quickly responded to and recorded.

When people were in the lounge area we saw staff were in close proximity. Staff were carrying out supportive observation to protect people from risks whilst allowing them to be engaged in activities individually or with other people or staff.

The building, driveway and garden provided a safe environment for people using the service, visitors and staff. The building had been designed and purpose built by the provider to provide care and support for people living with epilepsy and other complex health conditions. We examined the interior and exterior of the building and found it was well maintained. Inside the building was warm, well-lit and comfortable. Doorways, corridors and lifts provided plenty of room for people to be transferred in wheelchairs.

Equipment was also well-maintained and regularly serviced. Specialist equipment had been installed to support staff to provide safe and appropriate care. Each bedroom had a ceiling hoist that tracked from the bedroom into the en suite facilities. A specially adapted bath had been purchased to meet the specific needs of individuals using the service. This required a total refurbishment of the bathroom. Specialist equipment was available to evacuate people in emergency situations, such as fire, when the lift could not be used. Staff were trained to use all the equipment safely to ensure people were not injured when it was being used.

Anything identified as requiring maintenance or repair was reported through the provider's 'Fix' programme and a response was arranged by staff at head office. This meant staff working at the service had no further involvement in making arrangements and were free to provide care and support.

People using the service had complex needs that created risks around their care and support. Risk assessments were completed for people reflecting their needs, preferences and goals. They provided detailed guidance for staff to address the risks and provide safe and appropriate care and support. We saw positive risks were included so people using the service could live a fulfilling life. The staff had a positive

attitude and found ways to ensure people were stimulated and did not become bored or isolated. For example, one person enjoyed going out and was supported to do so despite having a high incidence of seizures that were complicated by breathing difficulties and required oxygen. This person was taken out for up to three hours with their own emergency pack and portable oxygen. Due to the guidance in risk assessments, their training and experience staff were confident they could deal with any eventualities when this person was taken out.

We found there were sufficient numbers of staff to meet people's needs and keep them safe. Staff were suitably qualified and very knowledgeable about the needs and associated risks of people using the service. Planned absences for staff such as leave and training were accommodated within the staff rota. Short notice absences were covered by staff on duty (including staff at five other homes in the vicinity run by the provider), bank staff and occasionally agency staff. Agency staff had completed elements of the induction course at head office and had worked at the service previously.

Staff providing care and support for people were supported by staff in other roles in the service and at head office. The majority of domestic duties were carried out by a member of domestic staff. A specialist epilepsy nurse and an epilepsy specialist were available to provide advice when needed. They took turns to be available for advice 24 hours a day. Administrative tasks such as staff rotas, maintenance requirements, training and recruitment were handled at head office freeing up staff to concentrate on people's care and support. The provider ensured the service only employed suitable people by having robust recruitment procedures in place.

Medicines were managed safely. We found medicines were stored securely and appropriately. We examined the medicine administration records (MARs) which identified and recorded what medicines were given to people and when. They were up to date and had been completed correctly. The service had systems in place for ordering and returning unused medicines. Medicines were only administered by staff who had completed appropriate training and were assessed as competent to do so.

Good

Is the service effective?

Our findings

New members of staff joining the service completed an induction course of training, visiting services, shadowing experienced staff and demonstrating they were competent before they were allowed to work unsupervised. The initial training was designed to introduce the requirements of the Care Certificate. The Care Certificate sets out explicitly the learning outcomes, competencies and standards of care expected of care workers to ensure they are caring, compassionate and provide quality care. In addition, the induction included specific training about people living with epilepsy and behavioural support.

We saw staff regularly completed training and refresher training relevant to their roles. In addition staff completed training that was necessary to meet an individual's needs. For example, staff had received specific training in relation to percutaneous endoscopic gastrostomy which is commonly known as a PEG feed. This is where a tube is inserted through the abdominal wall into the stomach. The PEG allows nutrition, fluids and medications to be put directly into the stomach, bypassing the mouth and throat. Staff were trained so they were confident when providing care and support in relation to the PEG.

Staff were supported by the provider to complete further training relevant to their role. Irrespective of their experience staff continued to attend training in relation to epilepsy to ensure they were up to date with developments in the field reflecting the specialism of this service. One relative told us, "The staff have always been good, the training they get is amazing." A member of staff said, "L&D (learning and development) are very supportive with short notice training such as the PEG training we did." It was evident from the records we viewed and feedback from staff and relatives the training provided was regular, relevant and of a high standard. This meant staff had up to date knowledge that supported them to provide safe and appropriate care to people using the service. In addition to training staff were supported with regular supervision sessions. These provided opportunities to discuss performance, competency and development. One visiting professional told us, "I have to give credit to the support workers who are very observant and so knowledgeable about seizures.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found mental capacity assessments had been completed, and where appropriate best interest meetings held and DOLS authorisations obtained. DoLS authorisations were mainly around the use of lap belts for wheelchairs and

cot sides to prevent people falling out of bed.

Staff were aware of the dietary needs of people they cared for and care records confirmed a suitably balanced diet was provided to promote people's health and well-being. One member of staff told us, "PCPs [Person Centred Plans] give clear guidance on how people like to eat and the menus are done for us so there is a varied diet." Care records clearly reflected people's needs in relation to nutrition and hydration. In addition to advice from within the service we saw healthcare professionals had been consulted when required including a speech and language therapist, dietician and GP. Food and liquids consumed by people were recorded to ensure people were receiving enough food and liquids. Drinks and snacks were available at all times. Staff told us they usually took meals with people and ate the same food to encourage them to eat and drink and take part in a regular social activity.

People using the service were registered with a local GP who was regularly involved in their healthcare. People attended periodic appointments with the consultant neurologist at the local hospital. The service provided the neurologist with detailed reports of seizure activity. Each person had an individual seizure protocol to ensure they received the most effective care and support during and following a seizure. A specialist epilepsy nurse and an epilepsy specialist were always available to provide staff with advice and regularly reviewed care plans and medicines. We saw evidence of visits to and from health and social care professionals including the GP, dentist, chiropodist and a variety of therapists. People were supported by staff to attend these external appointments.

Good

Is the service caring?

Our findings

We spoke with relatives about the service and one told us, "They are all so lovely and caring, I think it's great." Another relative said, "They don't just care for them, they care about them. They are amazing." Another relative said, "The staff are really lovely. I would recommend the home to anybody." One relative told us, "I am extremely happy with them." Another relative said, "If I want to take [name of relative] out and need help they will make sure somebody is there to help."

We observed and listened to how staff interacted with people using the service. There was a calm and friendly atmosphere. Staff were patient, friendly and treated people as equals. People were encouraged and supported to do things they wanted to do. One person decided to get up and walk around the lounge. Staff immediately went to support them and walked around chatting until that person decided they had done enough walking. Their body language suggested they had enjoyed the experience. We paid close attention to people's body language which in the main was positive particularly when responding to staff providing care and support. It was evident there was a friendliness and familiarity between people and staff which contributed to the warm atmosphere in the service.

A key worker was assigned to each person using the service. For new people and their relatives this provided an immediate point of contact who could address concerns before and after joining the service. Key workers worked closely with individuals to get to know them well and be in a position to pass on useful information to other members of staff. A visiting healthcare professional told us, "Key workers know a lot about their residents and often come to me with suggestions." Key workers supported people to identify goals and aspirations in areas such as daily living, education, finance and activities and developed a plan to try to achieve them. To this end the key worker met with people at least once a month to consider progress. A monthly record identified what progress had been made in relation to goals, what had happened in the preceding month and what was planned for the next. Any new goals were recorded. We examined the last six months monthly key worker records and noted the amount of detailed information about people's care and support they contained.

We found people and relatives were involved in making decisions about their care and support. One relative told us, "I am involved in the care planning." Another relative said, "We work as a team, we get involved." One relative said, "I've been involved in his care planning. They always let me know what's happening and if there are any issues. I think they do really good here, he wouldn't be here otherwise." When we examined care records we saw evidence of relative's involvement in planning care and support.

Staff were aware of and took into account people's choices and preferences. Care records provided detailed information such as how they liked to get up in a morning, when they liked to get up, how they preferred to take medicines and what they liked to eat. People exercised choice. If people wanted peace and quiet they left the lounge area and went to their rooms or other areas where it was quiet. Although people could not communicate verbally staff knew people well enough to recognise non-verbal signs and communications to recognise what they wanted. Staff also used prompts and sign language to build relationships and communication. For example, when staff touched one person's wrist they knew staff wanted their attention.

We saw care records clearly identified communication issues and how to communicate effectively with each person. People were supported to maintain contact with family and friends. Due to the specialist nature of the service people's families and friends did not live nearby. The service encouraged people to use the technology available to everybody through telephone calls, Facetime, Skype for example in order to see and hear family and friends regularly and pass on photographs to show what they had been doing. The service also offered practical support in terms of transport and providing staff to assist relatives to take people out.

People were encouraged and supported to maintain and develop their independence as far as they were capable and in line with their wishes. This usually took the form of daily living or personal care. Although independence was limited to a large extent due to people's complex needs any acts of independence, no matter how small, contributed to people's self-esteem. Staff told us they gave people time to do things. It was apparent from our observations that staff were not task driven and were not pressurised to complete tasks quickly. For example, one person liked to be to be woken in a specific way where they were gently woken and left for a while to come around whilst listening to music they liked. We saw staff respected people's privacy and dignity. Personal care took place in private and usually in people's rooms or behind closed doors in bathrooms. When people wanted time to themselves they went into their rooms and their wish for privacy was respected by staff.

Outstanding ☆

Is the service responsive?

Our findings

People's needs were assessed before they came to live at the service. One new person had arrived since our last inspection. After a medical assessment had been completed the service decided it was in a position to offer a place. The person concerned had lived at another service for a number of years. To ensure Foxley Lane would be able to meet this person's complex needs and make the move successful a lengthy period of preparation and transition took place. This happened between May 2016 and August 2016. During this period staff from Foxley Lane visited the other service over a number of days and at different times of the day to observe how care was provided and to become familiar to the person moving. Staff from the other service also visited Foxley Lane on a number of occasions, sometimes with relatives of the person transferring, to discuss how to provide care and support and exchange information. The person concerned also visited the service.

This transition period enabled staff to develop detailed care plans and prepare for the move. This included a total refurbishment of one bathroom and the installation of a specific bath to meet the person's needs. On the day of the move staff from the other service accompanied the person to Foxley Lane and remained to settle them in bed for the night. They returned early the next morning to show some of the Foxley Lane staff how the person liked to be supported to get up. Foxley Lane held a welcome party later in the day which was attended by relatives and some staff and friends from the other home. The considerable efforts involved to make this transition safe and successful were a credit to both services involved bearing in mind they were 40 miles apart. It also enabled the person involved to settle in and feel at home more quickly. To provide extra support for a close relative the parent of another person using the service was asked to be their 'buddy' to help with any questions or concerns.

People using the service received care that was responsive to their individual needs. All available information was used in developing detailed, person centred care plans that provided guidance to staff so they could provide safe and appropriate care and support. We saw care plans comprehensively identified and addressed people's needs in areas such as medicines, moving and handling, therapies, activities and epilepsy. They were written in a person centred way to make sure people were not objectified in the records. Care planning also accommodated people's preferences as far as was practicable. For practical use, staff were provided with a 'daily delivery plan' for each person that gave them clear guidance and reminders of what they needed to do with that individual and how to do it. It was also where staff recorded the care and support provided. In our conversations with staff they demonstrated a good knowledge of people's individual needs and preferences which demonstrated, alongside our observations, they were providing person centred care.

The service provided specialist epilepsy care and the provider ensured staff had the training and skills to safely provide such specialist care including other neurological, physical and medical needs. In addition, a specialist epilepsy nurse and an epilepsy specialist ensured the service, and other services operated by the provider, were at the forefront of epilepsy care. They regularly reviewed care plans and medicines and where appropriate raised concerns with the relevant physician. The provider regularly sent them to national and international conferences to ensure they were aware of the latest developments in epilepsy and epilepsy

care so staff could benefit from knowledge and advice. They also maintained a close working relationship with Kings College Hospital (KCH) which carries out epilepsy research and, where appropriate and agreed, put forward people to be involved in that research. This meant the service had access to the latest developments in epilepsy care and treatment for people using the service. In this service, one person was benefitting from external trigeminal nerve stimulation (ETNS) which is non-intrusive treatment for drug resistant epilepsy. This latest treatment would not have been available to this person at the current time if the specialist epilepsy nurse and epilepsy specialist did not maintain a close working relationship with KCH.

Activities were an important part of people's lives and we found staff were confident in their experience and training to support people with complex needs in a range of internal and external activities. We found the service had access to two vans and employed a driver five days a week. Some other members of staff were also able to drive the vans. This enabled staff to take people to appointments, organised activities and trips out. The service ensured people were stimulated by encouraging people to be involved in a wide range of activities which could be as simple as watching TV with other people or engaging in either organised or unplanned indoor and outdoor activities. The service had nominated a member of staff as an 'activities champion.' They told us about trips out such as ice skating and holidays and said, "I try to make sure people get out and about." We saw records of regular individual and group activities. One relative told us some people went to Hayling Island on holiday. Whilst there the key worker had sent them videos and photographs of their relative enjoying the holiday. A variety of additional therapies, including music, art and rehabilitation were available to individuals with appropriate funding.

The relatives we spoke with told us they were regularly informed of any incidents and felt they could raise concerns with staff or the manager and they would be dealt with appropriately. One person told us, "If I raise anything it's dealt with straight away." Staff understood the complaints process and their responsibilities. The service had a formal complaints process. Any complaints were usually dealt with by the manager and reviewed at head office for any learning opportunities at service or provider level. The provider also had processes to gather information from various stakeholders including the relatives of people using the service. This took the form of an annual survey and in addition, a relative of a person in one of the provider's services telephoned relatives for feedback at least once a year. Any feedback was shared with head office to ensure both the service and the provider reacted positively to suggestions and ideas that could lead to improvements. We examined the most recent survey of relatives which in the main provided positive feedback.

Good

Is the service well-led?

Our findings

The service had an appropriately qualified and experienced manager who was registered with the Care Quality Commission. There was also a service manager and deputy manager because the registered manager was temporarily covering two services. Staff and relatives spoke positively about all of the managers and one relative described the deputy manager as 'the salt of the earth.'

We found there were processes to obtain feedback from staff. Staff told us they would feedback any concerns or ideas at the time and were confident they could speak openly with the management team of the service. There were staff meetings every month where staff were able to raise matters in the presence of their colleagues. A record of the meeting was made available to staff who could not attend. We saw there was an employee survey that allowed staff to provide feedback anonymously.

Accidents and incidents were recorded showing what action was taken at the time of the incident and subsequently. Any such reports were reviewed at head office to identify if any further actions were required and to see if there were any learning opportunities at service and provider level to improve the service provided to people.

We saw there was a framework of reviews, checks, visits and audits to monitor and assess service provision. These included reviews by the manager and the epilepsy specialist and nurse of medicines and care plans; checks carried out by staff and managers; periodic and unannounced visits by managers at weekends and nights; visits and audits by representatives of relatives; monthly audits by managers from other services; and, visits and audits by the Operations Managers and the Operations Director. As one member of a staff told us, "There's always someone coming unannounced to check what we are doing."

We examined a random sample of records for these reviews, checks, visits and audits to confirm they took place at intervals specified to us during the inspection. We found this framework enabled the service and provider to identify failings or problems and to address them with a view to improving the service for people living there.

We looked at a variety of records relating to the provision of care by the service. Records were accurate, up to date and accessible. Where appropriate, records were stored securely and limited to those people authorised to see them. Records were fit for purpose.

We found the service met the statutory requirements in relation to CQC notifications and reporting safeguarding. We checked our records and found the occurrence of these incidents were within normal parameters for comparable services. Details of any such incidents were reported to head office with a view to identifying any learning opportunities and making improvements at service or provider levels.