

iMap Centre Limited Hollybank

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 inspection took place on 21 March 2016 and was announced.

The service provides accommodation and support to four young adults with autism. This is a mental condition, present from early childhood, characterized by great difficulty in communicating and forming relationships with other people and in using language and abstract concepts. Whilst all autistic people share certain difficulties, being autistic will affect them in different ways.

The service is located within a detached property in a residential area of Weaverham, close to local amenities. At the time of the visit, there were four people living at 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.'

We previously inspected the service on 9 May 2014 and returned on the 2 March 2015 to ensure that improvements had made to the environment. At that time, we found that the registered provider met the regulations assessed.

People lived in a detached house that had been adapted in part to meet their needs and people had access to communal areas as well as the privacy of their own rooms. The building was kept clean in order to minimise the risk of infection. Remedial repairs and refurbishment took place when required. The registered provider ensured that all required checks were carried out on a regular basis.

Observations indicated that people were happy at the service and there were positive interactions with staff. People were mainly supported by staff that knew them well and could anticipate their needs. New staff shadowed existing staff until they knew the person well. People had busy social lives and encouraged to be as independent as possible.

The requirements of the Mental Capacity Act 2005 were partly met. Staff used a range of strategies to communicate with people to help them express themselves and to indicate consent. However, they did not document a person's ability to make decisions or those situations where they had to act in their "best interests". Applications had been made under the Deprivation of Liberty Safeguards where it was felt a person's liberty was being restricted or deprived.

Staff were aware what was required in order to keep people safe and there was evidence that they were confident to report matters of concern. People received care and support from staff that had been through robust recruitment procedures to ensure that they were of suitable character to work in this setting. Staff also underwent an induction programme to equip them with the knowledge and skills to support people

with complex needs.

Care records were personalised and gave a clear picture of a person's needs, wishes, preferences and personality traits. Risk assessments and management plans were written to direct staff in managing certain aspects of a person's care. This meant that staff not familiar with people at the service would be able to something know about them and how their support needed to be delivered. Medications were administered correctly which meant that people received the medication they needed to keep them well.

The registered provider ensured that audits were carried out on a regular basis in order to monitor the quality and effectiveness of the service. There was a complaints policy in place but there had been no formal complaints since out last inspection. Matters were usually responded to and dealt with informally.

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's family told us that they felt confident that the people who used the service were safe.

Risk management plans were in place to support the delivery of safe care and support. Medicines were administered safely.

People were supported by staff that had been recruited to ensure they were of suitable character to undertake their role.

Is the service effective?

Good ●

The service was effective.

Staff sought the consent of people in day to day decisions but where they lacked in mental capacity this was not clearly documented.

The service worked well with other professionals and agencies to ensure a holistic service that took into account all their needs.

Staff had received the training to ensure they had the skills and knowledge to work in the service.

Is the service caring?

Good ●

The service was caring.

Feedback from relatives and professionals was positive and people were supported by staff that were kind and patient. We observed positive interactions.

People's preferences and differing needs were recorded and care provided in accordance with wishes

Is the service responsive?

Good ●

The service was responsive.

There was a complaints process in place and relatives felt confident to raise a concern.

Care was personalised to each individual and this was documented so that staff knew what was required.

People were supported to engage in activities that they liked to take part in.

Is the service well-led?

Good ●

The service was well led.

There were quality audits in place to monitor and ensure quality and safety standards.

Staff told us that they felt well supported and that their views were taken into account.

A new management structure had been put in place to support the service.

Hollybank

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 21 March 2016. The inspection was announced. The registered provider was given 48 hours' notice because the location was a small care home for younger adults who are often out during the day; we needed to be sure that someone would be in.

The inspection was carried out by an adult social care inspector.

Before the inspection we gathered and reviewed information held on the service through our notifications and feedback from other professionals.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

People at the service were not able to express their views to us verbally. On the inspection we observed, where we were able, interactions with staff and people who used the service. We also spoke to seven staff on duty that day.

We looked at the records of the three people who used the service which included care plans, risk assessments and daily notes. We also reviewed the information kept around the management of the building, overall service and the staff. This included utility checks, quality audits, staff training and supervision. We had previously reviewed a number of recruitment files.

We gave the opportunity to the relatives of those people who used the service to provide us with feedback and they did so by email. .

We contacted the commissioners of the placements but we did not receive any comments to help us inform our judgement.

Is the service safe?

Our findings

Relatives told us that they felt "Assured that people were kept safe".

Staff had an awareness of safeguarding adults and were confident that they knew how to report any concerns. There was training and policies in place to support staff to ensure that they could recognise abuse or poor practice and take action. The registered manager had ensured that the CQC and local authority were aware of any potential safeguarding issues. Concerns of a low level were investigated and reported to the local authority monthly as per protocol. These included situations where there had been minor risks occurring as a result of an isolated poor practice such as inter- resident issues and medication errors

Staff received training in administration of medication as all of the people who used the service needed support with this.. Staff were observed carrying out this task initially under supervision. New staff told us that they did not have to do this until they felt absolutely competent as it was such an important task. Some people had complex drugs regimes for the control of seizures for example, and this required specialised training and careful monitoring. We checked the medication administration records for people and the medicines available and found them to be correct. There was also a process in place to ensure accountability when medication had to be taken off the premises. Some medicines were given on an "as required basis" such as pain relief or creams for skin conditions. It was not always possible from the records to tell what these were for and when they were to be used. We spoke with the registered manager about the need to ensure that this was documented clearly so that the medications were given in the way that they were intended.

Accidents and incidents were reviewed by the senior management team to identify any information that could point to themes or trends or indicate unsafe care practice or treatment.

Staff did what was required in order to keep people safe within their home. This extended to the wider community and when using vehicles. A series of risk assessments and management plans were in place that guided staff when supporting a person where risks had been identified. Management plans were followed to ensure that a person's care and support was delivered safely whilst promoting their independence. One risk assessment addressed a person's ability to assist in the kitchen. It advised that the person "Needed to be outside of the safety gate whilst cooking took place" but that they could "Still assist but this minimised the risk".

On the day of the inspection there was enough staff to meet the needs of the people at the service. Staffing was determined on a weekly basis and calculated to take into account the changing needs of the people and any activities that were planned that week. New staff had been recently recruited and were in the process of undertaking their shadow shifts. Staff told us that a number of staff had left and that they were hoping that the new starters would stay and bring stability to the household.

We had previously checked the recruitment processes in place for the registered provider and found that these were safe. All the required checks, including references and a disclosure and barring service disclosure

had been carried out before the staff worked in the household. This meant that people were supported by people deemed to be of suitable character to support vulnerable people.

The registered provider ensured that the premises were kept safe and clean. The registered manager showed us a report from the infection control team from Cheshire and Wirral Partnership who had recently visited and were pleased that the property was clean and well maintained. There were regular checks carried out on the gas, electricity and water supply. Checks were carried out on the safety and suitability of equipment and appliances used. We spoke with the registered manager about the requirement to ensure that fridge temperatures are carried out on a daily basis as these were not always evident. There was a fire risk assessment and evacuation plan in place. There was an independent Health and Safety Consultant who offered advice and support when required.

Is the service effective?

Our findings

Relatives indicated that the service was effective in meeting people's needs as it promoted their independence and kept them well. Records showed that people who used the service and their families were involved in decision about their care and support.

The registered provider had made the required adaptations to the property to ensure that it was safe, secure and met the needs of the people who lived there. There were a number of separate living areas, a variety of places to eat and a sensory room where people could go outside of their rooms.

Staff prepared meals and involved people where they were able. Staff carried out the shopping often accompanied by a person who used the service. Menus were on display but we noted that they did not offer a choice to a person. Staff told us that the menus were devised taking into account peoples likes and dislikes: if a person did not want to eat what was on offer then an alternative could be found. On the day of the inspection the fridges and freezer were not well stocked and there was little evidence of fresh fruit and vegetables available. Menus did not appear well balanced and some days were repetitive: for example chicken wraps for lunch and chicken fajitas for tea. We suggested that the registered provider review the nutritional content of the menus. People were able decide where they wanted to eat and this was noted in their care plans. Some people liked to eat together whilst another liked to eat alone in their room.

Relatives said that they thought there were a good range of activities available both inside the service and also in the community. On the day of the inspection, some people had gone swimming whilst others had a long walk out and a pub lunch. There was a programme of activities planned and so long as additional staff were available, these took place. An activities diary was in place to record what someone had done that day.

Staff training records were kept by the registered provider and training delivered across all of the registered provider services. All new staff received and induction to ensure that they had the skills, knowledge and values to support people who used the service. This was classroom learning followed by an introduction to the people they would support. The staff members shadowed an experiences staff member until they were assessed – and felt - confident to carry out the role. Staff we spoke with told us that this worked well and that they had very good guidance "On the job". Staff also completed the care certificate. This is a recognised set of standards and competence for new care staff to achieve. There was an on-going programme of training for staff to ensure that they kept their knowledge and skills up to date. Training areas included safeguarding, health and safety, food hygiene, epilepsy awareness and strategies for managing behaviours that challenged and communication. Staff said that they had the training to carry out their roles and that they also had very good day to day support.

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 procedure for this in care homes is 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.

DoLS requires registered providers to submit applications to a 'Supervisory Body' for authority to restrict or deprive someone of their liberty. All of those living at the service had a DoLS in place to support the restrictions and restraints that were sometimes placed upon them. These included situations where a person did not have the mental capacity to make decisions such as where to live or where someone's freedom within the service was restricted for example by the locked doors or room monitors. These were reviewed regularly by the supervisory body and copies of the assessments accessible to staff. Staff we spoke with was aware of these and were able to describe why these were in place and necessary.

There were systems in place for seeking and obtaining consent to care and people's human rights were respected. The service had a set of policies and procedures that informed staff about the rights of people who used the service. These included people's right to give or withhold consent and what to do if a person did not have the capacity to consent to care. We saw that staff used a variety of communication methods to try to seek consent and also they were very aware of non-verbal gestures

Not all of the people who used the service were able to make every decision for themselves. Support plans stated that people were not aware of the risks of their behaviours such as; refusing medication, the need to maintain dignity and how their behaviours affected others. However, staff did not make it clear what level of mental capacity a person had to make a specific decision and those circumstances where they would need to act in the persons "best interest". Some staff believed that families were able to make decisions on behalf of their relatives. As a result they had asked relatives to sign consent forms authorising interventions when no evidence of a legal authority (such as a Lasting Power of Attorney) was in place.

We recommend that the registered provider ensure that decision making is recorded in line with the mental capacity act and the associated code of practice.

Is the service caring?

Our findings

Relatives told us that they were happy with the care and support given to their family members and that a good standard of care was given. Comments included "We have no concerns and think all the staff do a good job"; "[relative] is generally happy there and is eager to get back even after a home visit where we spoil them for a few hours"; "Staff take great care of their personal care needs ensuring they look their best every day, even pampering them with massage and nail sessions".

Staff emphasised the importance of praise and encouragement. Interactions that we observed were positive and people were encouraged to do things that made them happy and relaxed such as playing music and singing. We observed positive interactions between people who used the service and the staff supporting them. People were relaxed in their company and staff understood or anticipated their needs.

Staff encouraged people to maintain relationships with their family and the community. A family member said "[relative] visits home with two members of staff who are always eager to ensure the visits take place". Family confirmed that they were kept informed by the service of matters relating to their relative. Staff told us that they liked to keep families up to date with people's achievements and especially when they had participated in something that they enjoyed. One staff member told us " We really like to praise people when they have done something really well and its good to share those positives with family". As an example, staff had emailed families pictures that caught a person's experiences on a day out. Each person also had a scrap book which included pictures of activities and trips out.

Staff understood the need to promote the dignity, respect, involvement and independence of the people who used the service. Training in promoting people's rights and respectful practices was part of the induction programme and on-going training for staff. There was an en-suite bedroom that was allocated to a female in order to maintain their privacy as the other people who lived there were male. Other people showed disinhibited behaviours and staff managed this well and ensured that their dignity was maintained at all times . They ensured that they were monitored in communal areas and took swift action where required. A number of male staff had recently been recruited so that there was an opportunity for male support to be provided to the men who lived there.

Staff explained the importance of keeping routines for people and the need for the continuity of staff. They told us that wherever possible they covered shifts for others as they were aware that the people supported do not react well with unfamiliar people. A health passport was completed for each person and this contained essential information about their needs. This ensured that if they had to attend hospital the staff would know something about them to ensure that their care was not disrupted and routines were maintained.

All staff were trained in recognising the importance of confidentiality, both in their induction and as part of their on-going professional training. This was reinforced in the staff handbook and in the code of conduct. Staff gave us examples of how they maintained confidentiality, including the secure storage of personal

data, finding private areas for discussions.

Wherever possible, the registered provider tried to involve people in the interview of new staff members. They tailor their involvement to either allow the person to interview or ask their own question, or a question can be asked on their behalf. Where the person is unable to generate a question, one from their family member or advocate can be included.

Is the service responsive?

Our findings

Relatives were assured that staff responded to individual needs. "Staff who works with [relative] has a very good understanding of their needs, which can be challenging at times. They know exactly how to deal with the changing behaviour throughout the day".

Each person had an initial profile and assessment to identify their needs, appropriate staffing requirements, assistive technology, and any compatibility issues. We looked in detail at the records of two people who used the service. There was evidence of good practice with support plans being written in a person-centred way. The support plans provided information around people's health, social, behavioural, learning and physical needs. They outlined the type of care and support that was required for each person.

One person had a care plan in place for occasions when they may refuse medication. Guidelines were in place that guided staff on how to approach the person in order to have the best chance of getting the person to accept medication. Another person was very particular about the clothing. Care plans gave clear direction to staff as to the type of clothing the person should wear.

Care plans also outlined behaviour traits and the habits people exhibited and what they might mean. This knowledge allowed staff to pre-empt a situation and anticipate what a person needed. All of the people who used the service had very limited speech and care plans indicated alternate communication methods such as the Picture Exchange Communication System (PECS). We observed staff interacting with people in this way. The staff demonstrated an understanding of people's care and support needs.

A daily record was kept for each person and this formed the basis of handover information between shifts. Records indicated how a person had been in mood and behaviour, what they had done, what they had eaten for example. Significant incidents that may have occurred were logged. Staff were aware of the importance of keeping detailed records and good communication between shifts. This ensured that staff were aware of concerns that could adversely impact people at all times.

One relative told us that "Attending to medical needs is a high priority for our relative and these are well looked after at Hollybank". Some people had very complex health conditions that required close monitoring. These included the occurrence of seizures which required rapid intervention by staff. Care plans and guidelines were available for staff to follow so that they could identify the signs of an imminent seizure. These included action to take during these episodes and aftercare. This ensured that people were kept safe and had their needs responded to quickly. The service recognised the importance of on-going health checks and how these may differ depending on gender. These were incorporated into the health care plans and people were given prompt access to medical support. Regular health checks took place and a health care diary action plan was in place. This ensured that regular appointments such as dentist and opticians were not missed. People were also supported to attend visits from their doctors or consultants.

There was evidence of a multidisciplinary approach with the service having worked in partnership with other agencies to enable the needs of the person to be met effectively. Care plans included any advice and guidance from other professionals. A communication care plan had been written with the involvement of an occupational therapist and covered all aspects of communication. It also addressed visual support and cues that staff used to communicate with an individual.

Is the service well-led?

Our findings

Relatives told us that the service was well led and transparent in their communications. Comments included "The staff and management are always helpful, open and keep nothing from us even when things are not going to well, every incident is always reported to us" and "We communicate well with staff to ensure our relative has the best of life possible and are very pleased with the care provided".

There was a registered manager in place and she was aware of her roles and responsibilities. CQC requires registered providers to inform them of key incidents and events that affect the service and the people who used it. The registered manager had ensured that the CQC were aware of such occurrences in a timely manner.

A number of staff events had been held to relay to all staff that their views and comments on the services provided by iMap had been taken on board. The priorities over the coming year would be a clear pathway for future service development and increased communication now that the service was based over several sites. As a result the registered provider had recently introduced a new management structure that it hoped would better support to its staff and the people they supported. A deputy manager was in place to oversee the day to day quality of the service and to provide support to staff. They were enthusiastic about this new role and explained the responsibilities that this brought with it. Key workers had also been introduced and they were to be responsible for the overseeing of care plans, health needs, family and professional communication for a specific person. Staff were pleased that they had the opportunity to take on new challenges and ways to improve the service.

Staff received formal supervision from a more senior member of staff and records of these discussions were kept securely. All staff told us that they felt able to go to another staff member with an issue and that they did not have to wait for supervision. Staff meetings were also held with day and night staff and minutes of these meetings were available. These were an opportunity for staff to raise issues of concerns about the service and the people they supported. They were also a forum to discuss policies, procedures or best practice. Senior staff also had the opportunity to meet with their counterparts in the other care homes run locally by the registered provider.

The registered provider had systems in place to obtain the views of the people who used the service, their representatives. Annual surveys were sent out to staff, the people who used the service and/or their representatives to find out their views about how the service was operating.

There were also systems in place to monitor the quality and effectiveness of the service. There were a number of daily, weekly and monthly manager and provider audit tools to monitor health and safety standards as well as the quality and effectiveness of the service. It was clear from these that if actions were required a person was nominated as being responsible for seeking a resolution and a timescale set.

The registered provider had planned a comprehensive review of all policies to standardise the format across all of the iMap services, and introduce easy read versions of key policies, and address any omissions. At present, policies and procedures were accessible in service via the company server, and all staff were issued

with a company handbook. We saw a new version of the service user guide that had just been updated in an easy read format so that it could be understood by those persons who used the service.