Allied Care (Mental Health) Limited

Clements House

Inspection report

36 Fish Lane,
Bognor Regis,
West Sussex
PO21 3AH
Tel: 01243 869004
Website: www.alliedcare.co.uk

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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

Overall summary

The inspection took place on 21 December 2015 and was unannounced.

Clements House is a residential care home which provides care and support for up to seven people with a variety of mental health needs and learning disabilities. At the time of our inspection there were six people living at the home.

Clements House is a detached two storey home. All bedrooms were single occupancy. There was a communal open planned lounge and dining room and a conservatory which was being used as a smoking area. There was a kitchen which people could use to prepare their own food. The home had a family cat.

There was a registered manager in place who was in day to day charge and worked alongside staff in order to provide care for people. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered managers, they are

Summary of findings

'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People said they felt safe at the home.

Systems were in place to identify risks and protect people from harm. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk actions were identified on how to reduce the risk and referrals were made to health professionals as required.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely.

There were sufficient numbers of staff on duty to keep people safe and to meet people's needs. Safe staff recruitment procedures ensured only those staff suitable to work in a care setting were employed.

The Care Quality Commission monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the MCA and DoLS. People at the service had capacity and the staff sought people's consent about arrangements for their care.

Staff were skilled in working with people who had mental health needs and learning disabilities. Training included positive communication, conflict management, schizophrenia and Asperger's syndrome, drug and alcohol awareness.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks.

Staff were caring, knew people well, and treated people in a dignified and respectful way. Staff acknowledged people's privacy. People commented that staff were understanding of their mental health needs and provided support during periods of distress. Staff had positive working relationships with people.

Care was provided to people based on their individual needs and was person-centred. People were fully involved in the assessment of their needs and in care planning to meet those needs. Staff had a good knowledge of people's changing needs and action was taken to review care needs.

Staff listened and acted on what people said and there were opportunities for people to contribute to how the service was organised. People knew how to raise any concerns. The views of people, relatives, health and social care professionals were sought as part a quality assurance process.

Quality assurance systems were in place to regularly review the quality of the service that was provided.

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.

Staff had received safeguarding training and knew how to recognise and report abuse.

There were sufficient numbers of staff to make sure that people were safe and their needs were met.

Risk assessments were in place and were regularly reviewed to ensure that they reflected people's current level of risk.

Medicines were managed safely.

Good

Is the service effective?
The service was effective.

Staff had received training to ensure that they were able to meet people's needs effectively. They received regular supervision.

People were supported to maintain good health and had regular contact with health care professionals. They had sufficient to eat and drink and were involved in menu planning.

The home had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures and staff were provided with training. The legislation was being followed to ensure people's consent was lawfully obtained and their rights protected.

Good

Is the service caring?
The service was caring.

People were treated with kindness and dignity by staff who took time to speak and listen to them. Staff were understanding of those with mental health needs. Staff acknowledged people's privacy.

People were consulted about their care and had opportunities to maintain and develop their independence.

Good

Is the service responsive?
The service was responsive.

People received care which was personalised and responsive to their needs.

There were structured and meaningful activities for people to take part in.

People were able to express concerns and feedback was encouraged.

Good

Is the service well-led?
The service was well-led.

The registered manager sought the views of people, relatives, staff and professionals regarding the quality of the service and to check if improvements needed to be made.

There were a number of systems for checking and auditing the safety and quality of the service.

Good

Clements House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered manager 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 21 December 2015 and was unannounced.

One inspector undertook the inspection.

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, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the registered manager sent to us. A notification is information about important events which the provider is required to send to us by law. We also reviewed feedback from health and social care professionals. We used all this information to decide which areas to focus on during the inspection.

During the inspection we spoke with three people who lived at the home. We also spoke with two care staff and the registered manager. We spent time observing people in the communal living areas.

We looked at the care plans and associated records for three people. We reviewed other records, including the registered manager's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for three staff were reviewed, which included checks on newly appointed staff and staff supervision records.

The service was last inspected on 02 September 2013 when no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, “Yes of course I do. If I didn’t I’d tell the manager, or area manager [name]”. Another person was able to explain an occasion they did not feel safe due to their relationship with another person in the home and what action they took, what the response was by the registered manager and how they felt supported.

The service had policies and procedures regarding the safeguarding of people, which included details about the definitions of what constituted abuse, how to recognise abuse and how to report any suspected abuse. There was a copy of the local authority safeguarding procedures on a notice board in the office so staff had details of how to report any safeguarding concerns. Staff had received training in safeguarding procedures. They had a good knowledge of what abuse was and knew what action to take. Staff were able to identify a range of types of abuse including physical, institutional, sexual, racial, financial and verbal. One staff said, “I would keep the person safe, observe the person, give them 1:1 if needed, talk to my manager and if needed CQC and/or the safeguarding team, I would complete an incident form and contact West Sussex County Council”. Staff said they felt comfortable referring any concerns they had to the registered manager if needed. The registered manager was able to explain the process which would be followed if a concern was raised.

Before people moved to the home an assessment was completed. This looked at the person’s support needs and any risks to their health, safety or welfare. Where risks were identified these had been assessed and actions were in place to mitigate them. Staff were aware of how to manage the risks associated with people’s care needs and how to support them safely. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk actions were identified on how to reduce the risk and referrals were made to health professionals as required. For example, the risk to people living with diabetes. These individuals had specific care plans and risk assessments on how to manage their diabetes, nutritional assessments had been completed, monthly monitoring of the person’s weight documented, diabetic annual eye screening arranged and followed up on where needed. People with a diagnosis of schizophrenia had specific medication for this which required four weekly blood test monitoring to check the person’s alertness. These blood test appointments were documented and care plans were seen to be updated based on those results.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. We observed medicines being administered and staff did so safely and in line with the prescription instructions. Medication Administration Records (MAR) were in place and had been correctly completed to demonstrate medicines had been given as prescribed. Medicines were locked away as appropriate. All staff were trained to administer medicines. The registered manager completed an observation of staff to ensure they were competent in the administration of medicines. We carried out a random check of the medicines and stock levels matched the records kept.

Staff had undergone pre- employment checks as part of their recruitment, which were documented in their records. These included the provision of suitable references in order to obtain satisfactory evidence of the applicants conduct in their previous employment and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Where DBS checks had raised concerns over candidates suitability these issues had been explored in depth by the provider. Prospective staff underwent a practical assessment and role related interview before being appointed. People were safe as they were supported by sufficient staff whose suitability for their role had been assessed by the provider.

Daily staffing needs were analysed by the registered manager. This ensured there were always sufficient numbers of staff with the necessary experience and skills to support people safely. Staff told us there were always enough staff to respond immediately when people required support, which we observed in practice. There were three staff on duty with a senior support worker leading the shift from 8am to 8pm daily. At night there was one awake member of staff and one sleep in person, in case of an emergency from 8pm to 8am. Rotas we reviewed confirmed there was always sufficient staff to meet people's needs safely. The rota included details of staff on annual leave or training. Shifts had been arranged to ensure that known absences were covered.

Good

Is the service safe?

Checks were made by suitably qualified persons of equipment such as the gas heating, electrical wiring, fire safety equipment and alarms, Legionella and electrical appliances to ensure they were operating effectively and safely. Each person had a personal evacuation plan so staff knew what to do to support people to evacuate the premises in an emergency.

Good

Is the service effective?

Our findings

People told us they were supported by staff who were skilled in working with people with mental health needs. For example, one person said, "Yes they do have the skills and experience to care for me. They show this by the way they talk to me and support me. They are patient and reassure me when anxious. They help me with my emotions. They wouldn't work here if they weren't able to". People said they discussed their care needs with staff members who had been assigned to them.

Staff received training, supervision and appraisal of their work so they had the skills and knowledge to look after people well. This included specialised training in mental health awareness, drug and alcoholawareness, awareness oflearning disabilities, schizophrenia and Asperger's syndrome. This training provided staff with the knowledge they needed to support people effectively.

Newly appointed staff received an induction training programme to prepare for work at the service. The registered manager told us this was comprehensive and covered the aims, objectives and purpose of the service. It also included an induction checklist to confirm staff were instructed in areas such as lone working, the care of people and staff conduct.

Staff confirmed they completed the induction and that the induction involved observation and assessment of their competency. Staff also enrolled for the Care Certificate which is a nationally recognised qualification from Skills for Care. This Certificate covers 15 standards of health and social care and are work based awards that are achieved through assessment and training.

The registered manager maintained a spreadsheet record of staff training in courses considered mandatory to provide effective care and recorded when staff had completed these. This allowed the registered manager to monitor this training and to check when it needed to be updated. These courses included infection control, moving and handling, fire safety, first aid, health and safety, report writing, equal opportunities and food hygiene.

The registered manager supported staff to attain the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. The registered manager confirmed four of the 10 staff were trained to NVQ level 2, two to NVQ level 3 and one to level 4. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

Staff told us the training they received was of a good standard and that the registered manager encouraged staff to attend training courses. Therefore staff were supported to achieve further qualifications to enhance their skills and knowledge.

Staff confirmed they received regular supervision which allowed them to discuss their work, training and future plans with their line manager. Staff said they found the supervision sessions useful. Records of staff supervision and annual appraisals of their work were maintained and covered the care of people, training and updates on relevant legislation. A member of staff said, "My manager is always available for support; we can always approach our manager and the area manager who visits regularly." Regular supervision allowed the manager to monitor staff competency and knowledge and respond to any improvements needed.

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). Staff were trained in the MCA and had also signed to acknowledge they had read and understood the provider's MCA policy.

Conversations with staff and people confirmed people were consulted and had agreed to their care, which was demonstrated in care plans which people had signed in agreement. None of the people at the service had been assessed as being unable to consent to their care and treatment. The registered manager described how any queries regarding people's capacity were discussed with

Good

Is the service effective?

the relevant social care professionals. A staff member said, “We must always assume they have capacity, act in their best interests when necessary and be aware that there will be times when some of their decisions are unwise.”

People's nutritional needs were assessed and recorded on a nutritional risk assessment; these included a risk score indicating if further action was needed. A record of people's weight was also maintained so any weight loss or gain could be identified. Where weight loss was identified this was followed up with the person's GP and recorded in their care records. Care plans included details where people needed to be monitored to ensure they maintained a healthy diet. Nutritional assessments were repeated at intervals for those identified at risk of weight loss. The Malnutrition Universal Screening Tool (MUST) tool was used. This tool identifies whether a person was malnourished or at risk of becoming malnourished. People who were at risk were weighed on a monthly basis and referrals or advice was sought where people were identified as being at risk.

Weekly meetings took place for people to discuss what they would like to eat and then staff created a menu plan. The menu plans sampled showed varied and nutritious meals. People said they were consulted about the meals and confirmed there was a choice. Meals for people with specific dietary needs were available. Food stocks were plentiful and included a mixture of fresh, chilled and frozen food. We observed people helping themselves to food and preparing light snacks in a kitchen specifically for their use between meal times.

Records showed staff supported people with their health care needs. The service had links with local health care services, including GPs, community nurses and mental health services. Records showed people were supported with lifestyle health care needs such as giving up smoking and the registered manager confirmed this had been successful for people at the provider’s other services. We saw minutes of a residents’ meeting; people had discussed smoking in the home and had agreed for the smoking room to be turned into a relaxation area in the future. People said this was a positive decision to help cut down on smoking and to create an area for relaxation and activities.

Care records showed people’s mental health and physical health care needs were assessed with corresponding care plans of how to support people with these needs. Arrangements had been made for people to have specialist assessments and treatment where needed such as for eye care, dental care and mental health conditions such as schizophrenia. Staff told us that some people needed support to arrange and attend health care appointments, such as with their GP. Staff told us that this support ranged from providing reassurance when people made their appointments over the telephone to attending the appointments with the person to ensure people arrived safely. People explained how staff helped them with their health care needs. Records showed staff either contacted health care services when people exhibited symptoms of illness or supported the person to contact health care services; to ensure they received the right health care checks and treatment.

Good

Is the service caring?

Our findings

People told us, “They are very caring, very kind”, “I love the staff. They are good staff here.” Staff we spoke with said, “We firstly respect their rights and choices. We give advice which they don’t have to take and they can make their own decisions.” Another staff member said “We always knock on their doors and then ask if we can go in. We give privacy.”

Staff took time to make sure people understood what had been said or asked by making eye contact and repeating questions if needed. We saw staff hold people’s hands in an appropriate manner when reassurance was needed. We saw that staff were gentle and friendly when they spoke with people and were quick to respond to requests in a kind and pleasant manner.

We saw that one person became anxious and upset when discussing their finances. The member of staff reassured this person that they were able to and could manage their money. The staff member offered the person a seat in the office and go through the process of using their bank card and how to obtain a bank balance. Later in the day the person returned from the bank and appeared very pleased showing the staff member the bank balance receipt. The person stated while they were out they went for something to drink and told us they were enjoying their day. People and staff appeared to enjoy each other’s company. Staff knew which people needed equipment to support their independence and ensured this was provided when they needed it. For example the use of a Zimmer frame to support mobility.

We spent time observing care practices in the communal area of the home. We observed staff maintain people’s privacy and they knocked before entering people’s bedrooms. Throughout our inspection we observed people were supported by staff to dress warmly and were reminded to check their watches were set at the correct time. People’s care plans contained guidance for staff on how to maintain people’s dignity while supporting them with personal care tasks.

People’s rooms were personalised with possessions such as pictures, family photographs and bedding of their choice People were able to bring in their own furniture to make the room feel more familiar and homely. Staff had a good understanding of people’s needs and individual likes and dislikes and understood the importance of building relationships with people. People and their family were involved in the care which they received. Minutes of reviews sampled showed family members in attendance. Relatives were also encouraged to be involved in people’s care and were sent annual questionnaires for feedback and suggestions. We have explored this further in the ‘Well Led’ section of this report.

Family and friends were able to visit without restriction. A member of staff told us they maintained relationships with people’s families and made them feel comfortable when they came to visit.

Good

Is the service responsive?

Our findings

People told us they received care specific to their needs. One person said, “I am diabetic and epileptic. I know what my care plan says. Staff do support me with testing my blood and sugar levels.” A staff member said, “When the care plans are reviewed and updated, we do that with them and their families.”

People were involved and consulted during the assessment and review of their needs. Conversations with people showed that people were involved in discussing and planning how their needs were to be met and risks should be managed. People said there were a number of ways the registered manager and staff listened to their views and concerns. These included discussion at residents' meetings, care reviews or by approaching staff directly with any issues they had. Minutes of the residents’ meetings sampled indicated that a person wanted to change their 1:1 supported activity to going to the cinema and the person’s activity records indicated this had happened. People discussed food choices and menu records reflected those choices. This demonstrated that staff listened and responded to people’s feedback and views.

Care records showed people's health and personal care needs were comprehensively assessed and that care was arranged to meet those assessed needs. Care plans showed care was individualised with bespoke arrangements based on each person's needs and preferences; this is called person centred care. For example, there were different arrangements for each person regarding the support they needed and this was recorded in their records as; 'Who I would like to be involved in my care,' 'Things that I am able to do,' and, 'Things that I would like you to help me with.' Each person had a named staff member during a shift who took lead responsibility for co-ordinating their care and support.

People’s mental and physical health needs were included in the assessments and records showed the staff were responsive to people's changing needs. For example, medical assistance was sought when people were unwell and less urgent needs were referred to the appropriate agencies. An example of this was a person who reported they had sore gums. This was recorded in the person’s daily notes. A dentist appointment was arranged and this was recorded in the person’s health records. Handover records were completed to inform the next staff on shift what the outcome was of the appointment so support could be given. Charts were used where appropriate to monitor changes in people’s behaviour or for other needs. Care needs were reviewed on a monthly basis so arrangements could be made to meet changing circumstances. Minutes of the reviews sampled showed that input was sought from multiple professionals involved in people’s care such as social workers, chiropodists, forensic community support officers and GPs to ensure continuity of care.

We observed a staff handover meeting when the staff teams changed shift where people's needs were discussed such as behaviour or their mood. This helped ensure people's needs were monitored and that all staff were aware of any changing needs. At handover a record was completed by a nominated staff member of each shift, recording what each person had done that day. It detailed what else was planned, a reminder for staff to read the house diary for appointments and the name of the staff member who was nominated to administer medication. It stated which staff were supporting people to cook their meals, which staff were supporting people checking toiletry supplies and do their agreed tasks of hoovering, dusting and other general house cleaning tasks.

Staff sought to enhance people's independence and involvement in the community and in the way the service was run. For example, people were supported to take part in cooking, cleaning and their own laundry. Support was given to people to access community facilities and people could do this independently if assessed as safe to do so. Everyone living at the service was able to access the community independently and were encouraged to do so.

Records were kept of activities undertaken by people such as shopping trips and visiting relatives. We observed people going out independently, visiting the bank, going to the gym and socialising with each other or spending time in their rooms. Records showed that activities occurred between other services run by the same provider. Recently there had been a birthday party which people from Clements House attended. This meant the service promoted people to have a fulfilled lifestyle which included contact with other people both inside and outside the home.

The service's complaints procedure was displayed in the hall so people could access information about how to make a complaint as well as information about how any complaint would be dealt with. The complaints procedure

Good

Is the service responsive?

was displayed in written and pictorial format to ensure it could be understood and met people's individualised communication needs. Details of any advocacy services people may wish to use if they needed support in making a complaint were also on display. The registered manager told us there had been two complaints made about the service in the last 12 months. Both these complaints had with dealt with within the timescale stipulated in the complaints policy and to the satisfaction of the complainant. People said the staff listened to their views and said they knew they could use the complaints procedure if they needed to. A person was able to give an example of how they have done this and how their concerns were resolved.

Good

Is the service well-led?

Our findings

People told us, “The manager is very nice”, “They ask for my feedback on how to make things better, I’ve just completed a questionnaire recently” and another person said, “The manager is very good, she is helpful. She is trustworthy. I have my cash card with me now, they trust me. She is very supportive and I can always come and see her.”

A staff member said, “[registered manager] is brilliant. It’s very good here. They are very open and helpful. Always available to give advice if we have any questions.” Another staff member told us, “It’s a pleasure to work here.”

Quality assurance systems were in place to regularly review the quality of the service that was provided. These audits were carried out by another employee of the provider such as a registered manager or area manager to provide a more objective view of the service. These audits were unannounced. There was an audit schedule for aspects of care such as medicines, activities, care plans, finance checks, accident and incidents, health and safety and infection control. Records we observed demonstrated that information from the audits were used to improve the home. Where issues were found a clear action plan was implemented to make improvements. For example the home has a house vehicle for people to use, staff who were able to drive the vehicle needed their documents such as driving licence and insurance reviewed by the provider to ensure they were still able to legally drive their vehicle. Risk assessments that needed reviewing were identified. Records demonstrated to us people, their relatives and professionals were contacted to hold the reviews and updated plans were needed. Specific incidents were recorded collectively such as falls, medication errors and finance errors so any trends could be identified and appropriate action taken.

Staff meetings were held every month and this ensured that staff had the opportunity to discuss any changes to the running of the home and to give feedback on the care that individual people received. Minutes of the staff meetings sampled indicated that a staff member suggested a person would benefit from a pictorial menu; this was discussed with the person and then actioned. Staff were consulted and given an opportunity to be part of an upcoming fire inspection, the minutes indicated who would want to participate. At the next staff meeting feedback was given on the fire inspection and the registered manager thanked those that had attended.

Staff said they felt valued and listened to. Staff shared that they felt they received support from their colleagues and that there was an open transparent atmosphere.

Staff were aware of the whistleblowing policy and knew how to raise a complaint or concern anonymously. The registered manager felt confident that staff would report any concerns to them. Staff said they felt valued, that the registered manager was approachable and they felt able to raise anything which would be acted upon. We were told there was a stable staff group at the home, that staff knew people well and that people received a good and consistent service. We observed the registered manager speak with people and staff in a warm and supportive manner.

People, relatives and professionals were asked for feedback annually through a survey. The last survey was in November 2015. At the time of our visit the registered manager was still awaiting more feedback from relatives and professionals. The survey completed by people included people’s views on the manner of staff, whether people felt listened to and if they knew how to make a complaint. The registered manager told us that people completed these with support from staff. The responses from the last survey were all positive.

The survey completed by relatives included their views on the standard of the accommodation, if they were made to feel welcome and if staff had a good understanding of people’s needs. The responses from the last survey were overall positive. The comments read, “I believe that Allied Care itself at Clements House does do its best, given the resources available. I am appreciative of all help given”, “Very satisfied. Thank you for caring so well for my daughter.”

The survey completed by professionals asked for their views on the care provided and the response from staff. Two health professionals responded and the comments were positive. One comment read, “I usually deal with the manager of the home who has a good understanding of the diagnosis, symptoms and needs of the service users. All staff have always been polite and helpful to me”.

Good

Is the service well-led?

The registered manager described the vision and values of the home. They told us, “It’s our aim to ensure we provide a high quality level of care, by making sure we treat our people with dignity, privacy, respect and choice.” Staff told us, “We want a home from home; it has to be like that. Would we want to live here?” Overall staff said their focus was to ensure the quality of care provided, was to ensure people and their relatives were happy. We observed these values demonstrated in practice by staff during the provision of care and support to people.