Look Ahead Care and Support Limited

Nimrod House Supported Living

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 the 5 October 2018 and was announced.

At our last inspection on 29 August 2017 the service received an overall rating of 'Requires Improvement'. We identified four breaches of the regulations relating to safe care and treatment, fit and proper persons employed, staffing and good governance.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective, Responsive and Well- Led to at least good. At this inspection we found the provider had made the necessary improvements to meet the standards required of them.

Nimrod House provides care and support to people living in a supported living setting. Each person's flat had a living area, separate bathroom and kitchen. People live in their own flats so they can live as independently as possible. People's care and housing are provided under separate contractual agreements. The Care Quality Commission does not regulate the premises used for supported living; this inspection looked at people's personal care and support.

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.

People had risk assessments in place and now clearly stated how to mitigate against risk. Staff supported people to take risks in a safe way so that their freedoms were respected. Relatives told us their family members were kept safe at the service by staff.

Staff understood the different types of abuse and how to report abuse if they suspected it. Staff also knew when to whistleblow if they witnessed poor practice.

Staff were recruited safely and relevant checks were performed to check for suitability before staff could work with people at the service.

People's medicines were managed safely and the registered manager regularly checked staff competency in medicine administration to ensure safe practice.

The risk of infection was minimised as staff were provided with personal protective equipment and they kept people's living areas clean and tidy.

People's needs were assessed before they began to use the service and people were involved in the care

planning process along with their relatives and health professionals. People's care plans were person centred and people were given the opportunity to speak with their key worker each month to discuss their care.
Staff received mandatory training and specialist training in Autism and diabetes, specifically related to the people they supported which ensured they received good care from staff who understood their health needs. Staff were supported by management and received regular supervision and an annual appraisal where appropriate.

People were offered choices and staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) Where needed the registered manager had made appropriate applications to the Court of Protection where people's liberty was being deprived.

People's dietary and food preferences were now clearly recorded, people were supported to eat and drink well. People were supported to access health services to maintain good health.

People were supported by staff who were kind and patient. We observed people laughing and dancing with their key worker. People's privacy and dignity was respected. People were supported to explore personal relationships.

People took part in a number of activities of their choice and records showed people suggested new activities they wanted to try.

The registered manager had an open-door policy and staff felt well supported by management and other staff at the service.

The registered manager had a variety of monitoring tools they used to check the quality of the service. The service sought feedback from people who used the service via people's key worker sessions and feedback from relatives and health professionals. The service now held a quarterly coffee morning to provide people's relatives with a forum to discuss their family members care and any other matters.

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 now safe.

Risk assessments had improved and provided clear details on how to mitigate risk.

The service now carried out safe recruitment practices before new staff began to work with people.

Staff knew how to identify abuse and how to respond to an allegation of abuse.

People's medicine was managed safely and the risk of infection was minimised due to use of personal protective equipment.

Is the service effective?

Good

The service was now effective.

Relatives thought staff were good at their job and supported their family member well.

Staff now received effective training in specialist areas to support people at the service. People were offered choices and staff understood the principles of the MCA.

People were supported to maintain good health and were taken to health appointments by staff.

People's dietary needs and food preferences were clearly documented. People were supported to eat healthily and stay hydrated.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service was now responsive.

Care plans were detailed and more person centred. The service

used more pictures to support the care planning process and involve people in their care. People's preferences were recorded clearly.

People were encouraged to choose and take part in a number of activities.

People were supported to make complaints and relatives complaints were recorded and responded to in line with the service's policy.

Is the service well-led?

Good

The service was now well- led.

People were comfortable around the manager. Staff and relatives could approach the manager and felt they did a good job.

Quality systems were in place to monitor the service and to make improvements.

Best practice was shared amongst staff and they felt they were always supported to improve the quality of care.

Feedback on the service was requested from people, their relatives and external stakeholders.

Nimrod House Supported Living

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 5 October 2018 and was announced.

We gave the service 48 hours' notice of the inspection visit because it is a small service and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection was carried out by one inspector.

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 improvements they plan to make. We reviewed the information we already held about the service which included notifications. A notification is information about important events which the service is required to send us by law.

We viewed two care records and associated risk assessments, three staff files including their recruitment and training and supervision records. We also reviewed various meeting minutes, policy documents and audits relevant to the management of the service.

We spoke to two people who used the service, two support staff, the registered manager and one relative. We sought feedback from the local commissioner after the inspection.

Good

Is the service safe?

Our findings

At our previous inspection people's risk assessments were found to lack detail and did not provide staff with actions on how to mitigate risks. We viewed people's risk management plans and these were now more robust. They included different assessed risks such as absconding, self-neglect, challenging behaviour and physical health. In each risk plan the risk was described, the triggers, signs to indicate the risk is about to happen and measures to reduce the risk. For example, someone known to abscond, the service would monitor these possible signs; person was not complying with their medicine or displaying behaviours that challenged. Staff at the service were to observe and speak with the person to see what was bothering them and to monitor the assistive technology door sensors which would alert them if the person had left their flat.

The service used assistive technology to keep people safe in their flats. The registered manager told us about a new system which notified staff if a person left their flat. The service also used CCTV in the communal areas to keep people safe. In one person's flat where they displayed a behaviour that could cause injury to their head the service had put foam barriers above the door ways to protect them. A member of staff told us this person also used to wear a helmet but this was not worn anymore as the behaviours had reduced. Staff received training in lone working and the registered manager had implemented a watch alarm system that could be used to call for emergency support from staff.

The registered manager told us they still used positive behaviour support (PBS) which is a person-centred approach to help staff support a person. As described by the service to "support people consistently, appropriately and be able to identify my anxieties and support through each level." Records showed these plans provided details on what triggered people to behave in a way that presented a risk for them and others around them. Pictures of how people may feel or what they may do were provided to help staff identify the triggers.

The service did not use restraint and we observed different techniques staff used to calm people down which included using hand massage, high five actions over a repeated time and dancing. We informed the registered manager a technique we saw being used to calm someone was not in their care record. Furthermore, this information was not clear for visitors who may interact with this person. This was updated immediately in the care record. After the inspection we were sent further information to show the service had updated the support plan and risk assessment to clearly explain the steps to follow to keep the person and any visitors safe.

At our previous inspection staff recruitment was not carried out safely. During our current inspection we reviewed three staff files and found recruitment had improved. Staff had to complete an application form detailing previous experience and they received an interview which was scored. The registered manager said, "We ask questions to check staff understanding of autism and epilepsy. We don't believe in just saying the right thing, are they [staff] showing empathy and good attitudes."

Records showed staff had provided proof of identity, documents to confirm right to work, two references which were checked by head office and a completed criminal records check. This meant the service was

carrying out safe recruitment.

Staff understood their safeguarding responsibilities and could tell us the different types of abuse. A member of staff said, "There's financial, physical, psychological, sexual, neglect." Another member of staff said, "There are different types, financial, sexual, physical, psychological. If I saw anything I'd report it to the manager or learning disability team." Staff confirmed they would observe people for any unexplained bruises and if they suspected abuse they would inform the manager. Staff also told us they would contact their operations manager and social services if they had concerns. When prompted staff said they would inform the Care Quality Commission (CQC). The service had a safeguarding procedure on display in the staff area of the service. We noted contact information for the CQC was not provided on the procedure. We informed the registered manager and they rectified this straight away by sending us an updated procedure.

People's medicines were managed safely at the service. The registered manager told us they had prepared a medicine workbook which was used to check staff competency in the administration of medicine. They had a strict process in the event of a medicine error whereby the staff in question would not be able to administer for two weeks. The registered manager would check staff competency before they were able to administer again. If there had been no improvement staff would have to complete medicine training. The service held protocols for medicine needed on "a as required" basis (PRN). This explained the reason for the medicine and in which circumstance the medicine should be administered. This showed the service had systems in place to manage medicines safely.

Staff told us they minimised the risk of infection by keeping people's flats clean and tidy and by using personal protective equipment when carrying out personal care, such as aprons and gloves. We saw the service had a good supply of personal protective equipment.

Good

Is the service effective?

Our findings

During our last inspection feedback from relatives on the quality of the staff varied. A relative we spoke to said, "I have confidence in the staff, there's been a good improvement." The same relative said, "They (staff) encourage him, now he's going to everything. He has a routine." This meant relatives thought staff had the skills to meet people's needs. We spoke to one person at the service and they told us they thought the staff were helpful. The registered manager said, "I think they [staff] give good care. People are happy they look healthy and there is no abuse." The registered manager told us staff followed plans for people's care and would come and ask for help if they needed guidance. This meant staff were always trying to give effective care as they followed people's documented care plan.

Staff support and training had improved, the training matrix we viewed confirmed staff received training in Autism and a two day diabetes awareness course which gave them specific skills to support the people at the service. In addition, staff also received mandatory training in; safeguarding, health and safety, fire safety, medicines, manual handling, food safety and nutrition, equality and diversity, infection control, lone working and personal safety, first aid, personal care, mental capacity act and Deprivation of Liberty safeguards, epilepsy and managing challenging behaviour.

Staff received an induction which lasted five days and consisted of new staff having classroom based training and then paired with a member of staff to commence shadowing. Staff were given the opportunity to read people's care files and policies and procedures.

Staff feedback on the quality of induction was mixed but staff told us they felt confident to raise their concerns and were given further support before they started to work with people on their own.

We reviewed the services supervision policy which stated supervisions should take place monthly or every six weeks. Records showed supervision was taking place more regularly and staff said they were attending them. Records also confirmed staff were receiving an appraisal or were preparing to receive one. This meant that staff were supported to monitor their development and discuss with the registered manager any concerns or training needs in relation to their role.

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 interest and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Records confirmed the registered manager had performed appropriate mental capacity assessments for the two people living at the service in order provide care. It was found they both lacked capacity. The registered manager showed us evidence that they had applied to the local authority to request applications be sent to the Court of Protection as the level of care needed amounted to a restriction. While there had been delays in getting a response the registered manager had been proactive in chasing an outcome for people living at

the service.

Staff understood their responsibilities under the MCA. Records showed that people were offered choices in an accessible format. People were encouraged to make their own decisions as much as possible. A member of staff told us how they helped people make their own decisions by showing them pictures and examples of toiletries people liked to use. People chose what clothes they would wear, with staff support. The same member of staff said, "I show him three different shirts and he will point." This meant that people were supported to make their own decisions.

People were supported to eat and drink healthily. Each flat had its own kitchen and staff would support people to make meals there. Records showed one person was able to make light meals independently. A member of staff told us they showed people pictures of different foods to help them decide what they wanted to eat. A member of staff said, "For food we show [person] pictures. We have a guide we follow from the diabetic nurse. [Person] enjoys salads."

Staff were able to demonstrate their awareness of diabetes and the importance of providing healthy food which was low in sugar to keep people in good health. A member of staff said, "We're sugar content aware, and give sugar free foods." Records showed the service had documented in detail how to monitor if someone became hyperglycaemic (high blood sugar or glucose) or hypoglycaemic (low blood sugar). The district nurses were involved in the administration of insulin however the registered manager had arranged training in this area and used a dummy tool to test staff competence every four months in insulin administration to ensure staff knew how to support people if it was needed. This meant the service provided staff with effective training to support people's needs at the service.

People were supported to attend health appointments which included the optician, podiatrist, chiropodist, district nurse and the GP. People's records contained health action plans and hospital passports to support good transitions when going to different health services. An example of the information included "how to know if I'm in pain, I might tell staff or I will become withdrawn". People visited health professionals to maintain good health which included the speech and language therapist, psychologist and occupational therapist. Staff would record the outcome after people had attended them and guidelines staff should follow were updated into people's care plan.

Good

Is the service caring?

Our findings

We observed caring interactions between staff and people at the service. We saw staff dancing and talking to people in a kind manner. For example, a member of staff was heard asking someone how they were that day. We could see people were enjoying this positive interaction. One person who spoke to us said, "They're [staff] kind to me." A relative said, "Everyone [staff] is very nice."

Staff profiles continued to be displayed at the service in the downstairs foyer area which provided information about their hobbies, interests and staff skills which people at the service could view to see what common interests there were.

Staff demonstrated they knew people well and could tell us what people they supported liked to do. A member of staff told us how they encouraged independence after watching previous staff control the TV in the person's flat. The member of staff said, "[Person] likes Countdown and music, I gave him the remote control and I just observed to see what he changed it to, I saw [person] knows what to watch." Staff were given time to read people's file and shadowed experienced members of staff before they were matched to work with people. A member of staff explained the importance of having the same staff support people for continuity of care and this helped people build trusting relationships.

The service ensured people were listened to when they wanted to speak to those who were important to them. For example, staff supported people to call their relatives and people were supported to visit family members on a weekly basis. This meant people were supported to see their family on a regular basis which improved their wellbeing.

Someone at the service was celebrating their birthday on the day of the inspection and other people living in the service were invited to have some food and join in the celebrations. The person said, "It's my birthday today." Staff showed their caring nature as they arranged a birthday card to be signed by staff at the service which made the person happy.

Care plans recorded people's religious beliefs and said whether people practiced their faith and the places of worship they would attend if they did want to practice this.

Staff respected people's privacy and dignity, we observed staff knock on people's flat door before they entered. A member of staff said, "I knock on his door, [person] will greet me at the door." Staff advised us when they supported people with personal care they would close the doors and let staff know personal care was in progress if they entered people's flat. Another member of staff said, "I close the bathroom door, ensure no one can just bump in." Confidentiality was maintained and a member of staff said, "In handovers we discuss but we don't mention it outside."

Staff received training in equality and diversity and explained that they did not discriminate against anyone at the service. We asked the registered manager whether anyone at the service identified as lesbian, gay, bi-sexual or transgender (LGBT). The registered manager told us no one identified as LGBT and they said, "Staff

have awareness and do not discriminate against people because of this." A member of staff said, "We don't discriminate we involve customers with each other [at the service]."

Staff showed an awareness around respecting people's private time in their flats and gave them personal space to be alone. A member of staff said, "That's [person's] personal time, private. I won't be there." This meant people's rights were respected while in their flat.

People had expressed in their care plans the desire to have a romantic relationship and staff told us they were trying to support people to do this. A member of staff said, "[Person] goes to friendship club, he has said he would like a girlfriend." A relative had told us they would like their family member to attend more social activities where they could meet other people with the view to developing a romantic relationship. We raised this with the registered manager after the inspection and they advised they would like to support people more but were constrained by the number of support hours from the local authority. This meant the service were aware of people's need to develop relationships important to them.

People at the service had also expressed interests in gaining employment which would improve their skills, independence and reach personal goals they have set. The registered manager told us after the inspection they supported people to attend job interviews however where people were focused on education the level of commissioned hours to support people find employment was lessened.

Good

Is the service responsive?

Our findings

The registered manager told us they assessed people before they moved into the service to see whether their needs could be met. People, their relatives, staff and health professionals were involved in care planning. The service operated a key worker system which was a named member of staff who worked with people at each shift. Staff told us they provided information at care reviews as they had a lot of involvement with people and could report on improvements and changes in their care. For example, where someone through their behaviour did not want to engage in personal care, staff explained they had improved this by talking to the person to prepare them to start personal care, offering lots of encouragement and praised positive behaviour, and records confirmed this.

At our previous inspection information about people's support needs was held in various care records. During this inspection we found that support plans and risk assessments were kept together, there was a separate file for monthly summaries, medication and for financial information.

Assessed needs included, personal care, nutrition, medicine, community access, relationships and sexuality, finance, religious, cultural and spiritual beliefs and activities. The service had improved their support plans and made them more accessible for the people at the service. Pictures were used a lot more to show examples of the activities people did and photographs of people accessing the community, going shopping and managing their finance were used to demonstrate people's needs were being met in those areas.

Support plans were personalised and explained to staff how to support people achieve their daily living goals and clearly said what people could do for themselves. The registered manager said, "Needs are different and specific, we don't have a generic plan. For example, a care record said, "I can put clothes in the washing machine and I have recently learnt how to use some settings on the washing machine" and "I can prepare light meals under supervision such as sandwiches, fry an egg, make a snack or drink." In another care record it said, "[Person] now mops his flat, washes up the dishes after eating his meals, goes to bathroom with minimal prompts.' This showed the service encouraged people to be independent and learn living skills.

People's preferences were recorded and respected, we observed people being called by their preferred name and records documented foods people did not like to eat.

The registered manager told us support plans were still being reviewed every six months unless the people's needs changed sooner, records confirmed this. For example, where someone through their behaviour did not want to engage in personal care, staff explained they had made improvements by talking to the person about their routine, encouraging and praising the person when they engaged in the activity. The support plan had been updated to reflect the improvement in this area.

Staff were vigilant to people's change in need for example if they were unwell staff could identify how people may look and the steps they would to take to ensure people were seen promptly by a health professional. For example, a member of staff said, "If [person] is unwell his eyes go red and he becomes withdrawn, I

would give him pain relief, which did help."

Staff completed daily care records at each shift, which advised the next staff what people had done during the day and their mood. People were supported to participate in a range of activities of their choice which included attending college, photography class, food shopping, swimming, playing basketball, drawing, days out including pub lunches and visiting the gym. While staff had to encourage and motivate people to do these activities it was recorded that people were in good moods once they had participated which meant staff were meeting the well-being needs of people using the service. The registered manger told us staff completed participation records to document how many different daily living skills they had done themselves and how often they took part in activities.

People at the service were supported to make complaints during feedback sessions and in the downstairs foyer area there were feedback cards in pictorial format to encourage people to make a complaint if they wanted to. Relatives advised they would contact the registered manager to make a complaint either by phoning them or by sending an email. A relative who had made a complaint advised that it was acknowledged and responded to appropriately. We viewed the service's record of complaints and saw they had been dealt with in accordance with the providers policy.

The service did not discuss end of life wishes with people and no one at the service required end of life care at the time of our inspection. The registered manager told us if they needed to plan end of life care they would ensure people felt safe and cared for and would speak to appropriate health professionals.

Good

Is the service well-led?

Our findings

During our last inspection the service was not seeking feedback from people who used the service or their relatives. The registered manager showed us records of how people's keyworker would seek feedback during their sessions by showing them pictures to support the process. Health professionals were sent a survey and feedback provided was positive about the service. This meant the service now had a system to gain insight into how people, their relatives and health professionals felt at the service. The service also held a coffee morning every quarter to provide relatives with an opportunity to talk with each other about their family members care and to raise any issues that needed to be resolved, for example maintenance work in people's flats.

It was also identified during the last inspection that there was no system for checking staff files. Records showed there was checklist on the front of staff files to confirm that all the correct documentation was inside. The registered manager performed a range of audits to check the quality of the service with completed actions. This included a monthly medicine audit which checked medicine administration charts had been completed correctly. The registered manager also carried out observed practise to see that staff were competent in medicine administration. They also performed a monthly audit to check people's finances and that what had been recorded as spent corresponded to the money people held at the service. The last check identified concerns. Health and safety checks were performed and the registered manager would check that staff were showing dignity to people through observing them.

The registered manager had introduced improvements to the service to improve the experience and quality of service for people. The registered manager had implemented a robust system for managing people's money. This minimised the risk of misappropriation of funds. The registered manager had also purchased new kitchen appliances such as a clothes dryer and a new fridge and freezer to provide more space to store food and to meet the needs of someone who was unable to store food in their flat. The registered manager had purchased two bicycles for the service for staff and people to use, which improved health and well-being.

As part of the registered manager's daily routine they informed us they would walk around the building to ask and see how people were at the service and staff. The registered manager felt they had the support from senior management and they said, "I feel very supported in my role, everything I have raised [for improvement] has been taken seriously." This showed there was a structure and system in place for the registered manager to raise quality issues for the improvement of the service.

People were observed to respond well to the registered manager of the service. A relative spoke positively about the management of the service. A relative said, "Things have improved since the new manager."

Staff were able to tell us who the registered manager of the service was. They told us they felt supported by management and that he operated an open- door policy. Staff said morale was positive and that everyone is always trying to improve something. We observed staff seeking guidance and advice during our inspection. A member of staff said, "He's very supportive [registered manager], he shows us how to do things better."

Another member of staff said, "I can come to him with a problem and voice my opinion." The same member of staff told us they were always supported to improve if the registered manager noticed something was not right. This showed the registered manager was guiding staff to always improve the quality of the service.

Records confirmed that staff had monthly team meetings and this was an opportunity to discuss people living at the service and share best practice. For example, the registered manager explained how they had decided to ensure someone ate in their flat instead of the downstairs kitchen to maintain their dignity even though they had to store their food in the downstairs kitchen due to displayed behaviour. A member of staff told us best practice that had been shared during a team meeting and they said, "It's mainly around record keeping, we now write down [what people did] for each shift."