The Regard Partnership Limited

Chertsey Road

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

This was an unannounced inspection that took place on 31 January and 2 February 2018.

The Regard Partnership Chertsey Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides support for up to five people with a learning disability. It is located in the Whitton area.

The home 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 and associated Regulations about how the service is run.

This is the first inspection since people had moved into a new purpose built bungalow erected in the garden of the old building. At the previous inspection conducted at the old building, on 3 and 6 July 2015 the home met all the key questions and was rated good in each with an overall good rating.

People enjoyed living at the home particularly now the new building had been completed and thought it was a good place to live. They liked the way that staff supported and treated them. During our visit staff enabled people to choose the activities they wished to attend and supported them to carry them out. The activities were a mixture of home and community based. Relatives said there were suitable staffing levels for people to do their activities and have their needs met.

The home provided a safe environment for people to live and staff to work in. It was warm and welcoming with a friendly and inclusive atmosphere. Throughout our visit people's body language and their interaction with staff and each other was positive.

The home was well maintained, furnished and clean.

The home maintained comprehensive records that the registered manager and staff kept up to date. People's care plans contained clearly recorded, fully completed, and regularly reviewed information. This enabled staff to perform their duties well.

The staff were familiar with the people who lived at the home and their likes, dislikes and support needs. They had the appropriate skills and the training required to meet people's needs and were focussed on providing care and support for each person as an individual. The support was provided in an enabling, friendly and professional way. Staff said they had access to good training and support.

Staff were aware of their responsibilities to treat people equally and respect their diversity and human rights. They treated everyone equally and fairly whilst recognizing and respecting people's differences.

People were protected from nutrition and hydration associated risks by being provided with balanced diets that also met their likes and preferences. People and their relatives told us that they enjoyed the choice and variety of food provided. People were encouraged to discuss health needs with staff and they had access to community based health professionals.

The home's management team were approachable, responsive, encouraged feedback from people and consistently monitored and assessed the quality of the service provided.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible with the organisation's policies and systems supporting this practice.

There was a comprehensive quality assurance system in place to support the home and staff in providing the support people needed.

The health care professional we contacted gave us positive feedback regarding the service provided by the home.

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 remains Good.'	**Good**
Is the service effective? 'The service remains Good.'	**Good**
Is the service caring? 'The service remains Good.'	**Good**
Is the service responsive? 'The service remains Good.'	**Good**
Is the service well-led? 'The service remains Good.'	**Good**

Chertsey Road

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 checked 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 was an unannounced inspection and took place on 31 January and 2 February 2018.

This inspection was carried out by one inspector.

There were four people living at the home. We spoke with four people, two care workers, the registered manager and contacted four relatives and a service commissioner.

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 also checked notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed the care and support provided, was shown around the home and checked records, policies and procedures. These included the staff training, supervision and appraisal systems and home's maintenance and quality assurance systems.

We looked at the personal care and support plans for two people and two staff files.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People and their relatives thought the home was a safe place to live. Although people did not refer directly to feeling safe, one person told us, "This is my home" and smiled. People's body language was relaxed indicating that they felt safe in the environment in which they lived. A relative said, "Very safe environment, especially now they have moved to bungalow."

Staff had received training in what constituted the different forms of abuse and the action they should take if it was encountered. This was included in the provider's policies and procedures. Staff were also trained in how to safeguard people and were aware of how to raise a safeguarding alert and the circumstances under which this was required. There was no current safeguarding activity. Previous safeguarding alerts had been suitably reported, investigated and recorded.

Staff provided people with information about how to keep safe and areas of concern regarding individual people were recorded in their files. People's awareness about their safety was demonstrated during the inspection, by one person telling the registered manager that there was a moped parked by the home that should not be there. The moped had been stolen and the police were informed.

Staff had received training in de-escalation techniques in instances where people may display behaviour that others could interpret as challenging. There were behavioural management plans contained in people's care plans and staff actions taken were recorded in them.

People had risk assessments that enabled them to take acceptable risks and enjoy their lives in safety. These included risk assessments regarding health, social activities and other aspects of their daily lives. The risk assessments were regularly reviewed and updated if people's needs and interests changed. The home also had general risk assessments that included equipment used. The equipment was regularly serviced and maintained. Risk assessments were partly used as opportunities for discussion if something had gone wrong so lessons could be learnt. The risk assessments were reliant to an acceptable level on staff observation and knowledge of people and the way they communicated as some people had limited capacity for verbal communication.

There were building and equipment risk assessments that were reviewed and regularly updated. The home's equipment was regularly checked and serviced. This included a fire evacuation plan. Staff had received infection control training and their working practices reflected this. There was also a good stock of gloves and aprons for giving personal care.

The staff recruitment procedure was comprehensive and each stage of the process was recorded. Posts were advertised and job descriptions and person specifications provided. Prospective staff were short-listed for an interview panel that included people living at Chertsey Road. The interview contained scenario based questions to identify people's communication skills and knowledge of learning disabilities. References were taken up, work history checked and Disclosure and Barring service (DBS) security checks carried out prior to starting in post. A DBS is a criminal record check employers undertake to make safer recruitment decisions.

If prospective staff had gaps in their knowledge, the organisation decided if the induction training could bridge the gaps and if the person should be employed. Staff were provided with a handbook that contained the organisation's disciplinary policies and procedures. There was also a six month staff probationary period.

Relatives thought the home had adequate staffing levels. People did not comment on staffing numbers. The staff rota showed that support was flexible to meet people's different needs and there were enough staff to meet people's needs during the inspection. This was reflected in the way people attended the activities they wanted to safely. There were suitable arrangements for cover in the absence of staff due to annual leave or sickness. The home currently had three staff vacancies that were being recruited to and used bank staff to cover vacancies in shifts.
The home had disciplinary policies and procedures that were contained in the staff handbook and staff confirmed they had read and understood them.

Medicine was administered safely, monitored at each shift handover and audited. The medicine was safely stored in a locked facility and appropriately disposed of if no longer required. The staff who administered medicine were trained and this training was refreshed annually. They also had access to updated guidance. The medicine records for all people were checked and found to be fully completed by staff and up to date.

The health care professional was satisfied that the home was safe.

Good

Is the service effective?

Our findings

People were supported to do the things they enjoyed and wished to do. One person said, "I'm in charge and will show you around." They added, "This is my home." A relative told us, "Excellent, I was there for a party yesterday." During our visit staff communicated with people in a patient, clear way that enabled people to understand what they were saying. People were also given the opportunity to respond at their own speed. For people with less developed communication skills, staff were familiar with what gestures, repetitive single words and short sentences meant.

Staff were equipped to support and meet people's needs effectively through the induction and mandatory training they had received including supporting people with learning disabilities. The induction followed the Skills for Care 'Common induction standards', was module based over a period of time and included a staff handbook. As part of their induction new staff shadowed more experienced staff to increase their knowledge of the home and people who lived there. The home had a training matrix that identified when mandatory training was due. The training was part e-learning and part classroom based depending on its nature. It included infection control, moving and handling, administering medicine, fire safety awareness and first aid. Staff also had access to specialist service specific training such as dementia awareness, end of life and challenging behaviour. Staff meetings included scenarios that identified further training needs. Six weekly supervision sessions and annual appraisals were partly used to identify any gaps in training. There were staff training and development plans in place and opportunities for advancement.

Staff received equality, diversity and human rights training that enabled them to treat everyone equally and fairly whilst recognizing and respecting people's differences. This was reflected in the staff care practices and confirmed by people and their relatives. People were treated equally and as equals with staff not talking down to them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked if 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. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by the provider, all applications under the DoLS had been authorised, and the provider was complying with the conditions applied to the authorisation. Best interests meetings were arranged as required. Best interests meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The mental capacity assessments were carried out by staff that had received

appropriate training and were recorded in the care plans. Staff received mandatory training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood their responsibilities regarding the MCA and DoLS. Staff continually checked that people were happy with what they were doing and activities they had chosen throughout our visit.

People's care plans had a section for health, nutrition and diet. Full nutritional assessments were carried out and regularly updated. Weight charts were kept and staff monitored how much people had to eat and fluid intake if required. There was information regarding the type of support required at meal times contained in people's care plans. Staff encouraged people to take part in meal preparation and weekly food shopping trips and meetings to decide what meals they wanted to eat. They also advised people about healthy options. The meals were a balance between what people enjoyed and eating healthily. Whilst showing us around one person opened kitchen cupboards and commented, "Look lots of food." The pastor from the church that people attended was going to visit and prepare and cook a meal with people. There were regular visits by a local authority health team dietician and other health care professionals in the community. People had annual health checks. Staff said any concerns were raised and discussed with the person's GP and relatives as appropriate. The records demonstrated that referrals were made to relevant health services as required and they were regularly liaised with.

The home had a clear policy and procedure for informing other services within the community or elsewhere of relevant information regarding changes in people's needs and support, if required. Records demonstrated that staff liaised and worked with relevant community health services including hospital discharge teams and district nurses, making referrals when required and sharing information. The registered manager also attended local authority hosted provider forums where information was shared.

The health care professional was satisfied that the home was effective.

Good

Is the service caring?

Our findings

During our visit the home had a comfortable and relaxed atmosphere that we saw people enjoyed. This was mainly due to the calm and friendly approach by staff who met people's needs in a skilful and patient way. This showed us staff knew people, their needs and preferences well. People did not directly comment regarding if staff cared, but there was a lot of laughter, smiling and good natured joking with staff that people clearly enjoyed. One person said, "They [Staff] are all lovely." Another person told us, "My friends [staff]." A relative said, "They [staff] do a first class job." Another relative commented, 'Impeccable' when referring to the staff team.

Relatives said that staff treated people with dignity and respect and we saw that people were given as much time as they required to have their needs met. Staff spoke to people at a pace that made it easy for them to understand and also enabled them to make themselves understood. If people had difficulty expressing themselves, staff listened carefully and made sure they understood what the person had said. Staff had received training about respecting people's rights, dignity and treating them with respect that was reflected in their care practices and patient approach to people during the inspection.

Staff involved people and encouraged them to join in with what was going on. They also supported people to do things for themselves and provided them with their own space. Staff facilitated good, positive interaction between people and promoted their respect for each other. A lot of activity took place in the communal lounge and dining area. There was good natured banter between people as well as with staff.

Staff spent time engaging with people, talking in a supportive and reassuring way that people's body language indicated was acceptable to them and they liked. There were numerous positive interactions between staff and people throughout our visit with lots of laughing and joking.

There was access to an advocacy service through the local authority. There were two people that had advocates appointed. The home had a confidentiality policy and procedure that staff were made aware of, understood and followed. Confidentiality was included in induction, ongoing training and contained in the staff handbook.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of people. Relatives said they were made welcome and treated with courtesy. This was what we found when we visited.

The health care professional was satisfied that the home's staff were caring.

Good

Is the service responsive?

Our findings

People and their relatives confirmed that the home and organisation asked for their views and opinions. They were given time to decide what they wanted to do and when by staff. We saw that if people had a problem, it was quickly resolved and people were supported and enabled to enjoy the activities they had chosen. One person said, "We went to the pub for a meal for [person] birthday yesterday." Another person told us, "I've been picking flowers, I like doing that." A relative said, "I always get feedback." Another relative said, "Staff do a superb job." People and their relatives said the care and support they got was what they wanted. It was delivered in a way people liked that was friendly, enabling and appropriate.

The registered manager explained that people were referred by a local authority that provided pre-admission assessments, care plans and information from any previous placement was also requested. This information was shared with the home's staff to identify if people's needs could initially be met. The home then carried out its own needs assessment with the person and their relatives. People had lived at the home for a long time and their assessment information had been archived.

The organisation's policy and procedure stated that people, their relatives and other representatives would be fully consulted and involved in the decision-making before moving in. They were invited to visit as many times as they wished before deciding if they wanted to move in. Staff told us the importance of considering people's views as well as those of relatives so that the care could be focussed on the individual. It was also important to get the views of those already living at the home. During the course of these visits the assessment information would be added to.

Although people had lived together for many years there was written information about the home and organisation available if a vacancy became available. There were regular reviews to check that the placements were working. If there was a problem with the placement, alternatives would be discussed, considered and information provided to prospective services where needs might be better met. People's needs were re-assessed with them and their relatives and care plans updated to reflect changing needs.

People's care plans were individualised, person focused and developed by people and their keyworkers who were identified lead staff. The care plans were live documents that were added to when new information became available. They were part pictorial to make them easier for people to use. They had goals that were identified and agreed with people. The goals were underpinned by risks assessments and reviewed monthly by people and their keyworkers. If goals were met they were replaced with new ones. One person said, "[Staff] is my keyworker."

The care plans contained personal information including race, religion, disability, likes, dislikes and people's interests and the support required for them to participate in them. Daily notes identified if the activities had taken place. This information enabled staff to respect people, their wishes and meet their needs. The care plans were comprehensive and contained sections for all aspects of health and wellbeing. They included support with my activities, communication, mobility, personal care, emotional needs and health and safety. They also recorded their wishes regarding end of life care.

There were also individual communication plans and guidance. If people had to visit hospital, a 'Communication passport' was provided and they were accompanied by staff. A communication passport provided information about a person for the hospital.

Activities were a combination of individual and group and home and community based. One person told us, "I go to the day centre four times a week to meet friends." Each person had their own weekly individual activity plan. The activities included personal shopping, music therapy, sensory sessions, pub or restaurant for dinner and visits to the park. People had lived in the local area for many years and were very much part of the local community being familiar to local shop keepers and neighbours throughout the road they lived in. They also had outings to the cinema and visited the Richmond theatre to see the pantomime Aladdin. A trip was also planned to Covent Garden to watch Chinese performers dance. Everyone had two holidays per year, one as a group and the other individually. This year the group holiday was to Dorset. One person said, "I'm looking forward to my holiday, I love Sandbanks." Sandbanks was the holiday destination. People improved and maintained their life skills by taking responsibility for tasks such as cleaning their room, changing their bed, going to the bank and shopping.

One person proudly showed us around the new bungalow, pointing out the different colour schemes people had chosen for their bedrooms. After the tour they joked, "I've shown you around, now you have to pay me." They were very aware of their environment and conscious of the importance of conserving energy, switching off lights each time we left a room. The kitchen work surfaces were at a level that made it easy for people to use.

People did not directly comment on the complaints procedure. Relatives told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them and was part pictorial to make it easier to understand. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly. There was a whistle-blowing procedure that staff said they would be comfortable using. They were also aware of their duty to enable people using the service to make complaints or raise concerns. Any concerns or discomfort displayed by people were promptly attended to during our visit.

The health care professional was satisfied that the home was responsive.

Good

Is the service well-led?

Our findings

People said they liked the registered manager and staff and this was reflected in their positive body language towards them and conversations they had with them. They said they made felt comfortable and happy. One person told us, "I love [registered manager]. Referring to the registered manager a relative said, "Always on hand and available." Another relative told us, "The [registered] manager is very approachable." During our visit the home had an open, listening culture with staff and the registered manager paying attention to people and acting on their wishes.

The organisation had a clearly defined vision and set of values that staff understood. The vision and values were reflected in the management and staff practices as they went about their duties. There were also clear lines of communication within the organisation and specific areas of responsibility and boundaries that staff understood and observed.

Staff said the registered manager supported them well and their suggestions to improve the service were listened to and given serious consideration. They said they really enjoyed working at the home. A staff member said, "I've been here since 2003, I must really enjoy it." Another member of staff told us, "[Registered manager] is very supportive."

The records we saw demonstrated that regular monthly staff supervision meetings and annual appraisals took place.

The organisation provided a policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in need and support as required. Our records told us that appropriate notifications were made to the Care Quality Commission in a timely way.

The quality assurance system was robust and contained key performance indicators that identified how the home was performing, any areas that required improvement and areas where the home was performing well. This enabled any required improvements to be made.

The home used a range of methods to identify service quality. These included daily, weekly and monthly registered manager and staff audits that included, files maintenance, care plans, night reports, risk assessments, infection control, the building, equipment and medicine. There were also quarterly audits by senior managers, from the organisation, on a rotational basis. Comprehensive shift handovers took place that included information about each person.

Monthly home meetings took place where people could voice their opinions and give their views.

The health care professional was satisfied that the home was well led.