Abilities Development Ltd

Abilities Short Breaks - Preston Road

Inspection report

340 Preston Road
Wembley
Harrow
HA3 0QH

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18 October 2016
21 October 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 inspection took place on 18 and 21 October 2016 and was announced.

Abilities Short Breaks - Preston Road provides flexible overnight stays for people with learning disabilities. The Local Authority agrees a package of care with families where people are allocated a set number of nights for a year or a set number of nights per month. The families booked for short break services according to their needs. At the time of this inspection, twelve people were using the service at different times. The service has the capacity to provide accommodation for up to three people at any given time.

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 and associated Regulations about how the service is run.

The service was not always safe. A health and safety inspection of the premises that was carried out in September 2016 had identified some shortfalls regarding health and safety checks. At this inspection we saw the service had taken appropriate actions to ensure people were kept safe and protected from foreseeable risks. Therefore it was too early for the registered provider to demonstrate the service was safe. To do so, the service must demonstrate a consistent track record of improvements. We will keep the service under review to check if the noted improvements are sustained.

There were procedures in place for monitoring and managing risks to people. When there were changes in the level of risk, the risk management strategies changed to reflect this. There were appropriate procedures in place to help ensure people were protected from all forms of abuse. Staff had received training on how to identify abuse and understood procedures for safeguarding people.

People were protected from the risks associated with the recruitment of new staff. The service followed safe recruitment practices. People were safe because staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs at all times.

Throughout this inspection we saw good examples of person-centred care. The care needs of people had been fully assessed and documented before they started receiving care. Staff were supported to carry out assessments to identify people's support needs and care plans were developed outlining how these needs were to be met.

People were supported to maintain good health. They had access to a wide range of appropriate healthcare services that monitored their health and provided people with appropriate support, treatment and specialist advice when needed. People were supported and encouraged to choose what they wanted to eat and drink.

Staff understood how to support people with dignity. Staff spoke with people in a respectful way, giving people time to understand and respond.

All staff had attended training on the requirements of the Mental Capacity Act 2005 within the last 12 months. Staff were knowledgeable and were aware of their obligations with respect to people's choices and consent. Records showed clear decision-making processes, mental capacity assessments and best interests meetings.

There was a quality assurance system in place. The registered manager and staff team were proactive in seeking out ways to improve.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. A health and safety inspection of the premises had identified some shortfalls regarding health and safety checks. We saw that the service had made improvements. The service must demonstrate a consistent track record of improvements. We will keep the service under review to check if the noted improvements are sustained.

People were protected from the risks of harm and abuse because staff knew safeguarding procedures.

Staff were able to talk about areas of risk knowledgeably and they correctly explained strategies which had been agreed to protect people.

Appropriate recruitment and selection processes were carried out to make sure only suitable staff were employed.

Is the service effective?

Good

The service was effective.

People received individualised care that met their needs. Staff had received relevant training.

The service had had an excellent working partnership with primary care services. People had access to healthcare services when they needed them.

People's nutritional needs were met and kept under close review. They were regularly consulted about their meals and their preferences were acted on.

The registered manager and staff worked within the principles of Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

Staff supported people with their communication needs.

Where people were not able to formally participate in planning their care, staff found ways for improving people's participation. People were involved in their care and their views were respected and acted on.

Staff were kind and compassionate and treated people with dignity and respect

Is the service responsive?

Good

The service was responsive. People's needs were assessed before the provision of care began to ensure the service was able to meet their needs.

Care plans were in place which were personalised to meet the needs of the people. These were kept under review and up-to-date to reflect the people's current needs.

People's views were taken into consideration and appropriate action taken to ensure the service was responsive to their needs. The service was in the process of improving the way it managed feedback from people.

Is the service well-led?

Good

The service was well-led.

The management had provided staff with appropriate leadership and support.

There was a quality assurance system in place. This had also been recently improved.

The registered manager and staff team were proactive in seeking out ways to improve.

Abilities Short Breaks - Preston 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 & 21 October 2016 and was carried out by one adult social care inspector. It was announced. The provider was given 24 hours' notice because the location provides a short-break service and we needed to be sure that people would be available to speak with us on the day of our 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 improvements they plan to make. We also reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

There was one person using the short-break service during this inspection. The person and most people who previously used the service had complex needs and were unable to tell us about their experience of using the short-break service. In order to help us gain an understanding of this we spent a significant part of the inspection observing how people were supported by staff. We also spoke with the registered manager, deputy manager, staff and five relatives of some people who used the service. Some were relatives of people who had previously used the service and may use it again in the future.

We also spent time looking at records, which included the care records for five people. We looked at the recruitment, supervision and appraisal records of staff, a full staff training matrix and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People's relatives told us they felt the service was safe and trusted staff. One relative told us, "My relative is safe at the home. Staff are very reliable and helpful." Another relative told us, "My [relative is safe. The manager pays attention to small detail." A third relative said, "I am satisfied my [relative] is safe." In a survey that was carried out in October 2016, families who responded indicated the service was 'safe'.

There was a safeguarding policy and appropriate procedures in place to help ensure people were protected from all forms of abuse. Staff had received training on how to identify abuse and understood the procedures for safeguarding people. They were able to describe the different ways that people might experience abuse and the correct steps to take if they were concerned that abuse had taken place. Staff told us they were confident that any concerns reported to managers would be treated seriously and appropriately. They told us they could report allegations of abuse to the local authority safeguarding team and the Care Quality Commission if management staff had taken no action in response to relevant information.

Risk assessments were in place to reduce risks to people's safety. We saw assessments, including for those at risk of choking, epilepsy and participation in particular community activities. These were reviewed regularly to ensure appropriate action was taken to mitigate the risk. However, in some examples there was little detail on how to manage risks associated with epilepsy. The risk assessments lacked a step by step guidance to support staff in dealing with epilepsy emergencies. For example, there was no detailed information regarding what staff must do when a seizure lasted longer than normal. Although staff we spoke with were aware of what to do to make people safe, this was not well documented in the guidance. Following the inspection, the service sent us improved risk assessments for people with epilepsy. The Care Quality Commission will be monitoring the improvements made to the risk assessments and also to verify if they are sustained.
Risk assessments for the environment had been drawn up and were regularly reviewed with the changing needs of the people in mind. We examined a health and safety action plan, which had been developed following a health and safety inspection of the premises in September 2016 by a independent consultancy company. The registered manager told us, "As a company we have consulted an independent company to support us to ensure that we are meeting all our health and safety requirements." This inspection identified some areas that needed improving. This included regular testing for emergency lighting, and replacing old window restrictors. At this inspection we saw the service had taken appropriate actions to ensure people were kept safe and protected from foreseeable risks. Again, the Care Quality Commission will be monitoring the improvements made to the environment and also to verify if they are sustained.

Each person receiving care had a personal emergency evacuation plan (PEEP) in place. These described step by step how each person was supported to evacuate the building if there was an emergency.

We checked to see if there were sufficient numbers of staff to meet people's needs. The service was small and was supporting a maximum of three people at a time. The registered manager explained there were sufficient staff to meet the needs of people on planned placements. We saw the service had sufficient staff to respond flexibly and to accommodate the times families requested. The registered manager showed us

evidence they were actively recruiting to expand their pool of bank staff to increase flexibility around emergency placements. The provider had other locations. The registered manager told us in emergencies staff from the other locations where used to cover shifts. We spoke with staff and we found they knew people well and were familiar with people's needs.

Appropriate recruitment checks took place before staff started work to reduce the risk of unsuitable staff being deployed at the service. Staff told us they went through a thorough recruitment and selection process before they started working at the home. Staff files evidenced that all necessary checks were completed prior to staff beginning employment. These checks included a Disclosure and Barring Service (DBS) check, evidence of identity, right to work in the country, and a minimum of two references to ensure that staff were suitable and not barred from working with people who used the service.

There were suitable arrangements for the recording, storage, administration and disposal of medicines in the home. We checked medicine administration records and found all medicines administered had been recorded and each entry had been signed appropriately. There were no gaps in the medicine administration records. Medicine administration records tallied with the stocks in the medicines cabinet.

There was a clear procedure and protocol for the medicines to minimise any potential drug errors. The service considered how they obtained a supply of medicines for the duration of people's stay. For example, before people were brought into the service a list of current medicines with instructions for administration was obtained. All the medicines entering the home were recorded according to the policy and procedure. At the end of the respite stay, the staff completed a 'medication return' form, which was signed by the person or family.

Good

Is the service effective?

Our findings

Relatives of people receiving care were complimentary about the quality of care. They told us, they were 'happy' with the service provided. The relatives confirmed that staff had the right skills and knowledge needed for their role. One relative told us, "Staff have the right skills for the job." Another said, "I would give the service 100% for providing good care. Otherwise I would not send my [relative]."

The service ensured the needs of people were met by staff who had the right competencies, knowledge, and skills. The registered manager told us the service was committed at developing staff skills through training for the benefit of people. Staff had received relevant training to carry out their responsibilities in providing people with the care and support they needed. Learning and development encompassed both e-Learning and face to face training. All staff had had a personal development plan and had completed mandatory and specialist training, such as health and safety, moving and handling, food hygiene, safeguarding, epilepsy, medicines, respect and dignity. We found staff to be knowledgeable in relation to these areas. All this meant that people were supported by staff who had the skills to meet their needs and ensure their safety.

Staff confirmed they had a comprehensive induction period which included completing specific training and shadowing more experienced members of staff. The induction followed the Care Certificate induction standards, which are nationally recognised standards of care which care staff needed to meet before they can safely work unsupervised. Relatives told us they thought the staff were highly trained and knowledgeable.

We saw from people's care records that people were asked to give their consent to their care, treatment and support. Staff knew what they needed to do to make sure decisions were taken in people's best interests. We also saw from records that where people did not have the capacity to make decisions they were are given the information they needed in an accessible format, and where appropriate, their relatives were involved.

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). The registered manager showed us documentation which confirmed when people were deprived of their liberty; this was done lawfully and in line with the requirements of the care setting.

Relatives told us staff knew people's routine health needs and preferences and consistently kept them under review. We saw from care records that people had access to general health care services. The service consulted with local primary care providers to ensure people who used the service had relevant healthcare support. There was evidence people had access to a range of health professionals including; GPs, behaviour therapist, psychiatrists and speech and language therapists to make sure they received effective healthcare

and treatment. However, we felt that communication with families and carers could have been better coordinated to ensure that valuable information would not be missed. As a short breaks service, people moved between their permanent homes and the service, which meant there was a risk of current information about people being missed such as updates in health needs and changes in medicines. However, following the inspection the service has since coordinated with families to jointly develop health action plans, which would facilitate coordinated input. We have since received examples of the improvements made.

Staff protected people from the risk of poor nutrition and dehydration. We looked at the menu and saw that there was a choice of main meals each day plus a selection of alternatives that were always available. There was a choice of foods that suited the people's recorded needs and preferences. Relatives told us, people were supported to eat appropriate food and drink that met their needs.

Good

Is the service caring?

Our findings

Relatives were consistently positive about the caring attitude of the registered manager and staff. One relative told us, "The manager and staff are very caring. [My relative] is really happy and smiling when he sees staff." Another relative said, "[My relative] has used the service for a long time. We have never had any problems with staff. They are committed to their work."

Kindness, respect, compassion, dignity in care and involvement were the key principles on how the service recruited, trained and supported its staff. Staff recognised the importance of the values of the service and challenged behaviour and practices which fall short of this. This was evident from staff meeting minutes we read. We also observed staff understood how to support people with dignity and respect. We observed the interaction between staff and one person who had just arrived to commence a three day short break stay. The person came during this inspection and staff managed the settling in process well by giving consideration to the person's needs. Staff did not appear hurried. They spoke with people in a respectful way, giving people time to understand and respond.

People received care and support from staff who knew and understood their history, likes, preferences, needs, hopes and goals. For example, we spent time in respective communal areas observing care and it was evident that staff knew people well. The atmosphere was calm, friendly and inclusive. Although, our observations were limited to one person, even so, the interactions between staff and the person were caring, respectful and spontaneous. The person was comfortable and happy around staff. We observed staff were attentive and responded to this person's needs.

Staff knew, understood and responded to each person's diverse cultural, gender and spiritual needs and met them in a caring and compassionate way. We spoke with staff about diversity and human rights. Staff spoke knowledgeably about what they would do to ensure people had the care they needed for a variety of diverse needs, including spiritual and cultural differences.

Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people were able to say how they felt about the care. From people's care records we saw some were able to express themselves, but there were others whose views may not have been so easily heard. There was evidence the service engaged a range of ways of involving people so they were consulted, empowered, listened to and valued. Information was presented in different formats for people to enable them to communicate to the best of their abilities. We saw many examples of communication tools and systems, each tailored to the specific needs of the person, including gestures, Makaton, symbols and objects of reference. There were examples demonstrating how people's lives had been transformed through increased involvement, choice and independence. People could choose what activities they wanted to engage in and type of food they preferred.

Staff were given enough time to get to know a person who is new to the service, and read through their care plan and risk assessments. Rotas were organised so that people received care from a small number of staff who understood their needs and got along with them. We evidenced from the rotas that people were

matched with staff who had experience of working with them.

Good

Is the service responsive?

Our findings

Relative's feedback about the responsiveness of the service describes it as consistently good. One relative told us, "If I have any emergency the manager organise people who can work with [my relative] at short notice." Another relative said, "The manager contacts me to give feedback or to ask for information." A third relative said, "Staff always listen to us."

People received personalised care and support. People were involved in identifying their needs, choices and preferences and how these were met. Their care needs had been fully assessed and documented before they started receiving care. The registered manager told us, "We work with families to decide what the best way of introducing [people] to the service is." This was confirmed by families we spoke with. People's care needs had been fully assessed and documented before they started receiving care. The initial assessment involved people visiting the short break service prior to receiving care. This identified people's support needs and care plans were developed outlining how these needs were to be met. This meant if the person chose to use the short break service staff were ready to meet their needs on the day of their arrival.

People's care and support were set out in care plans that described what staff needed to do to make sure personalised care was provided. A relative told us, "Staff are competent. They are all knowledgeable about [my relative's] needs because this is well documented in the care plan." We saw multi-component person centred support plans, each containing a communication profile, behaviour support plan, and a risk assessment. The care plans reflected people's likes and dislikes and included details about people's life histories. People and their relatives were actively involved in developing care, support and treatment.

The service was aware of the potential difficulties people could face in moving between home and the short-break service. For example, there was a potential risk vital information could have been missed as people lived with their families. However, we saw that strategies were in place to maintain continuity of care when people were moving in. There were robust systems to make sure that changes to the needs of people were communicated to the service. The service had designed a form, which was given to families to provide information of any changes in people's needs just before the next short-break visit. A relative told us, "We share information with the service regularly. The service sends us a form we have to complete. I find the form helpful because as a mother it is important that the service has up to date information about [my relative's] needs. As a result the service has acted appropriately whenever any need arose." It was evident during the inspection that the service had up to date information about people, which ensured care and support were always personalised.

The service protected people from the risks of social isolation and loneliness. People were enabled to carry out person-centred activities and encouraged to maintain hobbies and interests. A relative of one person told us, "They go for walks and the service has a sensory room, which [my relative] loves." The home had a varied programme of activity and entertainment on offer. People attended a Saturday Club, which offered activities such as arts and craft, bowling and cinema. There were also in-door games such as board games. At the time of the inspection the sensory room was being adapted to meet the needs of people.

People's changing care needs were identified, and were reviewed with the involvement of the person and or their relative and put into practice. However, as a short-breaks service the registered manager indicated it was not always possible to get families to attend the review meetings as people lived with their respective families or carers for most of the time. However, records showed where possible relatives or representatives were involved in the care plan review and were actively encouraged to participate. There were a range of ways in which people or their relatives could feed back their experience of the care they received. During people's stay relatives phoned for updates and the service also contacted families if they wanted anything clarified or to report any changes in needs.

A process was in place to record and respond to complaints. The service had not received any complaints. However, the registered manager told us concerns and complaints would always be taken seriously, explored thoroughly and responded to in good time if they arose.

Good

Is the service well-led?

Our findings

People's relatives described the service in complimentary terms. They praised the manager for her leadership and dedication. One relative told us, "The manager is amazing. She is very open, transparent, and approachable and always keeps us up to date." Another relative told us, "The manager is exceptional. I would give the service nine out of ten. Even though the service is good but it can never be as good as home.

The service had a clear vision and set of values that included involvement, compassion, dignity, independence, respect, equality and safety. These are understood and consistently put into practice. We asked staff and were aware of these values. These values were embedded in the service through talking to people's relatives and staff. People's records also confirmed this. There was evidence people were involved in the delivery of care; people were supported to make choices about the service they received, and we saw the service respected and maintained the dignity and privacy of people who used the service.

There was an open and positive culture within the service. Members of staff were aware of the whistleblowing procedure. They told us if they needed they would report any concerns or ill treatment of people to external agencies if the service did not take appropriate action. Open and transparent communication was promoted and encouraged by the registered manager. We read staff minutes, which confirmed staff were encouraged to be 'open and transparent'. Staff told us the registered manager was approachable and always took the time to listen to all members of staff. Staff told us and meeting minutes confirmed they had the confidence to question practice and report concerns about the care offered by colleagues, carers and other professionals. They told us when this happens they were supported and their concerns were thoroughly investigated.

The service had enlisted input from a private consultancy company to implement a new IT system to improve how they managed and coordinated care with families. The new IT system, which we were told was going live in January 2017, would enable staff to account for all tasks and activities with people in real time. The registered manager told us, "It also allows for more consistent family involvement and communication as family members will be able to log in and see what care and support their relative were being given at any point." This also meant potentially, managers could easily account for actions, behaviours and the performance of staff.

The service manager ensured staff were kept up to date and were knowledgeable about best practice. For example, the provider kept journals and guidance from reputable national organisations for good practice reference. The service had guidance available from the National Institute for Care and Clinical Excellence for managing behaviours that challenged the service. This ensured staff were kept up to date with the latest developments so they could effectively support people.

Quality assurance arrangements were in place and the need to provide a quality service understood by all staff. Audits were completed on a regular basis. For example, we saw health and safety, medicines and care records had been completed. This enabled any trends to be spotted to ensure the service was meeting the requirements and the needs of people being supported. Where actions were needed, these had been

followed up.