The Fremantle Trust

Lady Elizabeth House

Inspection report

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Date of inspection visit:
23 October 2018
24 October 2018

Date of publication:
04 December 2018

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 inspection took place on 23 and 24 October 2018. It was an announced visit to the service.

Lady Elizabeth House provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented from a housing association and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service. Nineteen people were being supported by this service at the time of our inspection. People varied in age from younger adults to older persons and had a range of personal care needs and levels of independence. Each person had their own self-contained flat. There was a communal lounge and dining room people could use and an on-site day service run by the provider. Some people received personal care from other agencies as well as staff at Lady Elizabeth House.

We previously inspected the service in August 2017. The service was rated 'requires improvement' at that time. Following that inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions 'effective' and 'well-led' to at least 'good'. On this occasion, we found improvements had been made to people's care. These included notification to us of incidents of abuse, assessment of people's mental capacity and recording when medicines for occasional use had been offered to people. A deputy manager position had been introduced at the service and feedback showed this arrangement was working well.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We received positive feedback about people's care. Comments included "Without any sort of a lie I can say the care is actually excellent," "The carers are exceptional" and "They are very friendly to (us). They laugh and joke and look really happy."

Staff received the support they needed to meet people's needs, through supervision, training and a structured induction. Appraisals also took place to assess staff performance. Thorough recruitment procedures were used.

Each person had a care plan which outlined the support they required. These had been kept up to date and were accompanied by risk assessments, to minimise the likelihood of injury or harm. Staff supported people with their medicines and nutritional needs, where this was part of their care package.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible; the policies and systems in the service supported this practice.

Quality of care was monitored by the provider through visits to the service, audits and surveys. People were asked for their views in tenants' meetings and during quality reviews. Complaints were responded to and actions were taken to make improvements, where necessary. The service worked well with other agencies and departments to make sure people received effective and continuous care. This included the housing association and other care providers.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from harm because staff received training to be able to identify and report abuse. There were procedures for staff to follow in the event of any abuse happening.

People's likelihood of experiencing injury or harm was reduced because risk assessments had been written to identify and minimise areas of potential risk.

People were supported by staff with the right skills and attributes because robust recruitment procedures were used by the service.

Is the service effective?

Good

The service was effective.

People received safe and effective care because staff were appropriately supported through a structured induction, regular supervision and training.

People were encouraged to make decisions about their care and day to day lives. Decisions made on behalf of people who lacked capacity were made in their best interests, in accordance with the Mental Capacity Act 2005.

People received the support they needed to attend healthcare appointments and keep healthy and well.

Is the service caring?

Good

The service was caring.

People were supported to be independent and to access the community.

People's views were listened to and acted upon.

Staff treated people with dignity and respect and protected their privacy.

People had the opportunity to share their views and receive updates about the service.

Is the service responsive?

Good

The service was responsive.

People's preferences and wishes were supported by staff and through care planning.

There were procedures for making compliments and complaints about the service. Changes were made, where necessary, to improve care.

People's wishes were documented in their care plans about how they wanted to be supported with end of life care.

The service responded appropriately if people had accidents or their needs changed, to help ensure they remained independent.

Is the service well-led?

Good

The service was well-led.

The provider monitored the service to make sure it met people's needs safely and effectively.

Improvement had been made to the reporting of serious occurrences or incidents to the Care Quality Commission. This meant we could see what action they had taken in response to these events, to protect people from the risk of harm.

People were cared for in a service which was open and transparent when things went wrong.

Lady Elizabeth House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection took place on 23 and 24 October 2018. It was an announced visit to the service. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that managers and staff would be available to assist with the inspection.

The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. They were present for the first day only.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted community professionals, for example local authority commissioners of the service, to seek their views about people's care. We spoke with seven people who used the service and one relative.

We spoke with the registered manager, the deputy manager, a senior support worker and a support worker. We spoke with a human resources manager by telephone and had email correspondence with the interim director of the service (who line-manages Lady Elizabeth House). We attended a handover meeting between staff from a morning to an afternoon shift.

We checked some of the required records. These included four people's care plans, seven people's medicines records, four staff recruitment files and four staff training and development files. Other records

included complaints and compliments, staffing rotas, quality assurance documents, minutes of staff meetings, minutes of tenants' meetings, accident and incident reports.

Good

Is the service safe?

Our findings

We asked people about feeling safe. Everyone told us they felt safe when care workers came into their homes. A relative commented about timing of care visits. They said "It's very, very rare they come late, perhaps if they are short of staff. They apologise and explain why. If I need more time they will give it to me."

The service had systems and processes for safeguarding people from abuse. These provided guidance for staff on the processes to follow if they suspected or were aware of any incidents of abuse. Staff had also undertaken training to be able to recognise and respond to signs of abuse. Staff were able to explain to us their responsibilities to protect people. They said they did not have any concerns about how people were cared for at the service but would report concerns, if they arose.

People were protected from the risk of harm during the provision of their care. Written risk assessments were in place for areas such as helping people to re-position, manage medicines, access cleaning products and health and safety. Risk reduction plans had been written where the person was at risk of injury or harm. For example, where people required hoisting, two staff were always present to ensure this was carried out safely. All the risk assessments we read had been kept up to date to make sure they reflected people's changing circumstances.

We saw emergency evacuation plans had been written for each person. These documented the support and any equipment people needed in the event of emergency situations. Staff had been trained in fire safety awareness and first aid to be able to respond appropriately. There was an emergency procedures folder readily available, which contained information about a range of situations. These included missing persons, sudden death, adverse weather and influenza pandemic. Missing persons profiles were in place in some of the files we checked.

Staffing rotas were maintained and showed shifts were covered by a mix of care workers and senior staff. The service used robust recruitment processes to ensure people were supported by staff with the right skills and attributes. The staff files we checked contained all required documents, such as a check for criminal convictions, proof of identity and written references. Staff only started working with people after all checks and clearances had been received back and were satisfactory.

People's medicines were managed safely. People were supported to manage their own medicines where possible, subject to risk assessment. There were medicines procedures to provide guidance for staff on best practice. Staff handling medicines had received training on safe practice and had been assessed before they were permitted to administer medicines alone. People told us they received their medicines when they needed them. We saw staff maintained appropriate records to show when medicines had been given to people.

Accidents and incidents were recorded appropriately at the service. We read a sample of recent accident and incident reports. These showed staff had taken appropriate action in response to accidents, such as a fall and a scald. The registered manager had taken action in each case, to prevent further injury to people.

For example, referral to the community falls team.

Staff received training to ensure they followed safe practices when they supported people. This included first aid training, moving and handling and fire safety awareness. Updated courses were attended to keep these skills refreshed.

The registered manager took action where staff had not provided safe care for people. For example, where errors had occurred. Records were kept of meetings held with staff following incidents of this nature, to determine what had happened and to prevent recurrence. Disciplinary proceedings were used, where necessary.

People were protected from the risk of infection. Staff undertook food hygiene and infection control training. There were policies and procedures to provide guidance on safe practices. Staff had access to disposable gloves and aprons and wore these when personal care was carried out.

People's records were accessible in their homes with copies kept securely in the office. These were accurate and had been kept up to date following changes to people's care needs.

Good

Is the service effective?

Our findings

People received effective care which respected their rights. 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. At our last inspection in August 2017, we recommended people's mental capacity was assessed, where necessary, to make sure they could make decisions about their care and support. On this occasion, we saw this had been done.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. Applications in this type of care setting must be made to the Court of Protection (CoP). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. At the time of the inspection, no one had a deputy appointed by the CoP to make decisions on their behalf. In one of the files we checked, we saw a record that the local authority was intending to apply to the CoP regarding the management of the person's finances.

Staff received appropriate support to meet the needs of people at the service. At our previous inspection in August 2017, we noted training was not up to date for a small number of care workers. On this occasion, we found staff had kept their skills and knowledge updated in all areas the provider considered necessary. This included moving and handling, safeguarding from abuse and basic life support. Staff were encouraged to undertake further training, such as Business and Technology Education Council (BTEC) awards in dementia and management.

New staff were also enrolled onto the nationally-recognised Care Certificate. The Care Certificate is an identified set of standards that health and social care workers need to demonstrate in their work. They include privacy and dignity, equality and diversity, duty of care and working in a person-centred way.

Staff received regular supervision from their line managers, to discuss their work and any training needs. This meant staff received appropriate support for their roles. Appraisals were now being undertaken regularly, to assess and monitor staff performance and any development needs.

People's support needs had been thoroughly assessed before they received a service. This included assessment of their physical and emotional care needs. Assessments took into account equality and diversity needs, such as those which related to gender, sexuality, disability and culture.

Staff communicated effectively about people's needs. Relevant information was documented in daily notes written for each person and a staff communications book. Written and verbal handovers took place to share information between staff.

People were supported with their nutritional requirements, where this was part of their assessed needs. Care

plans contained information about how to support people appropriately. People said they had their meals when they wanted them, at times convenient to them. They told us staff asked them what they would like. People had the option of having their meal in the communal dining room, which staff facilitated.

People were supported with their healthcare needs, where appropriate. Care plans identified any support people needed to keep them healthy and well. Staff maintained records of when they had supported people with healthcare appointments or visits and the outcome of these. During staff handover, we heard how staff planned to support one person to attend a dental appointment and the preparation required for this.

Staff worked together within the service and with external agencies to provide effective care. For example, where people received support from more than one care agency we saw there was effective communication between the two services, to ensure people received continuity of care. We read survey feedback from another service provider. It included "All staff at Lady Elizabeth House are friendly and pleasant and I enjoy the working relationship that I have with all the staff members." A community professional had completed a survey and commented "Care staff are always helpful, knowledgeable and approachable. Patients we see are well cared for."

Good

Is the service caring?

Our findings

We received positive feedback from people about the caring approach of their care workers. Comments included "Without any sort of a lie I can say the care is actually excellent.... (care workers) usually pop through three times a day, morning, lunch and evening." The person added "They help me with my memory, they make sure I've got everything…they're an excellent, calming influence." Another person said "The carers are exceptional. I'm terribly spoilt as far as I'm concerned. I don't need their help quite honestly. I do appreciate them offering it. Nothing's any trouble. They're so nice." Further comments included "I've no criticism of the carers at all. They're very good. Generally speaking they're excellent. They do everything they can and ask me if I want anything else, I always say I'm fine." A relative commented "They are very friendly to (us). They laugh and joke and look really happy."

People told us staff were respectful towards them and treated them with dignity. For example, one person told us "If they see the shower light is on (when they call) they will loiter respectfully away or make themselves known they are in the building." We heard staff knocked on people's front doors before they went in to see them.

Staff were knowledgeable about people's histories and what was important to them, such as family members and any interests they had. Staff spoke with us about people in a dignified and professional manner throughout the course of our visit. Doors were closed when confidential information was being discussed, to protect people's privacy. Staff had been advised of the provider's email, Internet and social media policy, to ensure people's privacy and confidentiality were respected at all times.

People told us they were involved in making decisions and to express their views. This included decisions about meals, going out into the community and managing their medicines, where they were able to. Tenants' meetings were held at the service each month. We read the minutes of the two most recent meetings. These showed people had the opportunity to request improvements. For example, one person raised the possibility of having seating outside the main entrance. We saw the registered manager had contacted the housing association to request this. In another example, people requested advertising evening events held in the communal lounge, such as playing cards and a karaoke evening. We saw posters had been made and were displayed.

People were also asked for their views via provider surveys. We read the results of surveys from April this year. People had commented positively about the support they received. For example, 14 out of 15 people said call times suited them, all said staff were polite and courteous and that their care requirements were being met.

The service ensured that people had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. For example, one person's care plan had been produced with their involvement, using pictures. This extended to some of their

risk assessments as well.

Information was displayed regarding advocacy services. Advocates are people independent of the service who help people make decisions about their care and promote their rights.

The service promoted people's independence. Risk assessments were contained in people's care plan files to support them to do as much as they were able to.

Good

Is the service responsive?

Our findings

People received care which was responsive to their needs. A care plan had been written for each person, to outline the support they required. People's preferred form of address was noted and referred to by staff. Essential information was recorded, such as next of kin, who to contact if the person became unwell and GP details. Care plans took into account people's preferences for how they wished to be supported. Any cultural, religious and other diversity needs were noted. One person we spoke with commented staff were "massively supportive" regarding their diversity needs. Staff gave an example of how they supported someone with their religious needs by informing them about particular requirements. We saw there was information to help staff to support people with medical conditions. For example, epilepsy and where people received anti-coagulation therapy to prevent blood clots.

People's wishes were documented in their care plans about how they wanted to be supported with end of life care. Their choices regarding resuscitation were recorded on the appropriate forms. In one care plan file, we saw a pictorial terminal care plan format had been used, to help a person with learning disabilities record their wishes. This included how they would like their funeral service conducted and the hymns and other music they wanted.

We asked about training on end of life care. The registered manager told us this had been requested for the staff team but was later cancelled. They intended to source further training from the provider. There were no current links with local hospices or palliative care specialists, as no one required end of life care at the time of the inspection or in the recent past. The registered manager told us they intended to establish links with a hospice.

The service supported people to take part in some social activities, although this was not part of its contractual agreement with the local authority or required through the type of registration with us. Some people attended a day service which was on-site and run by the provider. Occasional meals out were arranged. Information was displayed and shared with people about local community events, such as a local churches together Christmas lunch and a gym for people with disabilities.

The service responded to people's changing needs. One example was regarding a person who found it difficult to turn in bed at night. Staff researched equipment that would help the person remain as independent as possible. They found a type of slide sheet that enabled the person to move safely. This equipment was then provided, in consultation with an occupational therapist. In another example, a board was put up in the flat of a person who has dementia, to help orientate them with daily events. Staff recorded the times of their visits on the board and other information such as the date and when their shopping was due. Labels were also put on their clothes drawers, to help them find items to put on.

We also heard about a 'Wishes Come True' scheme organised by the provider. Staff from all of the provider's services were able to nominate someone they supported to realise their dream. We heard how the registered manager had nominated one person from Lady Elizabeth House who adored monkeys. The nomination was successful and they and some of their family members were taken on a trip to monkey-

themed park. We heard they thoroughly enjoyed this.

There were procedures for making compliments and complaints about the service. A feedback box and forms had been added to the entrance area, for people to post any comments about the service. Formal complaints procedures were displayed on the main communal noticeboard. The provider's survey results showed everyone who responded (15 people) felt any queries about their care were resolved. One person told us "When you complain nothing really happens." However, another person gave an example of mentioning something to the registered manager which was then dealt with appropriately. We looked at how three complaints had been managed. We saw the provider took appropriate action in each case. For example, customer service training took place to improve how staff responded to people. Feedback surveys had also been adapted so that people did not feel obliged to write their name on them.

Good

Is the service well-led?

Our findings

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. These incidents include serious injuries, deaths and allegations or incidents of abuse. At the last inspection in August 2017, we had concerns because we had not been informed about all allegations or incidents of abuse. The incidents had been reported to the local authority at the time but not to us. We asked the provider to take action to make improvements at the service and to submit an action plan to us.

On this occasion, we found improvements had been made. We were able to see from notification records we had received since the last inspection, and other records during our visit, that incidents were now reported appropriately. A file was maintained in the registered manager's office of all notification forms, as a quick reference.

Records were well maintained at the service. We made a recommendation at the last inspection for staff to follow good practice by indicating on record sheets when medicines prescribed for occasional use had been offered to people. On this occasion, we saw clearer medicines records had been kept, to provide a more accurate audit trail.

People received care in a service which was well-led. This enabled then to receive safe, effective and co-ordinated care. A registered manager was in place. Since the last inspection, a deputy manager position had been created and filled. This arrangement was working well and staff gave positive feedback about this. Various new practices had been established at the service since we last visited. These included weekly senior staff meetings, weekly action plans and people's keyworkers carrying out quality reviews of care. An employee recognition scheme had been set up, to acknowledge where staff had 'gone the extra mile'.

People were cared for by staff who received appropriate support and training. As well as face to face supervision meetings, spot checks were undertaken when care workers were supporting people. Staff knew how to raise any concerns about people's care, both internally and to external organisations. Information was displayed on the main noticeboard about raising safeguarding and whistleblowing concerns. Whistleblowing is raising concerns about wrong-doing in the workplace. This showed the service had created an atmosphere where staff could report issues they were concerned about, to protect people from harm.

People's views were sought about the service through surveys. The feedback from these was displayed at the service, so that people could see the overall outcomes. Regular quality reviews also took place to make sure people were satisfied with their care.

The provider regularly monitored the quality of care at the service. Senior managers visited the service routinely and assessed how the service was performing. One of these visits took place at the time of the inspection. A comprehensive audit was undertaken annually. Actions which arose from audits were monitored for completion.

The service worked with other organisations to ensure people received effective and continuous care. For example, other service providers and healthcare professionals who were involved with people's care.

We found there were good communication systems at the service. Tenants' meetings were held regularly. These provided an opportunity for communication between people who use the service and staff about concerns or improvements that were being made. Staff and managers shared information in a variety of ways, such as face to face, during handovers between shifts and in team meetings.