iMap Centre Limited

42 Beeston Drive

Inspection report

42 Beeston Drive
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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 17 and 22 January 2016 and the first day was unannounced.

The service provides accommodation and support to four adults with autism. It is based within a detached property in a residential area of Winsford, close to local amenities. At the time of the visit, there were three people living at the service.

The service did not have 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.' This service had a manager who was the registered manager at another iMap location but she had applied to have this service added to her registration.

People lived in a detached house that had been adapted in part to meet their needs. Improvements were needed to ensure that the building was kept clean in order to minimise the risk of infection. We were informed that remedial repairs and refurbishment were planned to

Summary of findings

improve the communal areas and to give the service a more 'homely" feel. The registered provider ensured that it was safe and that all required checks were carried out on a regular basis.

Observations indicated that people were happy at the service and there were positive interactions with staff. People were supported by staff that knew them well and could anticipate their needs. The requirements of the Mental Capacity Act 2005 were met and staff used a range of strategies to communicate with people to help them express themselves and to indicate consent. Applications had been made under the Deprivation of Liberty Safeguards where it was felt a person's liberty was being restricted or deprived.

Staff were aware what was required in order to keep people safe and there was evidence that they were confident to report matters of concern. People received care and support from staff that had been through robust recruitment procedures to ensure that they were of suitable character to work in this setting. Staff also underwent an induction programme to equip them with the knowledge and skills to support people.

Care records were personalised and gave an accurate picture of a person's needs, wishes, preferences and personality traits. There were also risk assessments in place to direct staff in managing certain aspects of a person's care. This meant that staff not familiar with people at the service would be able to know about them and how their support needed to be delivered.

The registered provider ensured that audits (checks) were carried out on a regular basis in order to monitor the quality and effectiveness of the service. They responded in a timely manner to any complaints that were raised in line with their complaints policy.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Good

Safety checks were carried out on the building to ensure that it did not pose a risk to the people who lived or worked there. However, it would benefit from refurbishment and decoration in communal areas.

Staff knew about safeguarding adults and how to keep people safe. The registered provider had policies and procedures in place for staff to follow should they have any concerns.

Staff had been through the appropriate recruitment checks so that they were deemed to be of suitable character and skill to carry out their role.

Is the service effective?
The service was effective.

Good

People were given choices and staff tried to seek their consent. Staff had an awareness of the Mental Capacity Act and applications for Deprivation of Liberty Safeguards had been made.

The nutritional needs of people were met and people were encouraged to eat healthy foods.

People were supported by staff that received training and support to ensure they were confident and competent.

Is the service caring?
The service was caring.

Good

Staff had positive relationships with people and people were treated with kindness and respect.

People were encouraged to participate in activities that they enjoyed and they were supported to access local community facilities.

Is the service responsive?
The service was responsive.

Good

Records reflected a person's needs, wishes, preferences and behavioural traits. This meant that staff who had not previously worked at the service would know what care someone required.

There was good collaborative working with other agencies in order to make transition into the service easier.

Complaints and concerns were responded to in line with the registered providers policies and procedures.

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

Good

There had been recent changes in the management team and the staff felt that this had made things better.

Summary of findings

Regular checks were carried out by the manager and the registered provider to ensure the quality and effectiveness of this service was monitored.

The manager had applied to CQC to become the registered manager for this service.

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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.

The inspection took place on the 19 and 22 January 2016. The first visit to the service was unannounced.

The inspection was carried out by an adult social care inspector.

Before the inspection we gathered and reviewed information held on the service through our notifications and feedback from other professionals.

Prior to 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.

People at the service were not able to express their views to us verbally. 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.' On the inspection we observed, where we were able, interactions with staff and people who used the service. We also spoke to the five staff on duty that day and a manager from iMap.

We looked at the records of the three people who used the service which included care plans, risk assessments and daily notes. We also reviewed the information kept around the management of the building, overall service and the staff. This included utility checks, quality audits, staff training, supervision and three recruitment files.

We contacted the commissioners of the placements but we did not receive any comments to help us inform our judgement.

We gave the opportunity to the relatives of those people who used the service to provide us with feedback and their opinions were mixed.

Good

Is the service safe?

Our findings

Relatives had a differing view on the service. We were told that "Our loved one safe and secure" and that "Our relatives safety is always seen as a priority." However the experience of another was that "Staff do not always do all that they can to keep [relative] safe from others".

The staff we spoke with demonstrated a clear understanding of people's care and support needs and their role and responsibility to maintain their safety.

We found that improvements were required to the general cleanliness and upkeep of the service. Remedial repairs and decoration were required to areas of flooring and walls such as in the kitchen area. A review was required in terms of policy and practice in regards to infection control. In some areas the service was not visibly clean such as in the upstairs bathroom, the window ledges and flooring. This could pose an increased risk contracting an acquired infection to those people using the service. The registered provider informed us that there is to be a refurbishment of the kitchen and dining area and this will be completed in the next few months.

Staff had a good understanding of safeguarding people and talked to us about adult abuse, including how they kept people safe. There were procedures and policies in place for the reporting of incidents and staff were aware of these. The manager informed the local authority on a monthly basis of safeguarding concerns deemed to be of a low-level such as falls, unexplained bruising and altercations between people who used the service. They had also informed the Care Quality Commission of all relevant safeguarding occurrences. Action was taken to investigate such concerns and to take remedial action to prevent any further harm.

Staff knew about risk management plans and explained how they followed behaviour risk assessments in order to reduce the frequency of incidents between people who used the service. There were risk assessments in place to support people's self-determination whilst minimising risks to their wellbeing. There were risk assessments, for example, in place for self-harm, medication, self-neglect, domestic hazards and community visits. The organisation also had support from its positive behavioural support manager.

There was a policy and process in place for the reporting and investigation of accidents and incidents involving people who used the service. These were reviewed by the senior management team of the organisation to identify any themes, trends and information that may indicate unsafe care practices.

Some of the people at the service required medication to keep them well. There were systems in place for the ordering, recording, administration and disposals of these. We sampled the medications administration record sheets (MARS) for two people and found that they were correctly completed and reflected the medication given and available.

We checked the recruitment records of three staff and saw that the service had thorough recruitment and selection processes in place. All the required checks, including obtaining and verifying references and checking application forms were in place. A Disclosure and Barring Service (DBS) check was carried out before staff were employed to work directly with people who used the service. A DBS provides the employer with information about any criminal convictions or cautions and whether the person is barred from working with vulnerable adults or children.) This meant that people received support from staff assessed to be of suitable competence and character.

The registered provider ensured that the premises were kept safe and there were regular checks carried out on the gas, electricity and water supply. Audits were carried out on the safety and suitability of equipment used. We spoke with the manager about the requirement to ensure that fridge temperatures are carried out on a daily basis. There was a fire risk assessment and evacuation plan in place. Staff carried out regular drills that also included those that lived at the service. There was an independent Health and Safety Consultant who offered advice and support when required.

Good

Is the service effective?

Our findings

People were able to have food that they liked and could eat at a time to suit their own needs.

People ate meals mainly in the dining room. Staff were flexible as to when they supported people with meals. People were encouraged to have healthy eating and to take a varied diet. Drinks and snacks were available and we observed people being encouraged to take them throughout the day. Not all meals were prepared for the household which meant that individuals had a choice. One person also helped with the shopping and enjoyed going out to do this.

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 procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). 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 were being met.

DoLS requires registered providers to submit applications to a 'Supervisory Body' for authority to restrict or deprive someone of their liberty. We found that the registered provider had made applications where appropriate and was able to explain to us why these had been made. These included situations where a person did not have the mental capacity to make decisions such as where to live or where someone's freedom within the service was restricted for example by the locked doors or sensors. Staff were also aware of those persons subject to DoLS. We spoke with the registered provider about the need to ensure that copies of the DoLS application and/ or authorisation were kept on the persons care file so that staff were aware of any conditions and limitations.

There was close circuit television (CCTV) that overtly monitored the personal space of a person. The registered provider had followed their own appropriate guidance and consultation before this was installed and was aware of the Care Quality Commission document "Using Surveillance". This had been authorised through the court of protection.

The registered provider had ensured that staff received training and staff we spoke with understood the basic requirements of the Mental Capacity Act, and the requirements of the DoLS.

There were systems in place for seeking and obtaining consent to care and people's human rights were respected. The service had a set of policies and procedures that informed staff about the rights of people who used the service. These included people's right to give or withhold consent and what to do if a person did not have the capacity to consent to care. We saw that staff used a variety of communication methods to try to seek consent and also they were very aware of non-verbal gestures. Records also showed that 'best interests' meetings were held with relatives and health and social care professionals involved in the person's care, if the person did not have capacity to consent to care themselves. It was clear in care plans that 'parents cannot give informed consent if the person is over 18 unless they have a lasting power of attorney for health and welfare'.

Staff said that they were provided with the training they needed to meet the needs of the people who used the service. They said the new management team were supportive and that they had started to receive regular supervision where they were able to discuss their training and development needs. A staff meeting was also held every six weeks.

We looked at staff training records and saw that all new staff received an induction to ensure that they had the skills and knowledge to support the people who used the service. This started with two weeks classroom learning, followed by an introduction to the people they would be supporting and shadowing an experienced staff member until they were assessed as competent to carry out their role. Staff achieved Care Certificate upon completion. This is an identified set of standards that new health and social care workers should adhere to.

There was a programme in place to ensure that ongoing training courses were available for staff to attend to refresh their knowledge. These included first aid, infection control, safeguarding adults from abuse, moving and handling,

Good

Is the service effective?

health and safety, food hygiene and data protection. The induction also included training in various forms of communication techniques, person centred planning, medication, epilepsy awareness, autism awareness and strategies for crisis intervention and prevention. After a six month probationary period staff were put forward for national vocational qualifications in health and social care. Senior staff had the opportunity to complete management qualifications.

Good

Is the service caring?

Our findings

A relative gave feedback that " Our [relative] has shown they are happy and comfortable to return to the house when we have taken them out on visits." and that "42 Beeston Drive is the best anyone could wish for. Our [relative] is treated with the utmost respect and all their needs are understood and met by the staff." Another had a differing view and told us that their relatives social and health needs were not always met.

Staff commented: “It’s all about the people here, I go home shattered but knowing that people are settled and happy”.

Wherever possible, iMap try to involve people in the interview of new staff members. They tailor their involvement to either allow the person to interview or ask their own question, or a question can be asked on their behalf. Where the person is unable to generate a question, one from their family member or advocate can be included.

We spoke with a staff member who was aware of how to promote the dignity, involvement and independence of the people who used the service. Training in promoting people's rights and respectful practices was part of the induction programme and on-going training for staff.

Each person was encouraged to decorate and personalise their bedroom to their own tastes. Their opinion and that of families was also sought in planning the new refurbishment programme. Staff had volunteered to carry out the painting so as to minimise the anxiety as those they supported do not cope well with new faces and change.

There was a vacant room at the service. The manager informed us that there have been enquires but that it is really important that they match the needs and the personality of new applicants with the people who currently live at the service.

Staff spoke to us about the needs of the people they supported with kindness and affection. They explained the importance of keeping routines for people and the need for the continuity of staff. They told us that wherever possible they covered shifts for others as they were aware that the people supported do not react well with unfamiliar people. We also saw this reflected in care plans that clearly outlined what people needed in order to keep their anxiety levels low. One person, for example, was able to feed themselves but it was essential for “Everything to be ready and set up before they sat down as they could not tolerate having to wait”.

Staff also emphasised the importance of praise and encouragement. Interactions that we observed were positive and people were encouraged to do things that made them happy and relaxed. Staff used language warm and friendly to describe people such as “Mischievous” and “A real softy”. Staff had to be firm on occasions but were direct without being controlling.

The service recognised the importance of ongoing health checks and how these may differ depending on gender. These were incorporated into the health care plans and people were given prompt access to medical support.

Good

Is the service responsive?

Our findings

One person told us that specified activities for their relative did not always take place as often as they should. They had raised this with the manager and the matter was being investigated further.

Staff told us that they had established from people who used the service and their relatives what activities they liked to do. We were told that activities were carried out every day and included cooking, going for walks, going to the pub and shopping.

Relatives were actively encouraged to contribute to all person centred plans, including support plans, risk assessments and behaviour support plans.

Each person had an initial profile and assessment to identify their needs, appropriate staffing requirements, assistive technology, and any compatibility issues. We looked at the records of three people who used the service. There was evidence of good practice with support plans being written in a person-centred way. The support plans provided information around people's health, social, behavioural, learning and physical needs. They outlined the type of care and support that was required for each person. Staff told us that all care plans were being reviewed to further improve the quality and detail of information in them.

All of the people who used the service had very limited speech and care plans indicated alternate communication methods such as the Picture Exchange Communication System (PECS) and Dynovox. We observed staff interacting with people in this way. The staff demonstrated an understanding of people's care and support needs.

Care plans also outlined behaviour traits and the habits people exhibited and what they might mean. This knowledge allowed staff to pre-empt a situation and anticipate what a person needed. For example, we learnt that someone played a particular song when they were not happy. The service had a crisis management plan in place for dealing with unforeseen emergencies. This was accessible to the staff. Care plans also included goals for each person that were broken down into small and achievable action points: for example to engage in physical activity with only one prompt and to identity one, then two and then three different animal's at the farm.

Daily record books were kept for each person that indicated how they had been throughout the day and night, what they had done, what they had eaten or drunk as well as the level of support that had been provided. These were up to date and acted as a good handover record between staff.

The service worked well with other agencies and services to make sure people received care in a coherent way. Some people had moved into the service during a transition period between children's and adults services. We saw that there was a transition plan in place, the move was made on a gradual basis and that a settling in period was reviewed. A social worker we spoke with confirmed that iMap had been thorough and responsive during this transition phase and afterwards. Any adaptations to the environment or living spaces were made ahead of the person moving. Staff members and management team all confirmed that the service worked in partnership with other health and social care providers to enable the care, treatment and support needs of people who used the service to be met. Records showed clear involvement of other people that they were involved in the assessment, care planning and review process.

People had a health action plan and a hospital passport that provided information about their needs should they require admission to hospital.

The people who used the service and/or their relatives were provided with a brochure about the service which included the complaint procedure. These were also available in an easy read format. There were forms available for comments, compliments or complaints.

One relative felt that their concerns were appropriately responded to whilst another felt that they were "Appeased on occasions". There was a complaints process in place. We saw that the registered provider had responded appropriately to complaints raised by external parties about the service and were taking steps to address a umber of issues.

Good

Is the service well-led?

Our findings

A relative told us that "The staff have been very supportive when we have been through difficult times" and another comment was "We have had a good relationship with long serving members of staff past and present."

The service had a manager who was a registered manager for another iMap location. They had applied to the CQC to become the registered manager for this service. She told us that she was working hard to make changes and improvement to the service following the resignation of the previous manager in August. A staffing restructure was also taking place across all iMap services.

A number of staff events had been held to relay to all staff that their views and comments on the services provided by iMap had been taken on board and the main driving force for staff over the coming year would be a pathway for future development and increased communication now that the service was based over several sites. Deputy Manager and key worker posts were due to be formalised this month.

There were systems in place to obtain the views of the people who used the service and to monitor the quality of the service provided. Relatives were asked their views and had opportunities to attend meetings that influenced the service provided. Staff said that they had regular contact to ensure that the service continued to meet the needs of the people who used the service and to identify any changes they required.

Annual surveys were sent out to staff, the people who used the service and/or their representatives to find out their views about how the service was operating. The registered provider had been disappointed that there had been no feedback about this service at the last survey.

Confidential staff personnel files and other records relating to the management of the service were kept locked in a filing cabinet in the service's head office. Any disciplinary or performance issues were managed through the company procedures and we saw evidence of this. Staff were made fully aware of the registered providers expectations.

Staff meetings took place and we saw records of these. These were an opportunity for staff to raise issues of concerns about the service and the people they supported. They were also a forum to discuss policies, procedures or best practice.

There were a number of daily, weekly and monthly manager and provider audit tools to monitor health and safety standards as well as the quality and effectiveness of the service. It was clear from these that if actions were required a person was nominated as being responsible for seeking a resolution and a timescale set.

We were told that there were plans to increase the involvement of people who used the service through forums when it was hoped that the service could gain their ideas on positive changes for the service.

The registered provider had planned a comprehensive review of all policies to standardise the format across all of the iMap services, and introduce easy read versions of key policies, and address any omissions. At present, policies and procedures were accessible in service via the company server, and all staff were issued with a company handbook. We saw a new version of the service user guide that has just been updated in an easy read format so that it could be understood by those persons who used the service.