Community Integrated Care

Glen Cottage

Inspection report

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Date of inspection visit:
27 April 2017

Date of publication:
24 May 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on the 27 April 2017. At the last inspection we said the quality of the service was good but it needed to improve the way in which the Mental Capacity Act 2005 was applied. At this inspection we found the service remained good and the required improvements had been made.

Community Integrated Care are a national charity delivering care and support to people with a diverse range of needs including people with learning disabilities, mental health concerns and health related problems. Glen Cottage is registered to provide accommodation and personal care for one person. The home is located in a residential area close to community facilities. At the time of the inspection there was one person living at Glen Cottage.

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 registered manager also managed three of the provider's other registered services in the local area and was providing temporary management support to a nearby supported living service managed by the provider.

Our last inspection had found that mental capacity assessments had not been undertaken when required and that aspects of the care and support being delivered, whilst in the person's best interests, amounted to a deprivation of the person's liberty, however, an application to authorise the restrictions had not been submitted. The application had now been submitted to the local authority and was awaiting approval and relevant mental capacity assessments were now in place. This meant that the person was supported to have maximum choice and control of their life and staff support them in the least restrictive way possible; the policies and systems in the service supported this practice.

Recruitment practices needed to be more robust to ensure that all of the relevant checks were completed. Full employment histories had not been obtained for two staff members. This information has now been obtained.

Improvements could be made to the training programme to ensure that staff had more up to date training which was also specific to the needs of the person using the service. We have made a recommendation about this.

Relevant risk assessments were in place and covered activities and associated health and safety issues both within the home and in the community.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Staff had clear guidance about what they must do if they suspected abuse was taking place.

There was sufficient staff to meet the person's needs. The person was supported by a stable staff team who were experienced and knew and understood their needs.

Appropriate arrangements were in place to manage the person's medicines. There were policies and procedures in place to ensure the safe handling and administration of medicines, which were only administered by staff that had been trained to do this.

The person was supported to have enough to eat and drink and their support plans included information about their dietary needs and risks in relation to nutrition and hydration. Staff involved the person in decisions about what they ate and they were assisted to remain as independent as possible with eating and drinking.

Where necessary a range of healthcare professionals had been involved in planning the person's support to ensure their health care needs were met.

We observed interactions between staff and the person which were relaxed and calm. Staff showed the person kindness, patience and respect. Staff were aware from the person's body language whether they were comfortable with the care being provided or wanted space or time on their own.

There were systems in place to assess and monitor the quality and safety of the service.

Further information is in the detailed findings below.

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 is now rated as 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**

Glen Cottage

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.

The inspection took place on the 27 April 2017. The registered manager was given 48 hours' notice because the location is a small care home supporting one person and so we needed to be sure that someone would be in. The inspection was undertaken by one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with the registered manager and two support staff. We reviewed the care records of the person who used the service, the records of two staff and other records relating to the management of the service such as audits, policies and staff rotas.

Due to complex nature of the needs of the person using the service, we were not able to seek their views about the care and support they received. We therefore spent time in communal areas listening to interactions between them and the staff supporting them. Following the inspection we spoke with their relative and sought the views of two health and social care professions about the care provided at Glen Cottage.

Glen Cottage was last inspected in May 2015 when we found two breaches of the legal requirements.

Good

Is the service safe?

Our findings

Registered managers are required to perform a range of checks to ensure that only suitable staff are employed to provide care and support to people. We were able to see that photographs of staff were in place, as were references. Checks had been carried out with the disclosure and barring service (DBS). DBS checks identify whether a staff member has a criminal record or is on an official list of people barred from working in roles where they may have contact with adults who may be vulnerable to harm from others. However, the registered manager was not aware that there were gaps in the employment history of two staff who had worked for the provider in other locations but were now employed at Glen Cottage. The registered manager had taken action to obtain this information, however, we recommend that they review all staff records to assure themselves that all of the required checks are complete and satisfactory.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The organisation had appropriate policies and procedures and information was readily available on the local multi-agency procedures for reporting abuse. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. Staff had access to a whistle-blowing line to report concerns about poor practice. A care worker told us, "I have not seen anything that has made me feel that is not right, if I did I would report it, if it doesn't sit well with me, its not right, I would 100% report it".

Risk assessments were in place to manage aspects of the person's care and support. These included the person's healthcare needs, personal care, accessing the community, mobility and the management of their finances. Staff were well informed about the potential risks associated with providing the person's care and support and had for example, attended training on dysphagia. (Dysphagia is the medical term for swallowing difficulties). Incidents and accidents were recorded by staff and reviewed by the registered manager which enabled them to maintain oversight of risks or incidents within the service. The service had a 'Read and Sign File' which contained key information about new risks or policies. For example the file contained a new post falls policy. Staff were required to read this and sign to confirm they understood the information.

Staffing levels were adequate to meet the person's needs. Each day one member of staff worked from 10am to 11pm and then slept in until 8am the next morning. They then worked from 8am to 10am at which point the next worker came on shift. At night the member of staff sleeping in had access to alarms and monitoring equipment which alerted them should the person need their assistance. Rotas showed that at a second staff member was rostered when required to enable the person to take part in specific activities or appointments. There was currently a team of four staff providing the person's care. Agency staff were not generally used and gaps in the rota were covered by the existing staff team which could at times be challenging. The registered manager told us they were currently recruiting one more care worker to provide additional flexibility within the rota and to assist with covering leave. The person's relative told us, "[the person] is very fortunate to have had the same or similar staff for so long. It is also my firm belief the fact that the staff have become so familiar with [the person] over the years this has helped [the person] to enjoy as much quality of life that is available to her".

Systems were in place to manage medicines safely. There were policies and procedures in place and medicines were only administered to people by staff who had been trained to do this. This included an annual review of their skills, knowledge and competency to administer medicines. We observed staff administering the person's breakfast medicines, they explained that the medicine was going to be on the first spoonful of their cereal, this was in line with the care plan which stated that the medicines should not be given covertly. There were protocols and guidance in place for the use of emergency or 'if required' medicines, but these could be more personalised. Since the inspection, the registered manager has confirmed that these have been updated. Medicines were stored safely in a locked medicines cabinet. We reviewed the person's medicines administration record (MAR) and saw these contained sufficient information to ensure the safe administration of their medicines. We recommend that the provider ensure there are clear procedures, following in practice, for the documentation of the administration of the prescribed thickener. Thickeners are added to drinks following the advice of a healthcare professional to change the consistency of the drink to aid safer swallowing.

Glen Cottage retained a homely feel and we found it to be clean throughout. There was evidence that staff understood and following infection control measures and good food hygiene practices.

Good

Is the service effective?

Our findings

The person was supported by staff who had a good knowledge of their needs and of their likes and dislikes and during our inspection we observed that staff delivered care effectively and to an appropriate standard. Their relative told us, "I believe that the care provided is of the highest quality possible". A health care professional told us, "From what I observe, they are excellent, I have no issues".

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. Our last inspection had found that relevant mental capacity assessments and best interest's consultations had not taken place and staff had not received training in the MCA 2005. This inspection found that some improvements had been made. There was evidence that when the person was unable to make more complex decisions about their care, staff were guided by the principles of the Mental Capacity Act (MCA) 2005. Staff were aware that decisions made on behalf of people must be in their best interests and made in consultation in relevant persons. The registered manager had completed and documented mental capacity assessments to determine whether the person could consent to the care and support being provided, to the administration of their medicines, sharing information and to the management of their finances. There was a record of the decisions that had been made in the person's best interests.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Our last inspection had found that although aspects of the care and support provided amounted to a deprivation of the person's liberty, an application for a DoLS had not been submitted. This has now been submitted and is waiting to be assessed by the local authority.

New staff undertook a six day induction which included a range of essential training. Upon successful completion of this, staff were awarded the Care Certificate. The Care Certificate was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. The staff files viewed showed that staff had completed the Common Induction Standards which were a forerunner to the Care Certificate. Staff also completed a site specific induction which involved learning about the needs of the person using the service, the layout of the building and fire procedures for example. A care worker told us, "I read all the care plans on my first and second shift". We did note that in the case of one of the workers, this induction had not been fully completed by their previous manager. We brought this to the attention of the registered managed who arranged for this to be completed the week following our inspection.

Staff completed a basic training programme which consisted of food hygiene and moving and handling training on an annual basis and safeguarding and first aid training every three years. Staff completed medicines training every three years also and had an annual assessment of their competency to administer

medicines safely. Other training such as infection control, mental capacity act and end of life training was either completed during the induction of new staff or available on request, but was not routinely undertaken or refreshed. This is not in line with best practice guidance. Training records showed that not all staff had recent training in caring for people living with epilepsy. None of the staff currently had fire training. One member of staff did not have current moving and handling training. We discussed this with the registered manager who told us arrangements would be made to ensure this training was updated. Staff told us the training provided was adequate but "Not as regular as it used to be". One staff member said, "When you do it, it is very good".

We recommend that the provider review its training programme to ensure it is in line with best practice guidance and with the needs of the person using the service.

Records showed that staff had supervision intermittently. This was an opportunity to discuss their training and development needs. Staff told us they felt supported and felt able to approach the registered manager at any time to discuss a matter or seek advice.

Staff supported the person to choose their own meals from a range of known preferred foods. Staff had a good understanding of the person's food likes and dislikes. For example, we saw that staff were aware that when ordering a particular type of take away, this should be ordered with no onions. The person had specific needs around their nutrition to avoid the risk of choking and these had recently been reviewed and updated guidance provided was displayed within the kitchen. Staff had a good understanding of these specific needs and were able to clearly describe how these were catered for. We spent time listening to how staff supported the person to eat their breakfast. This was done in a person centred manner. Staff talked to the person throughout, telling them what the meal was, chatting about the fact that they too had had Weetabix for breakfast. Records showed the person was supported to maintain a healthy diet and to stay hydrated.

Where necessary a range of healthcare professionals including GP's, dentists and speech and language therapists had been involved in planning the person's support to ensure their health care needs were met. Referrals were made quickly to healthcare services when the person's needs changed. Due to their complex needs, the person was not able to tell staff if they feeling unwell, so it was important staff observed for signs which might indicate this. We saw the GP had been called promptly when needed.

We looked around the premises and examined records in relation to the maintenance of the building. The premises were of a suitable design and layout to meet the person's needs. A number of improvements had been made since our last inspection, for example, the provider had funded new flooring in the lounge. The provider did not own the premises and repairs and improvements to the property were the responsibility of their landlord. There was evidence that improvements and repairs to the property were not always completed in a timely manner, but we were able to see that the registered manager was taking action to try and ensure the landlord addressed maintenance issues.

Good

Is the service caring?

Our findings

The person living at Glen Cottage was not able to tell us how caring the service was and so we spent time listening to how staff spoke with them and delivered their care in communal areas. We heard staff engage positively with the person, for example, we heard staff knock on the person's door and then enter saying 'Good morning [the person]'. This was said in a happy and cheerful manner. Staff were gentle, encouraging and supportive. We heard the staff member assisting the person to eat and drink saying, "Well done that was fab". At the end of the meal they said, "I'm just going to wipe your mouth, there you go, thank you". The staff team spoke to us of the kindness of their colleagues. One staff member said, [Care worker] is the kindest soul I have ever met in my life, she never loses her nice calm voice". They told us how their colleague cuddled the person when they wanted this and held their hand while they dropped to sleep. They said, "it's a wonderful thing to see". Another care worker said, "They all [the staff] have a lot of patience". Their relative told us, "I am very happy with the care provided by a very caring and professional team".

Staff had clearly developed a meaningful relationship with the person. Even though the person was not able to answer or converse with them, staff were observed to be engaging with them in a meaningful way. For example, we heard a staff member say, "If you don't mind, I'll do your drinks and [staff member] will help with your breakfast" and "Are you going to help with shopping later". A staff member told us, "The staff treat [the person] with kindness, they make sure she has enough fruit and veg, they do the extra little things for her, like today, [staff member] blended some figs for her, they all seem to genuinely care about her".

Staff showed they had a good knowledge and understanding of the person they were supporting. Staff were able to give us examples of their likes and dislikes which demonstrated they knew them well. We were given examples of the types of food the person liked to eat and what activities they enjoyed as well as their preferred daily routines. This information was also reflected in the person's support plan. The person's relative had complimented the service saying, 'I really do appreciate all you do for [the person] making her life as pleasurable as possible'.

The person had a communication care plan which described how the person communicated and the techniques they used to express their wishes. For example, we saw that if the person pulled the bed covers over their head, this meant they wanted to stay in bed a little longer. Declining to put their shoes on meant they did not want to go out. The person was able to use facial expressions to identify their food choices when staff were planning the weekly menu. Staff understood how the person communicated and used this effectively to ensure that the support provided was centred around the person's needs and wishes.

Staff tried to encourage the person to maintain their independence. One staff member said, "In the morning I give [the person] the towel to dry themselves, they can throw it away, but they can do it. With drinks if you hold from just one side, they can hold the other side, they may accept help with washing their plate too".

The person's privacy and dignity was respected. Staff were observed to ensure doors were closed when personal care was being provided. Staff also knocked before entering the person's room. The importance of privacy and of having time to themselves was a common theme throughout the person's support plans and

staff had an understanding of the importance of this to the person, for example, they told us how they were aware from the person's body language whether wanted to be on their own and instead observed from a distance so that they could be aware whether the person needed their assistance.

Good

Is the service responsive?

Our findings

It was evident that staff were very knowledgeable about the person's needs which meant that they were able to provide care with was responsive to their needs. Any new staff were introduced very slowly to the person. This was because the person found it very difficult to accept care from new staff members who they did not know and feel comfortable with. Initially the new worker simply observed, from a distance, the delivery of the person's care by other staff. During the next stage, the new worker came into the person's room whilst others were providing care. Then very gradually and with the consent of the person, they began to be directly involved in some basic care provision until it became evident that the person was comfortable with the new worker allowing the experienced workers to gradually withdraw. This process allowed the new workers to really learn about the person's needs, their routine, risk management strategies and communication methods. A new worker told us, "Its nice they have given me time I don't want to do things wrong, helping with food has been a good way to bond".

The person's care and support plans were person centred and contained detailed information about their likes and dislikes, their preferred daily routines and the things that made them happy. For example, the person's care plan provided information about what was important to them. This included listening to music and talking books. We saw that staff were supporting the person to have access to both of these. Care plans included information about the person's life before coming to live at Glen Cottage and about the people who were important to them. Information was available about how the person preferred their personal care to be provided, the support they needed to eat and drink and the support they needed to access the community. The care plans were generally detailed, although we did see several examples where the information provided was not fully personalised to the needs of the person using the service or up to date. We spoke with the registered manager about this, who advised that the care plan would be reviewed to remove these errors.

Staff maintained detailed daily records which noted how the person had been, what they had enjoyed, whether they had experienced any anxiety or agitation and what foods they had eaten. Staff were monitoring whether the person had any seizures. The daily records and our observations indicated staff were following guidance in the support plans and were encouraging the person to direct their own care whenever this was able. For example, we were able to see that staff had noted that the person had indicated that they did not want a particular meal and so an alternative had been offered. On another occasion staff had noted that the person had not appeared to want time on their own and so they had stayed close by. A care review took place annually and this was an opportunity for the person's relative and relevant health and social care professionals to make their views known about the care provided by the service.

Staff supported the person to pursue activities they found meaningful. Staff told us how they accompanied the person on walks, drives and trips to the shops or to open air concerts. The person was supported to listen to music and talking books. They had regular massage sessions On the day of our inspection, the person went shopping and had lunch out. Previous holidays had a been a success and so there were plans to arrange another for this year. There were also plans to borrow some equipment to see if this might allow the person to once again access hydrotherapy which they had previously enjoyed.

There was a complaints process available and this was displayed in the communal area. There had been no complaints recorded since the last inspection. Staff we spoke with knew how to respond to complaints and understood the complaints procedure.

Good

Is the service well-led?

Our findings

The registered manager at Glen Cottage was also responsible for managing three other nearby services. This meant they spent on average a day in each of the homes. Despite this, it was evident they were very familiar with the needs of the person supported at Glen Cottage. Staff spoke positively about the registered manager and their leadership style. One staff member said, "Its lovely having [the registered manager] she knows her onions, has plenty of time for you and for getting things done for [the person], she would come in if we needed her whether it was 11am or 11pm…They are the best manager I have had in a long time". Another staff member said, "Whenever I have needed anything, she has sorted it out, she has always got back to me".

Staff meetings were held and were used as a forum to share ideas and discuss issues such as safeguarding alerts, medicines safety, policies, rotas and any complaints or compliments that had been received. Staff completed a daily shift planner. This was a record of which staff were on duty, who had been responsible for administering medicines, information about any incidents or medicines errors that had occurred or important messages that needed to be shared. This helped to ensure that the service was effectively managed in the absence of the registered manager

There were some systems in place to assess and monitor the quality and safety of the service and to ensure the person was receiving the best possible support. The person's money was checked daily to ensure this was being managed safely and to avoid the risk of financial abuse. Medicines audits were undertaken daily and monthly. The registered manager completed a monthly report for the provider which included information about any complaints or incidents, issues affecting the person being supported and maintenance matters. An external service audit had been completed in February 2017. This had recommended a number of actions and included timescales within which these should be completed. Most of these had been completed, although we noted that one of the findings had been that the person's support plans be reviewed to ensure that they were fully robust. It was not evident that this had as yet been completed.

Staff completed a range of health and safety checks to help identify any risks or concerns in relation to the environment and equipment used for delivering care. For example, checks were made of the fire, gas, electrical and water safety systems within the service. A fire risk assessment had been just been completed although the report for this was not yet available. There was evidence that fire drills had been undertaken. A fire grab pack was available and the person had a personal emergency evacuation plans (PEEPS) which detailed the assistance they would require for safe evacuation of their home. A business continuity plan had been developed which set out the procedures for dealing with foreseeable emergencies such as loss of power.

The registered manager was confident that the staff team were suitably skilled and familiar with the person's needs. They said, "Communication is good, they don't need me checking on them [the person] is quite safe…They keep on top of stuff, but know they can come to me, if there is a problem, I can drop everything and come over". They told us they were proud of the staff team and of the way in which they

continued to work hard to ensure that the person was offered choices and supported to make decisions. They said, "[the person] comes first, she is their main concern, they are a very person centred team".