Housing & Care 21

# Housing & Care 21 - Highdown Court

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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 3 April 2017 and was announced.

Housing & Care 21 Highdown Court is an extra care service consisting of 54 individual apartments within the building, 34 of which are rented by people or people have a shared equity. There is an office base and care staff provide people with a range of services including personal care, medicines management, shopping and cleaning services. At the time of our inspection, 37 people were receiving care and support from the provider.

A manager was in post and they were completing the process to register with the Commission. 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.'

People felt safe living in their homes at Highdown Court. Staff had been trained to recognise the signs of potential abuse and knew what action to take if they had any concerns. Generally people's risks were identified, assessed and managed appropriately. Where risk assessments were not in place in a couple of areas, these were discussed with the manager, who undertook to complete a review of all risk assessments. Staffing levels were sufficient to meet people's needs and new staff were recruited safely. Care staff administered or prompted some people with their medicines; other people managed their own medicines. Medicines were managed safely.

Staff had completed training in a range of areas considered essential by the provider to enable them to support people effectively. New staff completed the provider's version of the Care Certificate, a universally recognised qualification. Staff received supervision meetings every three months and attended staff meetings organised by the manager. Staff had been trained in mental capacity and worked within the principles of the Mental Capacity Act 2005. However, people lived independently in their own homes and were not subject to the requirements of this legislation. People had access to a range of healthcare professionals and services and staff supported them to contact professionals as needed.

People were looked after by kind and caring staff and positive relationships had been developed. People were treated with dignity and respect and staff understood how to support people in an unobtrusive and discreet manner. If appropriate, people were supported by staff to stay in their own homes as they reached the end of their lives.

People received personalised care and care plans provided information and guidance to staff on how to care and support people in line with their preferences. People said that care staff were punctual in their call times. Generally, activities were organised by the housing provider, but care staff did plan some activities with people. Many people organised their own social lives and accessed the community independently.

The provider had a complaints policy in place.

People were asked for their feedback about the service and the provider had recently sent out the latest survey. Results from the 2016 survey were positive. Staff felt supported by management and they could access senior staff and management at any time. People spoke positively about the care they received from staff. Audits were in place to measure and monitor the service provided. Where improvements were identified, actions were taken to address these.

## 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.

Staff understood how to protect people from harm and had been trained appropriately. Overall, people's risks were identified and assessed, with guidance provided to staff on how to mitigate risk.

Staffing levels were adequate, although some people felt staff did not always have time to sit and chat with them.

Medicines were managed safely.

### Is the service effective?

Good

The service was effective.

Staff had been trained in a range of areas and were encouraged to study for additional qualifications. Supervision meetings were organised regularly, as were staff meetings.

The registered provider was working within the principles of the Mental Capacity Act 2005.

People had access to a range of healthcare professionals and services.

### Is the service caring?

Good

The service was caring.

People were looked after and supported by kind and caring staff who knew them well.

People were encouraged to be involved in all aspects of their care. They were treated with dignity and respect.

At the end of their lives, people were supported to have a comfortable and dignified death.

### Is the service responsive?

Good

The service was responsive.

Care plans provided detailed information about people and how they wished to be supported by staff. People were involved in reviewing their care plans.

Some activities were provided by staff, however, the housing provider also organised a range of activities.

A complaints policy was in place and people knew how to make a complaint. No complaints had been received since 2015.

## Is the service well-led?

Good

The service was well led.

People were asked for their feedback about the service through annual surveys.

An 'open door' policy was in place and staff were encouraged to discuss any issues with the management team.

A system was in place to measure and monitor the service and audits were in place which identified areas for improvement.

# Housing & Care 21 - Highdown Court

**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 3 April 2017 and was announced. We gave 48 hours' notice of the inspection because this service provides personal care to people living in their own homes. We needed to be sure that staff would be available at the time of our inspection. One inspector undertook this 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 any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including four care records, two staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan and other records relating to the management of the service.

On the day of our inspection, we met with four people who received personal care from the service and spoke with one relative. We chatted with people in their homes. We spoke with the manager, the care team leader, the regional manager and two care staff.

This is the first inspection since the service changed providers.

Good

# Is the service safe?

## Our findings

We asked people whether they felt safe in receiving personal care from staff. One person said, "I feel safe, because the wife's here!". Security systems were in place so that visitors to Highdown Court had to be admitted by nominated staff or by people who lived there. Staff had been trained to recognise the signs of potential abuse and knew what action to take if they had any concerns relating to people's safety. Guidance on adult safeguarding was available for staff to refer to in the manager's office. When asked how they would respond to any safeguarding issues, one staff member said, "I would report it immediately". This member of staff gave examples of types of abuse and said, "Verbal – shouting at someone, unexplained bruising and neglect". Another member of staff said, "People are safe here. We keep an eye on people and they can be as independent as they want".

Risks to people were managed so they were protected and their freedom was supported and respected. Generally, people's risks had been identified and assessed appropriately. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. Risk assessments provided guidance to staff on how to support people safely. A range of risk assessments was in place including falls, medical conditions, moving and handling, neglect and environment. Each risk assessment identified the risk or hazard, actions required and control measures in place to mitigate the risk. For example, one person was at risk of falls and was unsteady when walking. A referral had been made to the local authority falls team for advice and guidance. However, there was no risk assessment in place for another person who experienced seizures. Whilst a factsheet in this person's care plan provided information to staff about their particular medical condition, no specific advice was in place to guide staff in the event this person suffered a seizure. In another care plan, we read that the person was a smoker, but there was no risk assessment in place to ensure their safety whilst smoking. We discussed these issues with the manager who agreed to review people's risk assessments to ensure all areas of risk had been addressed and guidance for staff put in place. Accidents and incidents were reported by staff to the management team and logged on the provider's database.

There were sufficient numbers of staff on duty to keep people safe and meet their needs. At the time of our inspection, 34 people were receiving personal care and support from staff. People had different views when asked about staffing levels. One person, when asked whether staff had time to chat with them said, "It depends how busy they are". They added that they usually spent half-an-hour with night staff who made the last care visit of the day and said, "We have a laugh and a coffee". Another person did not feel staff had time to chat with them and said, "They're supposed to spend 30 minutes with me, but after that they don't have time. They do what they have to do and then they're off". Staffing rotas we checked confirmed that four care staff were on duty in the mornings and three care staff in the afternoon, with two care staff on waking night duty. However, these were minimal levels as staff overlapped their shift times. One member of staff told us that agency staff were not required as any absences could be covered by existing staff. We were told that staff were available to people in an emergency 24 hours a day, seven days a week, outside of the contracted visits with people. Another member of staff said, "You have to prioritise what you need to do. You don't always have time to sit down and chat with people".

Safe recruitment practices were in place. Staff files we checked showed that potential new staff had completed application forms, received a job specification, two references had been obtained to confirm their suitability and good character for the job role and checks made with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and help prevent unsuitable staff from working with people in a care setting.

People's medicines were managed so they received them safely. Some people were able to manage their own medicines, whilst others required assistance from care staff, who either administered people's medicines or reminded people to take them. Staff had been trained in the administration of medicines and one member of staff told us, "We go with what the care plan says, prompting people or administering medicines". A senior member of care staff completed spot checks and observed care staff to ensure they were competent in the administration of medicines. These spot checks were documented and kept within staff files.

Good

# Is the service effective?

## Our findings

People received effective care from staff who had the knowledge, skills and training they needed to carry out their roles and responsibilities. All new staff were required to complete the provider's version of the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. New staff shadowed shifts with experienced staff until they felt ready to work more independently.

The provider organised mandatory training for staff in the following areas: moving and handling, safeguarding, medication, nutrition and wellbeing. In addition, staff completed training in fire safety, equality and diversity, infection control, dementia/mental health, learning disability, mental capacity and first aid. Some training was through e-learning and other training was delivered face to face with staff. Staff told us they could request additional training if they felt this would help them in supporting and caring for people more effectively. For example, training in medical conditions such as Huntington's disease and Parkinson's disease. Managers completed the same training as care staff. Staff were encouraged to study for qualifications, such as diplomas in health and social care. Staff training was logged on the provider's database and this ensured that training could be monitored and updated as required. Staff were happy with the training on offer. One staff member said, "They train you regularly and keep you updated". Another staff member said, "[Named manager] is very good at identifying all the training we need. If you listen, you learn to meet clients' needs". One person said, "The carers all work differently. None are the same".

Staff received supervision with their line managers every three months. Staff told us they found these supervision meetings helpful and an opportunity to discuss their work and any personal issues. Records we checked confirmed that staff had received regular supervision meetings. For example, in one supervision record the member of staff was asked what they enjoyed about their work, any challenges they faced, the support they needed, career aspirations and development opportunities. Staff supervisions were recorded on the provider's database to ensure that staff received regular supervision meetings. Staff meetings were also organised throughout the year. We looked at minutes of meetings held in January, May and November last year and at minutes for a meeting held in January 2017. The minutes of this last meeting showed the following topics had been discussed: CQC, staffing rotas, feedback from the local authority, log sheets, support plans, alarm calls, annual leave, smoking breaks and confidentiality. If staff were unable to attend a staff meeting, they were provided with a copy of the minutes afterwards.

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). No-one receiving care from staff was subject to DoLS; people lived in their own homes and were free to come and go as they pleased. Staff had completed training on mental capacity and understood the importance of gaining people's consent.

People had access to a restaurant and lunchtime meals were included for some as part of their housing agreement with the housing association. Catering arrangements were managed by the housing provider and are outside the remit of this inspection.

People had access to a range of healthcare professionals and services. Care plans recorded the involvement of health or social care professionals. One person said, "If I have a bad time, [named wife] rings the button and staff will come. Staff are very good in getting healthcare help. They stay with us". A staff member said, "We always try and encourage the customer to make contact with district nurses direct". Another staff member said, "We notice if people need a GP if their health deteriorates". The housing provider also organised healthcare visits for people.

Good

# Is the service caring?

## Our findings

Positive, caring relationships had been developed between people and staff. One person said, "I've a great respect for the carers. They all have a good sense of humour and overall the care is very good". Another person talked about their preference not to be supported by male staff first thing in the morning and said, "They're good about that. I'm fairly laid back and the girls have got to know me". It was clear from our discussions with care staff that they knew people very well. One staff member said, "You do become attached to people. It's knowing where the line is and not stepping over that". They added, "Our clients are like family really". Care plans provided staff with details about people's personal histories which included their preferences on how they wished to be cared for and supported by staff. Another member of staff explained, "Staff read people's care plans and get to know the person and families of course. They're a big part of helping that person really". People confirmed to us that they were encouraged to express their views and were involved in making decisions about their care, treatment and support.

People were treated with dignity and respect by staff and people corroborated this. One person said, "It's supportive care and it's unobtrusive. You get as much as you want". A staff member said, "I always speak to people with respect and how they would like to be called. When I'm doing personal care, the door is closed and the person is asked. I always ask people what help they need. It's their own flat and their own home. I always put the person first, this is their private space".

People were supported at the end of their lives to have a comfortable and dignified death, if it was appropriate they could stay at home and in line with their last wishes. We saw that some people had 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) forms in their care plans. DNACPRs are in place to decide whether a person should be resuscitated in the event of a cardiac arrest and are completed by healthcare professionals, in collaboration with people and their families. One staff member said, "Sometimes we are people's family. I would try and attend people's funerals". We looked at a compliment written by a healthcare professional which stated, 'Please can I say how pleased I was that you as a care team actively fought for this lady to return to her own home to spend her last days. You all acted with such professionalism and care and you enabled [named person] to pass away in her own home being cared for by staff that knew her'.

Good

# Is the service responsive?

## Our findings

People received personalised care that was responsive to their needs. Care plans provided detailed information about people in a person-centred way. The essence of being person-centred is that it is individual to, and owned by, the person being supported. A person-centred approach to care focuses on the person's personal needs, wants, desires and goals so they become central to the care process. People's needs take priority. For example, one person's care plan included their goals and objectives and what was important to them. We read, 'Regular contact with friends and carers. Likes conversation and to socialise. Respected and to be as independent as possible'. The care plan also stated, 'Care staff to prompt me to attend to my personal care as I can neglect this. It is important for me to be encouraged to be independent'. Each care visit recorded the time staff spent with people and the personal care they supported the person with. For example, 'My morning support – shower/strip wash, dress, bathroom left clean and tidy, breakfast, ensure I have my care line', together with lunch and teatime support visits. Each care plan provided detailed information for staff on how to support people, including a pen portrait of each person. Care plans were reviewed annually or earlier if people's care or support needs changed. A senior member of staff said that if call times were not sufficient as people's needs changed then, "[Named manager] will contact social services if people need a review. We try and act quite quickly". People had signed a statement to show their care plan had been discussed with them and that they agreed with it. We looked at people's care plans which were kept in their homes and these recorded the daily visits completed by staff and care provided.

People told us that care staff were on time with their calls and in line with people's care contracts. One person confirmed care staff were prompt and said, "I'm very flexible time-wise. Sometimes care staff can be later if there's an emergency". They added, "If staff are going to be late or earlier, they let me know the night before. I have no problems with the care and I prefer female staff". Another person, when asked about the timing of calls, told us, "Staff are bang on time". A third person said, "The carers are very good and they come on time".

Generally, activities were organised by the housing provider. However, care staff did organise some events with people on a daily basis. On the day of our inspection, the communal lounge had been decorated for Easter and people were enjoying a coffee morning. Some funding had been provided from the local authority which was being used for additional activities. These were planned to include coffee mornings, arts and crafts, quizzes and exercises. One staff member said, "We try and have a minibus trip in the summer and we're trying to do 1:1 with people. It's about keeping people as independent as possible". One person told us they did not always choose to be involved with the activities on offer and said, "I try and join in when I can". The majority of people were independent and arranged their own social lives, going out into the community with family or friends.

The provider had a 'Complaints Guide for Customers' which stated that any complaint would be responded to within two working days and handled within 15 working days. No complaints had been recorded since 2015 when we checked. One person said, "If you've got a problem with any carers, you just see the manager". Another person said, "If I had a complaint, I would speak to the management, but I don't often complain".

Good

# Is the service well-led?

## Our findings

People were actively involved in developing the service and were asked for their feedback. The last care satisfaction survey on file was completed in February 2016 and the latest survey had just been sent out at the time of this inspection. The last survey asked people about the call times, care staff and what they liked about the care service they received. Comments from people included, 'Always care staff around 24 hours a day' and 'Very happy with care service'. One area for improvement was highlighted relating to the consistency of care staff, but the manager told us this was no longer an issue, as a stable work force was now in place. The 2016 survey had been completed by 18 people and an overall satisfaction score with the service was rated at 100%. Residents' meetings were held by the housing provider and are outside the remit of this inspection. However, the manager told us they would attend these meetings if there were any issues relating to people's care that needed to be addressed.

A new manager was in post and was completing the process to register with the Commission. Staff felt supported by the management team. We observed that staff had easy access to the manager's office and were encouraged to discuss any issues; an 'open door' policy was in place. People also felt that senior staff and management were accessible. One person said, "The management are extremely approachable and if there's anything I'm entitled to [referring to government benefits], they're very good with that".

People were positive about the care they received and support from staff. One person said, "I think it's fabulous. I'm extremely happy here and I'm just pleased. Staff understand me, I'm not someone who's bewildered". Another person said, "I like the nice big room [referring to their flat] and on the whole I think the carers are pretty good". A third person said, "It's not bad here and it's better than a care home. Most of the carers are very good". They added, "Sometimes you get a carer who doesn't do the bed properly".

Audits to measure and monitor the quality of the care delivered were organised by the provider's internal quality team. A new regional manager had recently commenced employment and explained it was their job to support the manager, to maintain and improve the care delivered to people. The regional manager told us they planned to undertake quarterly monitoring visits to the service and would explore different areas of the service at each visit. A 'buddy' system was in place so that managers from the provider's other locations could support each other. We looked at audits which covered medicines, staff training, care plans, risk assessments, staff supervisions, policies and procedures. Where areas for improvement had been identified, actions were recorded on what steps would be taken to address these. For example, some staff training had become overdue and this was an area that required improvement. Accidents and incidents were reported appropriately and an analysis was completed to identify any emerging trends or patterns.