Aitch Care Homes (London) Limited

Arundel House - Frinton-on-Sea

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 16 March 2017 and was unannounced. Arundel House is a ten bed service for people with a learning disability and supports people to live within their community. On the day of our inspection there were nine people using the service.

There was a manager in post at the time of the inspection. 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 comments from people using the service where they were able to verbally express their views and their relatives about the staffing arrangements in the service. Staff followed instructions to minimise known risks to people's health and well-being. Measures had been put into place to ensure risks were managed appropriately.

People were supported by staff who had received training and who had been supported to obtain qualifications. This ensured that the care provided was safe and followed best practice guidelines. Robust recruitment checks were in place to ensure new staff were suitable to work with people who used the service.

People received their medicines safely. Staff responsible for administering medicines had received relevant training.

Some staff we spoke with could not demonstrate a confident knowledge in the requirements, and their responsibilities in line with the Mental Capacity Act 2005. This was because they had not yet completed updates in training in this area, however this was planned for the future. Not all applications to apply for Deprivation of Liberty Safeguards (DoLS) to protect the rights of people had been submitted to the local supervisory body for authorisation.

People had access to a variety of food and drink which they enjoyed. People were supported to eat and drink sufficient amounts to help them to maintain good health.

People were supported to have access to a wide range of health care professionals and were involved where able in the planning and reviewing of their care. Care plans we saw included people's personal history, individual preferences and interests and reflected. People's care and support needs. They also contained specific information and guidance for staff to enable them to provide individualised care and support.

People told us, or indicated that they were happy living at the service. We saw people continued to pursue individual interests and hobbies that they enjoyed. People were able to choose whether they wanted the opportunity to participate in meaningful activities.

People using the service and their relatives knew how to raise complaints. The complaints procedure was displayed in different formats to support people's preferred way of communicating.

Systems were in place to monitor and improve the quality of the service provided. The quality audits addressed areas of concern in ensuring the service maintained compliance with the regulations and was consistently meeting people's needs.

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 kept safe from avoidable harm by the actions taken by staff and identified risks were being well managed.

There were sufficient and suitable staff to meet people's individual needs.

Medicines were safely managed to keep people safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the MCA had not always been applied, and people were not always assessed appropriately in relation to Deprivation of Liberty Safeguards (DoLS) applications. A few staff had not completed updates in training and could therefore not demonstrate they not fully understood the requirements of the Mental Capacity Act.

Staff had the knowledge and skills they required to meet the needs of the people and were well supported.

People were supported and encouraged to maintain good health and to eat well.

Is the service caring?

Good

The service was caring.

People were well supported by staff who provided respectful care in a sensitive and dignified manner.

People's choices and rights were respected.

Staff knew how to support people's dignity and ensured that people's privacy was maintained.

Is the service responsive?

Good

The service was responsive.

Care plans were informative and included people's personal history, individual preferences and interests.

People were supported to maintain relationships in line with their wishes.

People told us they were supported to pursue their interests and hobbies within their home

People and their relatives were aware of how to make complaints and share their experiences and concerns.

Is the service well-led?

Good

The service was well-led.

Systems were in place to monitor and improve the quality of the service provided, they had been effective in identifying any areas of concern, compliance with the regulations, and consistently meeting people's needs.

The management team were knowledgeable, approachable and accessible.

Arundel House - Frinton-on-Sea

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 16 March 2017 and was unannounced. The inspection team consisted of one inspector.

Before our inspection we reviewed the information we held about the service, which included the Provider Information Return (PIR). This is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also reviewed other information we held about the service including safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law. We also looked at the action plan supplied by the provider and considered any information which had been shared with us by the Local Authority

We focused on speaking with people who lived at the service who were able to verbally express their views about the service. We also spoke with staff and observed how people were cared for. Most people had complex needs and were not able, or chose not to talk to us. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also observed the care and support provided to people and the interactions between staff and people throughout our inspection. We used observation as our main tool to gather evidence of people's experiences of the service. We spent time observing care and support in the lounge, communal areas and during the lunch time meal.

We met all of the people who used the service and spoke with seven out of the nine people who used the

service. Some of the people we spoke with were only able to have brief conversations. We spoke with four care staff members, one visiting healthcare professional and one visiting friend, and the registered manager. Additionally we spoke with relatives on the telephone after the inspection.

We looked at three people's care records, staffing rotas and records which related to how the service monitored staffing levels. We also reviewed daily records, recruitment and training records and records relating to the quality and safety monitoring of the service. We looked at the premises and also looked at information which related to the management of risk within the service.

Good

Is the service safe?

Our findings

People we were able to speak to with told us that they felt safe living at the service. One person told us, "Yes it's safe here." And another person smiled in agreement at the same time. Another person told us, "You are as safe as you can be here. I am good, yes."

People looked relaxed in the company of the staff and their environment. All of the relatives we spoke with told us people were kept safe at the home. People told us if they did not feel safe they would tell staff members. One person we spoke with told us, "I would speak to the manager if I needed to. They would know if I had any problems." A visiting relative/friend we spoke with told us, "Yes I believe [person] is safe and secure. There have never been any problems I am aware of regarding this."

We spoke with four members of staff; all had received safeguarding training and were able to identify the types of abuse people receiving care and support were at risk from. Staff training records we reviewed confirmed this also. Staff understood their own responsibility and told us that if they had concerns they would pass this information on to a senior member of staff and the manager and were confident this would be responded to appropriately. In addition the registered provider had appropriate guidance and policies in place such as a whistle-blowing policy. Staff we spoke with could describe how to raise concerns confidently. Staff knew the different agencies that they could report concerns to should they feel the provider was not taking the appropriate action to keep people safe.

Potential risks to people who used the service had been assessed and action plans had been put in place to keep people safe, whilst still promoting people's freedom, choice and independence. One person we spoke with told us, "I have someone with me when I go out which makes me feel safer." A relative who had completed a recent survey form to feedback on the service wrote," [Relative] is safe and secure, especially with new procedures in place." This was because the provider of the service had changed since the last inspection. Additionally a visiting relative/friend said, "Risks for [person] are assessed and managed well I think." Staff were aware of risk management plans and ensured they were applied. Staff told us that they were aware of the need to report anything they identified that might affect people's safety and confirmed that they had access to information and guidance about risks. One member of staff told us, "We always refer to people's risk assessments, they guide us on how to keep people safe from harm."

During the inspection we observed moving and handling transfers completed with the use of equipment. We saw that staff communicated well with people and as a result the transfers we saw were undertaken safely with an appropriate number of staff. For example, one person needed the assistance of two people to use the hoist. This was documented in their plan of care and we saw this was adhered to on the day of inspection. Additionally this person had their own individual sling to facilitate this.

Staff could consistently describe plans to respond to different types of emergencies. Staff we spoke with told us they were aware of the importance of reporting and recording accidents and incidents. Records we saw supported this; accident and incident records were clearly recorded and outcomes for people were detailed. We saw care records contained personal evacuation plans (PEEPS) in case an evacuation of the service was

required in an event such as a fire.

There were sufficient numbers of staff on duty to meet the individual needs of people using the service. A person we spoke with told us, "It can be busy at times but I think we have enough staff. " Another person told us, "I always get help when I need it, the staff are very good. I spend time in my room and staff are downstairs. I would like to be in my own home though." A relative/friend we spoke with told us, "There are enough staff on duty when I visit." Staff we spoke with told us that staffing levels were good and that there were enough staff to support people on every shift. Staff were visible in the communal areas and we observed people being responded to in a timely manner. The registered manager told us that they used a specific staffing level assessment tool to establish their current staffing levels based on dependency levels. Staff rotas showed that staffing levels had been consistent over the last four weeks prior to our visit.

At the time of our inspection the registered manager told us they were actively recruiting for new staff and a new member of staff was rostered on duty for that day. A member of staff who had recently been recruited told us, "I had all the checks done that are required. I had to give references to contact and complete a check with the Disclosure and Barring Service (formerly Criminal Records Bureau) before I could start work." The recruitment records we saw demonstrated that there was a process in place to ensure that staff recruited were suitable to work at the service.

People's medicines were administered safely and as prescribed by their GP. Staff had been trained to administer medicines safely and had competency assessments completed. Medication audits had been completed monthly and we saw these records. We noted on one medication administration record (MAR) that a transcribed recent medication had not been countersigned by another staff member. Whilst we acknowledge that this was just on one record, we discussed this with the manager who advised us this was not usual practice and would be addressed immediately. A countersignature would ensure that people did not get the wrong medication or dose.

Medicines were stored appropriately within a locked trolley. We looked at the medicines administration record (MAR) for three people and found that these had been completed correctly. There was a system to return unused medicines to the pharmacy. Protocols (medicine plans) were in place for people to receive medicines that had been prescribed on an 'as when needed' basis (PRN). Routine reviews by specialist healthcare professionals and annual GP reviews were also evidenced where required. We saw a member of staff preparing and administering medication to people; this was undertaken safely, and in a dignified and sensitive way. We saw staff explaining to people what medication they were taking and staff asked people if they needed their 'as required' medications such as pain relief.

Requires Improvement

Is the service effective?

Our findings

The provider was not always effective in responding to the requirements of The Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager told us they had applied for DoLS authorisations for six people living at the service. When we checked these we found that one person had not had their DoLs authorisation renewed and it was due for renewal in August 2016 so was now nine months overdue. The care plan for this person demonstrated that appropriate best interest decisions had been made and appropriate risk assessments were in place, for example for assessing the community with someone at all times. We spoke to the manager about this and received confirmation following the inspection that this application had been submitted and therefore had been rectified.

Additionally two of the new staff we spoke with did not understand the MCA and their responsibility to people. These staff on duty on the day of inspection were noted to have not yet completed training in MCA and DoLs. They were newly recruited staff and we noted this training had been planned for the near future. As these staff members had not yet completed the refresher training on MCA and DoLs they were not always clear on how to apply the MCA to people's care plans. However, the manager was able to demonstrate a more confident knowledge of the MCA and DoLS. This meant that in some cases people's rights were not always upheld, and restrictions in care were not always fully assessed to establish if they were lawful and proportionate. When we reviewed people's care we observed that rights were upheld when carrying out day to day tasks and peoples choices were respected by staff. When staff make assessments of a person's mental capacity, they have to have 'reasonable belief' they are acting in the person's best interests. They also have to take 'reasonable steps' to establish the person lacks capacity to make a decision and establish that the decision is in the person's best interests. Staff we spoke with and two out of the four care plans we reviewed did not fully evidence that these decision making stages had been fully considered and appropriate consent recorded. The manager told us that this would be attended to, and we were confident that this would be immediately addressed.

We therefore recommend the provider ensures that they can provide a full assurance that care and treatment is being provided in line with the principles of the MCA and that the decisions staff make are in the best interests of the people involved and that the least intrusive interventions are fully assessed.

We did see some examples where people had been supported and included to make key decisions regarding their care. Where people had lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. We saw this had in the main followed best practice in line with the MCA Code of Practice. For example staff had obtained people's consent around areas such as, having their photograph

taken for identification purposes and for staff to administer their medicines. One person told us, "I make my own choices and staff check before they do anything with my care."

We looked at how people's health was assessed and how staff accessed external support as part of monitoring people's general health and wellbeing. Care files showed people had appointments with a wide range of external health care professionals. A number of people required specific monitoring of their health and their care records showed input from the staff and external professionals to monitor the effectiveness of their treatment. We saw this for example when a visiting optician visited the service whilst we were there to carry out three people's eye tests. They told us the staff made referrals to them when external advice and support was required. We also saw that a person who had previously sustained an accidental fracture was receiving regular follow up appointments at hospital clinic appointments for the same. One person told us, "My health is well looked after."

Staff told us the importance of good communication and gave us examples of aids used to promote this. This included the use of expressive hand signals and ensuring good eye contact. Staff were knowledgeable around how people communicated their needs in accordance with their plan of care.

A number of people had challenging behaviour and guidance and treatment plans were in place. For example one person could become very impatient and was prone to self- injurious behaviour and aggressive outbursts. The plans were clear and staff were aware of the necessary steps to take and had a good knowledge of each person's needs.

We looked at the current training and support in place for staff. During the inspection the registered manager supplied a copy of a staff training schedule and records for training undertaken. We saw staff received training in 'statutory' subjects such as, medication, safeguarding, infection control, first aid, moving and handling and fire awareness. Staff also attended training in areas such as, person centred care, dementia, MCA/DoLs and behaviours that may challenge to meet the needs of the people they supported. A basic induction had been completed and the registered manager advised us that staff progressed onto enrolment of courses such as the Care Certificate. This is 'an identified set of standards that health and social care workers adhere to in their daily working life'. Formal training in NVQ (National Vocational Qualifications) in Care/Diploma had also been obtained by some staff as part of their learning and development. We found the registered manager and senior staff had been trained in understanding the requirements of the MCA in general and (where relevant) in the specific requirements of the DoLS. Despite this some staff were not able to talk about aspects of the workings of the MCA and discuss other examples of its use and how someone is deprived of their liberty.

Staff told us they felt sufficiently trained and experienced to meet people's needs and to carry out their roles and responsibilities. They told us staff support included staff supervision, staff meetings and appraisals. We were able to confirm this level of support when looking at staff records and also minutes of staff meetings. For example staff discussed forthcoming training courses relevant to their role. Staff told us the meetings were a good way of sharing information about the service; they also told us they received very good support from the registered manager.

We observed the lunch time meal. This was served by staff to people in two separate dining areas. Staff told us that some people preferred a quieter area to eat so this is why two dining areas were used. The main meal was served at tea time so a lighter meal was served at lunch time. We saw people being served plenty of drinks and snacks during the day and staff spoke to people about their own individual choices of meal and adhered to specialist diets. Some people were supported to prepare their own meals with staff assistance. Meals were served on time and the portion size was appropriate. Staff provided assistance with

meals in accordance with people's individual need. This support was given in a discreet and patient manner; people appeared to enjoy their meal and the time spent with the staff. Care staff had access to information about people's dietary needs and requirements and these were catered for. We saw this was the case for one person who required a specialist diet as they were being monitored by the hospital. For people who required pureed food the components of the meal were pureed separately so as to retain the colour, flavour and appearance. Menus were planned to provide a good choice of hot and cold meals with plenty of vegetables and fresh fruit. We were told people could choose alternatives if they did not like the menu of the day. People's comments about the food included, "I like my meals." and, "I can eat well here." Relatives were also complimentary regarding the standard of meals prepared. One person who completed a recent survey stated, "Yes generally very good." When asked about whether their relatives dietary needs were met.

Aids and adaptations were in place to meet people's needs and promote their independence. For example wheelchairs were provided for people so they could access the community. Staff told us they had sufficient equipment such as moving and handling hoists to support people safely.

Good

Is the service caring?

Our findings

People told us the staff were polite and caring in their approach. People we spoke with told us they were well cared for. One relative told us, "I am happy with things, and more important [person] is very happy in Arundel House." and another said, "Very happy with [person's] care."

We observed the support provided by the staff in order to help understand people's experiences around care. Our observations showed positive engagement between staff and the people they supported. The staff interacted well and demonstrated a good knowledge of people's individual care, their needs, choices and preferences.

When supporting people staff were patient in their approach, staff took time to listen and to respond in a way that the person they engaged with understood. Personal care activities were carried out in a discreet way and staff provided plenty of reassurance ensuring people's comfort before leaving them to assist someone else.

Care plans viewed included some details of a person's life history and preferences and staff were aware of these. Staff told us the staff team worked well together to endeavour to provide support in accordance with people's individual needs and wishes. We saw this during our visit. For example, one person had specific wishes around their gender, what they liked to wear and the staff group they wished to provide care for them. We saw staff adhered to this person's wishes and this was clearly recorded in their plan of care.

Adherence to promoting standards around dignity and respect when delivering personal care were recorded in people's plans of care. People's dignity was observed to be promoted in a number of ways during the inspection, for instance, staff were observed to knock on bedroom doors seeking permission before entering and using a person's preferred term of address. People were given plenty of time to eat their meals as they were not rushed in any way. A person told us the staff always shut their door when assisting them and provided support with bathing in a respectful manner.

Friends and relatives visiting during the inspection, told us there were no restrictions on visiting times, encouraging relationships to be maintained. People and relatives we spoke with told us the staff welcomed visitors to the home. One relative told us, "I am always made welcome."

For people who had no family or friends to represent them contact details for a local advocacy service were available and on display. People could access this service if they wished to do so with or without staff support. The registered manager told us about people who currently were using advocacy services to support them.

A 'service user guide' was available and this contained detailed information about the care home. Information about the services offered and was available for people including an 'easy read' version to help their understanding.

Good

Is the service responsive?

Our findings

We saw each individual had their own social activities plans in place. Staff informed us they had gained information about people's preferred interests and hobbies to help plan social pursuits. We asked about social activities for people and how people spent their day. An activities coordinator was not present on the day of our inspection and the registered manager informed us that staff facilitated activities as a part of their ongoing role. We noted good interaction between the staff and people taking part in the planned events. This included daily walks, trips to the shops and seaside, a drive out in the car and going out for lunch. One person went three times a week to a local drop in centre and we were told another person enjoyed, health and beauty and arts and crafts. We saw one person singing and who liked to use Spanish phrases when talking to staff. Time was also spent with people on a one to one basis. Staff told us they spent time getting to know people and to find out their interests. We saw minutes from a residents meeting in February 2017 that had highlighted some preferences for activities such as holding a valentines party which took place and making decorations. Another person wanted to visit a particular pub and staff had facilitated this. Because of people's differing needs a structured activities plan was not in place as people chose what they wanted to do daily where able. The manager said they were looking at more outings and activity provision and this would naturally increase with the summer approaching.

People we spoke with said they were happy with the care they received and we saw, where people were able to, evidence of their involvement and consent to the plan of care. There was also relative involvement, for example, if legally empowered to do so. A person told us they had been fully involved in all aspects of their care and treatment at the service. They went on to say the care was very much based around their needs and the staff approach was flexible when supporting them.

We viewed four people's care files. People's care was planned appropriately to meet current needs. The care plans recorded the support required by an individual and reflected people's preferences and choices. Care plans were updated to reflect changes in a person's needs, such as changes in dietary requirements or where a short term care plan was required. An example of this was the use of antibiotic therapy for a condition which needed immediate treatment and close monitoring by the staff.

Staff we spoke with told us they were informed of any changes in people's care needs. This was achieved through staff handovers and on-going discussions about people's care needs. Staff had a good knowledge of people's preferences and how to support each person in a way that they liked. Talking with staff confirmed their knowledge about people's care and how they responded if people were unwell or there was a change in their needs. Staff provided us with examples of when they supported people with extra fluids or how they cared for people who had nutritional imbalances. An example of this was one person whose relative highlighted on a recent survey that, "[Person's] weight has increased since new diet plans were introduced."

Staff recorded the daily care provision and also kept records in respect of people fluid and dietary intake and change of position to ensure their comfort. A staff member said they would always tell the staff member in charge if a person was not eating or drinking well.

The home had a policy and procedure for managing complaints and this was displayed for people to see. People who lived at the service and their relatives told us they had confidence the registered manager would investigate any concerns they had. A person we spoke with told us they would speak up if at all worried as they know that any concerns would be addressed immediately.

We saw the registered manager had recorded complaint investigations were required; this had been completed in in the required timescale of the home's procedure including the action taken and when the complaint was closed. Arrangements for feedback about the service included satisfaction surveys for people who lived at the service and for their relatives. The surveys provided positive feedback. Comments from relatives included, "All the staff are very kind." And, "[Person] receives good care." Feedback obtained from a visiting health professional was positive around staff caring for people well.

Good

Is the service well-led?

Our findings

People living at the service told us where they were able they had been asked to complete feedback surveys about how the service is managed. One person told us, "The staff talk to me about my care." The registered manager confirmed that plans were in place to support people to complete surveys and we saw that this had happened in practice.

There were systems in place for people to enable them where able to express their views and experiences of life at the service during residents meetings, we found that views had been used and recognised. For example, one person living at the service had requested a specific activity. There was evidence that this had been addressed and responded to. Relatives we spoke with told us they had been asked for feedback about how the service was managed through the completion of surveys. We saw that the registered manager had analysed the feedback to identify how people were satisfied with the service provided and what improvements could be made.

Staff told us that team meetings were held but not always regularly as they were a small staff team and discussion was ongoing and communication was good. Staff told us that they had been asked to complete staff surveys. Staff told us the registered manager consulted with staff to ensure that any concerns and feedback raised was used to ensure improvements could be made.

Systems were in place to monitor the quality of the service. We found the quality audits were robust enough to identify and address areas of concern. Assessments of people's capacity to make decisions when there were concerns about their ability and determination of their best interests had been undertaken in most cases. The registered manager had systems in place to review trends and themes in order to measure the quality of care. For example healthy eating plans had been introduced following a person being assessed as at risk due to their weight and professional advice sought.

People spoke positively about the registered manager and their relatives supported this. Feedback was good and some people knew the manager by their name and spoke very highly of them and told us they could approach them at all times. A person we spoke with told us, "I know who the manager is." And "I can discuss things with any of the staff." People we spoke with told us the manager's spent time talking to them and knew them well. We saw this on the day of inspection and that the manager had a good rapport with all the people in the service. One relative told us, "The manager is approachable, we can talk to them about anything." Staff told us the manager was supportive and was a visible presence in the service for the majority of the week.

The culture of the service supported people and staff to speak up if they wanted to. Information about raising concerns was clearly displayed around the home which was accessible in different formats to meet people's individual communication needs. Staff we spoke with were knowledgeable about how to raise concerns were able to describe their roles and responsibilities and knew what was expected from them.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain

events. The registered manager had ensured that effective notification systems were in place and staff had the knowledge and resources to do this. Our discussions with the registered manager showed that they were aware of changes to any regulations and were clear about what these meant for the service.