Apollo Care And Supported Housing Limited

Acash Lodge I

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 21 March 2017. The inspection was unannounced. Acash Lodge I is a care home registered for a maximum of six adults who have a learning disability.

At the time of our inspection there were four people living there permanently. Additional people stayed at the service on a short term basis to enable family carers to have a break. This is often referred to as a respite break.

The service was a terraced house, on three floors with a front and back garden.

We previously inspected the home on 17 May 2016 and we found the provider was in breach of standards relating to the safe care and treatment of people using the service. We also made a recommendation in relation to training.

There was no registered manager in place at the time of the inspection, however a manager had started in post in January 2017 and was applying to be the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection we found staff were not always following procedure in relation to completing body maps. Body maps are diagrams used to assist staff in recording unusual or unexplained marks on people's bodies. At this inspection we found that staff were routinely completing body maps and taking appropriate action in notifying relevant organisations if there were issues of concern noted.

There was a relaxed atmosphere at the service on the day of the inspection. We saw kind and caring interactions between staff and people living at the service.

The service was clean but we found one out of date meat products in the fridge which was removed immediately. There were repairs outstanding on the day of the inspection but the provider has since repaired these.

Recruitment checks were in place for the majority of staff prior to them starting work at the organisation. There were enough staff to meet people's needs although there had been a number of staff changes in the last nine months which impacted on the quality of the service.

Care plans were up to date and there were risk assessments in place for people living at the service. The manager was in the process of updating the risk assessments for people who used the service on a respite basis.

People's money was safely managed.

Medicines were stored securely, within appropriate temperature range and administered safely.

Staff received regular supervision and had undertaken training in key areas to support them in their caring role.

Quality audits were undertaken. These included health and safety, cleaning, medicines and finances management.

We have made a recommendation in relation to staff recruitment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. One staff member had started work prior to their references being received.

Risk assessments were in place for the majority of risks identified.

There were enough staff in place to meet people's needs.

Medicines were safely managed by the service.

People's money was safely managed by the service.

Is the service effective?

Good

We found the service was effective. There was evidence of regular supervision and training had been undertaken or planned for all staff.

People were supported to receive health care as required.

People were supported to eat a varied diet.

Is the service caring?

Good

The service was caring. We saw staff were kind and caring to people living at the service and this was confirmed by relatives.

People were encouraged to be as independent as possible.

Staff were aware of people's cultural needs

Is the service responsive?

Good

The service was responsive. Care plans were detailed and up to date.

There was evidence of person centred care.

There was a complaints process in place and complaints had been dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led. Since November 2015 there had been three managers employed to run the service. This had impacted on the quality of the service.

Audits were undertaken and these included health and safety, medicines and finances management.

Acash Lodge I

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.

This inspection took place on 21 March 2017 and was unannounced. The inspection team comprised of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we looked at four care plans for people using the service and three staff recruitment files. We checked training records for four staff and checked seven medicines against stocks and checked two medicine administration records (MAR). We also checked records against the balance for two people's money, and checked four receipts against records.

We spoke with two staff members, the newly employed manager and the provider. We also spent time with the people living at the service and talked with them. It was not always possible to get answers to our questions, as people had limited or no verbal speech.

Following the inspection we spoke with four relatives of people using the service, either on a permanent or respite basis and spoke with two health and social care professionals familiar with the service.

Requires Improvement

Is the service safe?

Our findings

One person gave the "thumbs up" when asked what it was like to live at the service. Relatives told us they felt their family member was safe at the service. There were no incidents of any service users assaulting other people who lived there.

Staff were able to tell us about safeguarding and what they would do if there was an allegation of abuse. Staff understood whistleblowing which is how to raise concerns about poor practice to the employer. There had been no safeguarding incidents since the last inspection.

At the last inspection we noted that staff had filed away a body map and were not able to explain what investigations had been taken to explain marks on a person. At this inspection we noted that staff were noting all marks on body maps and relevant organisations had been notified if marks were unexplained. Records showed one person's marks had been logged very extensively since the beginning of February 2017. The person's relative and the local learning disability team had been notified, and there were plans for this person to undergo tests to ensure there was no medical condition underlying the marks.

We saw recruitment checks, including Disclosure and Barring Service certificates, were carried out for the majority of staff before they started working with people. One staff member had originally been employed by another organisation and been working with a person living at the service in a different capacity, prior to starting work at Acash Lodge I. As the provider had seen this staff member's work with the person, they had allowed this staff member to begin employment at Acash Lodge I without references being in place. The references were received four weeks and ten weeks after the staff member's start date.

We recommend that written records of verbal references are recorded and retained by the provider prior to receipt of written references.

The service had two types of risk assessment on care records. One was a comprehensive risk assessment which outlined the range of risks and gave general information on how to manage these risks. Where specific concerns were identified and staff would benefit from additional guidance, specific risk assessments were in place. For people living permanently at the service both types of risk assessment were in place. For example, one person had their hair dyed regularly but was at risk of getting the dye in their eyes so staff were guided in how to minimise this risk. Other risk assessments addressed how to manage behaviours that challenge both in and outside of the service ranging from snatching food from strangers to sitting down in the street refusing to move.

For people using the service for respite, the comprehensive risk assessments had been recently updated, but the manager was in the process of updating the detailed risk assessments. The manager explained they were making contact with family members of people using respite to talk through people's current needs and would then update the detailed risk assessments which were dated 2015-16.

The service was clean as was the fridge. Food was covered and labelled, but one packet of out of date

cooked meat was found in the fridge which had been overlooked. It was immediately removed. Cleaning schedules had been introduced by the new manager to ensure specific cleaning tasks were undertaken. There were records for the previous weeks, but it had not been started for the week of the inspection.

There were some outstanding repairs on the day of the inspection. One wardrobe had tacks poking out of the back which was of concern as they were sharp. There was one room used for respite that had significant damage to the plaster in one area. Another room had been cleared of personal effects as it was due to be painted. Following the inspection the provider confirmed the repairs had been done. There were areas including the kitchen, where the décor looked tired and marked. However, the provider put in place a planned maintenance programme for the coming year to decorate all areas of the service.

Medicines were safely stored and managed. All stocks were checked at each handover which meant they were checked three times a day. We watched as the afternoon staff member checked in the medicines and we checked the MAR sheet for two people. Records detailed people's allergies and what the medicines were for. Formal medicine audits covering all areas of medicines management were undertaken by the manager every three months. The manager had taken remedial action when there was a recent medicines error and had ensured the whole staff team received refresher training in medicines management.

There were enough staff to meet people's needs. Family members told us there had been staff turnover in both care staff and managers in the last nine months and this had impacted on the quality of the service. Family members noted that some activities had been cancelled due to staff shortages in previous months, but acknowledged the staff team was now stable and activities were taking place. The provider was formalising staff members contracted hours in an attempt to retain good quality staff, and the manager was introducing regular agency staff to the service to provide back-up cover for sickness and leave.

Accident and incident forms were completed. We could see that learning took place as a result of incidents. For example, a staff shift plan had been introduced as a result of two incidents. The plan gave responsibility to specific staff members for tasks to be undertaken. We also saw the manager remind staff to: ensure one person had a wide range of snacks for outings as this person had reacted negatively when fruit was offered rather than the usual snack; to ensure there were no obstacles in another person's room as they had bruised themselves on furniture.

Window restrictors were in place at the service. Checks for essential services had been carried out in the last twelve months. Personal emergency evacuation plans were in place for people living permanently at the service and were being developed for people who used the service for respite. Four fire drills had successfully taken place in 2016.

Good

Is the service effective?

Our findings

Family members told us staff had the necessary skills to care for their relatives. We saw evidence that staff had a detailed induction. They told us they shadowed more experienced members of staff as part of the induction so they understood people's needs and preferences.

At the last inspection we noted that not all staff had been trained in giving a specific medicine for epilepsy nor had received training in Makaton, a simple form of sign language, used by a number of people using the service.

At this inspection we found that epilepsy training and Makaton training had taken place but due to staff turnover, some new staff were yet to be trained in these areas. The manager was investigating options for these courses, and in the meantime ensured that suitably trained staff were on the rota to work if a person with epilepsy was receiving a service.

Staff had received training in key areas to support them in their caring role. These courses included safeguarding, infection control, Mental Capacity Act 2005 awareness and challenging behaviour training. The manager had recently brought in a pharmacist to refresh staff training in medicines administration for the whole team. Staff were given four weeks to complete a workbook related to medicines and the manager planned to re-check staff competencies before issuing their certificates. Staff training records were kept individually in staff files but there was no up to date system to see when refresher training was due. The manager undertook to update the staff training matrix to ensure they could see when refresher staff training was due.

Staff supervision took place regularly and staff told us this was helpful in providing support to them. Records showed this was comprehensive and covered a range of issues. Formal supervision for the new manager had not taken place but the provider told us they communicated daily with the manager and planned to formalise supervision.

Records showed people had access to health care as required including dentists and annual health checks. My Health booklets outlined people's current health issues, and provided information on childhood illness' and their diet and exercise requirements. We could see that one person was due to have bloods taken and so a photo story had been developed to explain the process to the person. This was a good example of the service using a range of communication tools to explain events to people living at the service.

Staff used a number of methods to communicate amongst themselves including a staff handover book and communication book. Staff communicated with day centre staff through use of communication books so staff were fully aware of any issues that arose in the day for people, and day centre staff were aware of any issues at the service.

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). We could see from records that there were DoLS authorisations in place for two people living at the service and two applications were with the local authority for assessment.

There was evidence of best interest meetings taking place with other professionals and family members when it was unclear if a person living at the service was able to make important decisions regarding their health.

Staff understood the importance of gaining consent from people before providing care and were aware of people's preferences and routines.

DoLS assessments noted the need to have the kitchen door shut if particular individuals were in the living room without staff. However, on the day of the inspection the kitchen door was open at all times as there were staff available to supervise people in the living room and kitchen area.

We noted there were pictures of meals to enable people to make food choices, and care records noted people's preferences for food. However, there was no formal system for people to influence the menu weekly. We discussed this with the manager who told us they planned to reinstate the residents' meetings, to which family members would also be invited, and would discuss the menu then.

Good

Is the service caring?

Our findings

We saw staff were kind and caring in the way they spoke with and provided care to people living at the service, and this was confirmed by family members. One person had experienced a bereavement of a close family member and staff spoke about the different ways they were trying to support this person who had limited understanding of death. This was an example of their caring approach to people living at the service.

Staff were aware of people's cultural requirements and cooked a range of foods to meet people's needs. There was a sensory room in the garden, a trampoline and tables and chairs for people to sit outside.

People's rooms were personalised with photos and other items.

Staff showed people dignity and respect by offering choices to them, by closing the door before offering personal care, by knocking on their door and taking account of their wishes and preferences. One staff member told us when a person tried to take their clothes off in the lounge; they guided this person to their room so they maintained their dignity.

Staff knew who was important in people's lives and facilitated family contact in a number of ways. Staff celebrated people's birthdays and special occasions.

People were supported to be as independent as possible. We saw one person making tea, and being supported by staff to make lunch. Staff could tell us what people were able to do for themselves and this included assisting with washing, cleaning their room and helping with shopping. People's views were taken into account in the way their care was provided and family members were asked their views on how best to support their relative.

Good

Is the service responsive?

Our findings

Care records had key information regarding people at the service in case the person absconded. Care plans were detailed and had information regarding people's support needs, communication needs, likes and dislikes, including all the meals a person liked. Care plans were personalised. For example, one provided guidance to staff on how regularly one person needed support to shave and another to identify how a person liked their nails being groomed. The support plan gave a holistic view of a person and noted their important family and friends, their routines and the forms of transport they could use with support.

Communication passports were in place which made staff aware of people's behaviours with others. For example, one person liked to hug and kiss strangers, could use Makaton and had limited speech.

Care plans were person centred, for example, reminding staff that if a person couldn't sleep to let them come down and watch TV at night, or to let a person sleep in late at the weekend as they enjoyed doing this.

Due to changes in day care activities locally, a number of people at the service had started attending a new day centre locally. We could see from records the manager had liaised with other health and social care professionals to ensure the transition to this new centre was smooth and well planned. This showed the manager's ability to work in partnership with other agencies. The manager of the centre told us people had settled in very well and this was in part due to the work of the manager in facilitating this.

Attendance at a day centre for two people meant they had a range of planned activities. Another person went out daily with a staff member on a one to one basis and enjoyed a wide range of activities from swimming to going into central London, eating out and visits to the park. Other people went out regularly to local shops and restaurants and local facilities. One family member told us her relative went out on Mondays to a club with two other women. If this club was not running they went for a meal instead. Another family member told us her relative had been at the park having a picnic the day before as the weather was sunny and warm. In this way the service ensured people had a variety of activities to enjoy. People had a weekly activity chart which enabled the staff to plan for activities and the manager to ensure there were sufficient staff available to carry out the activities.

There was a complaints process in place and it was accessible to people. Staff told us people made their views known if they weren't happy. We saw that complaints had been dealt with promptly and appropriately in the last 12 months. Family members told us that if they raised issues they were dealt with quickly and they had confidence in the new manager to address any concerns they had. Another family member told us they contacted the provider if they were concerned and found him responsive.

Requires Improvement

Is the service well-led?

Our findings

The service had a clear vision, mission statement and aims and objectives, focusing on choice, independence, inclusion and people's rights as citizens.

Over the last 15 months there had been three managers employed sequentially to manage Acash Lodge I. This has meant there had not been continuity of management at the service. Family members noted this as an issue and together with changes in care staff had noted this impacted on the care delivered at the service and people's experience of the service. This was confirmed as an issue by a health and social care professional. One relative told us their family member did not want to return to the service following home visits, on a number of occasions, during this period of upheaval. Since the staff team has consolidated the person has shown no signs of distress on returning from home visits.

A new manager had been in post since January 2017 and family members spoke well of them, one family member said they "seem to be on the ball." A health and social care professional confirmed the new manager was proactive and responsive in dealing with issues. Another family member noted their relative was much happier at the service now staffing was more settled.

We saw from records there were staff meetings regularly taking place and staff confirmed they could discuss any issues there and felt their views were valued. Minutes showed discussions took place in relation to policies and procedures, people's well-being and care issues.

Quality audits took place by the manager and provider in relation to health and safety issues, medicines and the management of people's money. There were policies and procedures in place and procedures had been copied and placed in key areas for staff to confirm they had been read, for example, in the handover book.

New systems had been set up to ensure the service was kept clean throughout and there was a supervision planner. There was also a new log at the front of care files to note when specific documents were updated and required future updating. To gain the views of family members the new manager had drawn up a survey form and had started to send these out. A small number of forms had been returned at the time of the inspection. They were also meeting with family members or talking with them over the telephone to obtain the most up to date information regarding this person's care and to establish meaningful links with the family.

Residents' meetings had not taken place for some time, but a family member told us the new manager had planned a meeting for April 2017 to which family members were also invited.