Support for Living Limited

Support for Living Limited - 246 Haymill Close

Inspection report

246 Haymill close
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 19 and 20 January 2017 and was unannounced. At the last inspection on 19 and 20 March 2015, we found the service was not meeting all the required Regulations. There were monitoring systems in place to monitor the quality of the service however these were not always effective in identifying issues or used to make improvements to the service.

246 Haymill Close is a residential care home, which provides accommodation and personal care for up to eight people. The service specialises in the care and support of adults who have moderate to profound learning and physical disabilities. At the time of our visit there were eight people using the service.

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 2008 and associated Regulations about how the service is run.

Family members told us that the majority of staff at the service were caring and they were happy with the care offered to their relatives.

The service protected people from harm and abuse. Staff had safeguarding of vulnerable adults training and they knew how to report any safeguarding concerns they might have. Safeguarding information was displayed throughout the service.

The service assessed the risk to people's health, safety and welfare. Staff had detailed guidance on how to minimise risk to people's wellbeing.

The service had recruitment procedures to ensure only suitable staff were appointed to work with people who used the service.

There were sufficient staff numbers on each shift to meet people's needs.

Medicines were stored safely, and people received their medicines as prescribed.

Relatives told us they had confidence in staff and they felt the service had a good understanding of their family member's support needs.

Each new staff member undertook an in-depth induction that consisted of the training the provider considered mandatory. Staff also received yearly refresher training to ensure continuous review of the skills and knowledge needed to support people they cared for.

Staff received regular supervision and appraisal of their work to ensure the best possible support was

provided for people they cared for.

CQC is required by law to monitor the implementation of the Mental Capacity Act (MCA) 2005 and the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that people are only deprived of their liberty in a safe and least restrictive way, when it is in their best interests and there is no other way to look after them. The service met the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Where people did not have the capacity to consent to specific decisions, staff involved relatives and other professionals to ensure that decisions were made in the best interests of the person and their rights were respected.

The service had monitored people's nutritional needs to make sure these were being met. Family members told us they were happy with how the service supported people to have sufficient food and drink.

People were supported to maintain good health and to have access to healthcare services. The staff made appropriate referrals in a timely manner to ensure that people's changing health needs were addressed.

The service supported people in pursuing their individual choices and supported them in achieving personal goals.

Staff demonstrated a good knowledge of people's personal needs and preferences, which they knew from people's care plans and day-to-day interactions with them.

Staff delivered care which protected people's dignity and privacy. People could choose if a male or a female worker supported them during personal care.

People received care that reflected their needs, interests, personal preferences and aspirations. The staff encouraged people to make choices and have control where possible.

The service regularly reviewed people's care needs and involved people and their relatives in the process. Staff informed family members about any changes to people's health and wellbeing.

People who used the service had access to a range of activities in the home and the local community.

The provider had a complaints policy and procedure in place and family members said they were happy to approach the management team with any complaints.

The registered manager promptly addressed with staff any training gaps and performance issues.

The service had internal auditing and monitoring processes in place to assess and monitor the quality of service provided.

Family members and the staff team said that the service was well led and they felt supported by the registered manager.

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 received safeguarding training and people were protected from harm and abuse.

People had risks to their health and wellbeing assessed. The service had robust recruitment procedures in place to ensure only suitable staff were appointed to work with people who used the service.

There were sufficient staffing levels on each shift.

Staff followed procedures for the proper and safe management of medicines.

Is the service effective?

Good

The service was effective.

Staff received regular training and support to care for people effectively.

The service protected people's rights. The principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were followed and decisions were made on their behalf where appropriate.

The service supported people to have sufficient food and drink in accordance with people's needs and preferences.

People had access to healthcare services to meet their needs and the service worked well with other healthcare professionals to coordinate people's care.

Is the service caring?

Good

The service was caring.

Family members told us the majority of staff at the service were

caring and they were happy with the care offered to their relatives.

The service involved people in every aspect of their care ensuring that people's needs were being met.

Staff delivered care which protected people's dignity and privacy.

The service informed family members about any changes to peoples care, health and wellbeing.

Is the service responsive?

Good

The service was responsive.

People received care that was person centred and encouraged them to have choices and control where possible.

People had access to a range of activities at the service and in the community.

The provider had systems in place to respond to complaints about the service and the relatives of people using the service knew about them.

Is the service well-led?

Good

The service was well led.

The registered manager was supportive of the staff team and encouraged their professional development.

The registered manager promptly addressed with staff any training gaps and performance issues.

The service had auditing and monitoring systems in place to assess and monitor the quality of service provided.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 19 and 20 January 2017 and was unannounced. It was carried out by a single inspector. We looked at notifications received and reviewed any other information we held prior to our visit.

During our visit, the majority of the people using the service were unable to share their experiences with us due to their complex needs. In order to understand their experiences of using the service, we observed how they received care and support from staff. To do this 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 met all the people using the service, spoke with the manager, deputy manager and four care staff. We looked at records, which included four people's care files, four staff records, training information, and other records relating to the management of the service.

After the visit, we contacted three family members of people using service and asked them for their views on the care offered to their relatives. We also spoke with two external professionals and asked for their experience of working with the service.

Good

Is the service safe?

Our findings

The service had a variety of procedures in place to ensure safe medicines storage and administration, but these were not always followed. The service had a daily PRN (as required) medicine counting log to ensure the correct amount of PRN medicine on the premises. We saw that the counting did not take place every day.

We checked a sample of medicines and we saw one medicine had its expiry date rubbed off and a second medicine did not have a clearly prescribed date recorded on the packaging. However, the registered manager advised us that there was a system in place for checking in medicines.

Staff recorded all identified medicine errors on a medicine incident form. The errors were then investigated by the registered manager and actions were agreed to avoid mistakes in the future. The errors were then discussed in 1:1 and team meetings.

We observed medicines administration on both days of our visit. We saw that two staff members administered medicines, recorded and signed each administration on Medicines Administration Records (MAR) charts. MAR charts had details of the quantities of medicines received as well as medicines carried forward from the previous medicines cycle. The amount of medicine recorded on the MAR charts corresponded with the amount of medicine in the medicine cabinets.

People's care plans contained information about the medicines they had been prescribed and the support people required to take their medicines. Staff were aware of these guidelines. One staff member told us they always administered medicines to one person during meal times, as this was how the person preferred to take their medicines.

People were protected from harm and abuse. Family members told us they felt their relatives were safe at the service. One relative said, "Yes my relative is safe, I have no concerns whatsoever." A second relative stated, "Yes (person's name) is safe in the house. They would contact me in case of any concern. I have never observed anything that would make me feel concerned."

Staff received safeguarding training. We spoke with four staff members who described to us potential signs of abuse and were aware of the provider's safeguarding policies and procedures. We saw information on how to protect vulnerable adults displayed in the office as well as in the communal area of the service. We saw a central safeguarding register. The document showed that the service investigated and reviewed all safeguarding matters and took actions to avoid similar situations in the future. The safeguarding policy was available for staff guidance.

The service assessed risks to people's health, safety and welfare. Each person using the service had individual risk assessments and risk management plans in place. This meant that staff had specific guidance on how to minimise identified risks to keep people safe from harm or injury.

Risk assessments correlated with people's care plans. For example, one person's care plan said that they needed to use specialist equipment to enable them to eat and drink. We saw a detailed risk assessment guiding staff in the use of this equipment and what to do if the person felt unwell.

The service had various systems in place to ensure people lived in a safe environment. We saw evidence that daily, weekly, monthly and yearly health and safety checks took place. Amongst them were daily fridge temperature checks, weekly fire call points tests and fire drills, periodic Legionella and general health and safety checks and yearly fire risk assessments and safety checks of electrical equipment.

Staff received training in fire awareness, manual handling, health and safety and first aid. Everybody using the service had personal emergency evacuation plans (PEEPs) in place.

The service had recruitment procedures to ensure only suitable staff were appointed to work with people who used the service. The provider managed the process centrally, however, the registered manager invited candidates to visit the service before they were employed. This meant that potential candidates had the chance to present their skills in how to communicate and interact safely with people with learning disabilities. Additionally, people using the service were involved in the final decision on who would support them in the future.

The service had a rota system to ensure sufficient staff numbers on each shift. Documents showed that staff worked longer than their contracted hours. The registered manager explained that there were unfilled vacancies at the service and staff could work additional hours to cover all shifts and enable continuity of care. Overtime was optional and the provider monitored it. The service was in the process of recruiting more staff to fill vacant positions.

Good

Is the service effective?

Our findings

Relatives told us they had confidence in the staff and they felt the service had a good understanding of their family member's support needs. For example, one family member told us, "They (staff) have the knowledge on how to react to people." A second relative told us, "They seem to understand my relative." Another relative said external professionals came to the service to train the staff if needed. They added, "The staff know what they are doing."
Each new staff member undertook an in-depth induction that consisted of the training that the provider considered mandatory. These included moving and handling, health and safety, medicines administration and safeguarding of vulnerable adults. The training was followed by two weeks of shadowing more experienced colleagues.

Staff we spoke with told us they received regular refresher training. The registered manager provided us with a training matrix, which had detailed information on courses that staff had completed or were due to refresh. The majority of training was completed on-line, however, the staff also had access to classroom training delivered by external professionals. These included percutaneous endoscopic gastrostomy (PEG) training delivered by the district nurse.

The registered manager actively tracked staff progress on their learning. They discussed this matter in one to one meetings and if a staff member did not complete their courses as agreed the registered manager would send an email prompting them.

Records showed that staff received regular supervision and appraisal to seek to ensure the best possible support was provided for people they cared for. Staff we spoke with confirmed they took part in regular one to one meetings and yearly appraisal of their work. They also said they could ask for additional support if needed.

Staff had regular team meetings. The minutes showed that staff had opportunities to discuss the support people received, what improvements could be made to the service, their development and any other issues or concerns.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw evidence that DoLS

applications had been made for all eight people at the service as they required staff supervision when they went outside and this was a restriction on their freedom.

Staff received training in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood the principles of the MCA. One staff member told us, "People are able to make decisions, they can take risks but they have to be guided. All decisions must be made in their best interest." A second staff member said, "It is about people's ability to relate to their circumstances, you need to offer people different options so they can choose what is best for them."

Where possible, people were asked for their consent and were involved in decisions about their care. We saw information in care plans about people's capacity to consent and make decisions about their care. For example, the support plan for one person said they could make everyday choices and communicate with staff about what they wanted to wear. One section in peoples' support plans was dedicated specifically to decision making, detailing which decisions a person could make on their own (i.e. meal times) which decisions required support from others and which decisions could be made on behalf of the person (i.e. being moved to another home).

Relatives told us that staff at the service worked with their family members and care professionals to ensure that each decision was made in the best interest of the person and in line with the MCA. We saw reports from people's care review meetings which confirmed that such discussions took place.

Family members told us they were happy with how the service supported people to have sufficient food and drink. They said the staff were doing their best to meet people's needs and preferences. One relative stated that the staff understood the complex nutritional needs of their relative. They said, "My relative is happy with the majority of the food they get. The staff observed that they might have problems with swallowing and now all their food is mashed. Staff serve nutritional food and offer fruit, they do their best."

People's nutritional needs were recorded in their care plans and were reviewed regularly. Staff knew people's needs and preferences and prepared their meals accordingly. For example, we observed a staff member who was prompting a person to drink. We later saw in their care plan that although the person could drink independently they would not ask for it and staff members were required to offer a drink to them during meals and throughout the day.

We saw detailed instructions on how to support people during meals, which were displayed in the kitchen area. The document specified any risks associated with eating and drinking and the type of equipment people required to promote their independence. Therefore, some people had adapted cutlery or cups in place so that they could eat by themselves without staff support.

The service monitored people's nutritional needs to make sure these were being met. Staff monitored people's weight and we saw evidence of involvement of dieticians and the GP where weight loss had been identified.

People were supported to maintain good health and to have access to healthcare services. We observed staff discussing changes to people's wellbeing and agreeing what action they should take in order to address arising health issues. We saw evidence of appropriate referrals being made so any changes in people's health were addressed in a timely manner. External health professionals confirmed the staff acted quickly on any concerns they might have about people's health. They said. "Staff always ring to discuss people or make quick referrals, they don't wait on it".

Good

Is the service caring?

Our findings

We observed that during mealtimes staff did not always interact with people in an attentive and a meaningful way. We saw that some staff sat down with people when they assisted them to eat, but other members of staff remained standing above the person. We observed that the majority of time staff communicated with each other about the people rather than speaking with them directly. We saw a staff member assisting a person with eating in the lounge of the service. We observed them placing the plate with the person's food on the floor, rather than on the table, while eating their own lunch. The staff members action was discourteous towards the person. We spoke to the registered manager about our findings. They informed us they would address this matter with the staff team immediately. However, we observed that the majority of interactions between the staff and people using the service were caring and friendly and people were relaxed in the presence of staff.

Family members told us that the majority of staff at the service were caring and they were happy with the care offered to their relatives. One family member said, "I have no concerns, the care my relative is getting there is excellent. I do trust people he lives with." A second relative said, "I greatly approve of what they are doing. They are doing a good job." Another relative stated, "I always look at other people at the house to see if they are happy. I have never seen anything that concerned me." Family members recognised staff efforts and had nominated the staff team for the Provider's Excellence Award.

The service was striving to make people feel they mattered as staff involved them as much as possible in every aspect of their care. We saw evidence that the service supported people in pursuing their individual choices. Documents showed that the service also considered people's most personal needs, such as a need to express their sexuality.

People using the service had a learning disability and they needed intense staff support to meet their complex needs. The service worked towards ensuring that these needs were being met. Each person had an allocated staff member (a key worker) who was responsible for providing overall care, monitoring of the person's health and wellbeing and sharing the information with the team and respective health professionals. The service offered additional support if needed. For example we saw that one person had continuous one to one care and a staff accompanied them at all times to ensure that they were safe and well. The service also supported people in taking a yearly holiday to the destination of their choice. □

Staff demonstrated a good knowledge of people's personal preferences as stated in their care plans and ascertained from day-to-day interactions with people using the service. One staff member told us that one person using the service enjoyed car trips and another liked art sessions in the nearby community centre.

We saw that staff took immediate action to relieve people's distress and discomfort. For example, a staff member observed that one person's feet had become swollen. The staff gave the person a foot massage to relieve the pressure and we saw that the person was comforted by this. We observed the staff member discussing the person's wellbeing with a visiting professional and sharing their concerns in the team's handover meeting.

We saw that staff delivered care which protected people's dignity and privacy. Staff told us that when giving personal care they ensured the doors to the person's room or a bathroom were closed and people felt comfortable. One staff member told us, "You always ask them (the people) if they wish to receive personal care." A second staff member said, "Some people indicate they would like to have their door closed, and I always ensure that they are closed." People could choose if a male or a female worker supported them during personal care.

People using the service had end of life documents in place. This meant that the service considered peoples' wishes on what they would like to happen following their passing.

Family members told us that the service kept them informed about any changes to their relatives' care, health and wellbeing. One family member told us, "They keep me informed about any appointments or when health care professionals are coming to the house to take blood tests from my relative."

Good

Is the service responsive?

Our findings

People received care which reflected their interests and aspirations and encouraged them to have choices and control where possible.

Individual care plans included information on people's likes and dislikes, personal care needs and recommendations on how staff should support people to meet these needs. One person could not communicate verbally and their care plan stated that staff were required to speak clearly and give them time to respond. A second person could feel anxious in unfamiliar situations. We saw in their care plan guidelines on how staff could support them in new places and around people who they did not know. All care plans had information on what people enjoyed doing (i.e. go for walks, sit in a particular chair, travel) and how staff could promote their independence. For example, one person was able to choose their daily outfit, however, they needed support to ensure the clothing was appropriate for the season.

Staff had a good understanding of people's needs and preferences. We saw how a staff member supported a person who became distressed. Staff took appropriate action to lessen their anxiety and the person's mood improved. We looked at this person's file and we saw that staff had followed the guidelines agreed in their care plan.

The service regularly reviewed people's care needs and involved people and their relatives in the process. One relative told us, "They have care plan reviews every year and I am always invited. They (the service) will discuss my relative's needs and what needs to be done to meet these needs. I can also discuss things as they occur. I will say what is needed and they do it." A second relative said, "There were meetings with regards to my relative's general wellbeing, holidays and their day to day needs."

People who used the service had access to a range of activities in the home and the local community. Staff who knew people well were responsible for planning and organising activities that were tailored to the likes and dislikes of each individual using the service. The handover book had a section dedicated to daily activities. One relative told also us, "Staff often take my relative for walks and they have a lot of parties there and I am always invited." We saw records of events taking place, such as art classes at the local community centre, road trips, exercises or room tidying. We observed staff accompanying people for walks in the local area or offering relaxing and therapeutic foot massage. The service supported people to go on holiday once a year. We saw evidence of individual holiday planning in people's care review documents, and pictures from a variety of trips in this country and abroad.

The provider had a complaints policy and procedure in place. There was a complaint folder in the office which consisted of easy read, pictorial compliments, comments and complaint information. The same document was clearly displayed on the information board at the entrance to the service. This meant that staff, people using the service and their family members had easy access to complaints information.

Since our last inspection, the service had not receive any formal complaints. The registered manager told us

family members shared their observations directly with the management team and all raised concerns were dealt with as they arose. Family members confirmed they were aware of the complaints procedure and they were happy to approach the management team with any concern. One relative told us, "I would know where to go if I had any complaints." A second person said, "I would get in touch with the provider, they gave me information on how to complain."

Good

Is the service well-led?

Our findings

At the inspection on 19 and 20 March 2015, we found the service did not have comprehensive and effective systems to assess and monitor the quality of the service. At this inspection we found that improvements had been made.

The registered manager completed a monthly manager's audit and created an action plan which included information on what actions needed to be taken, by whom and by when. We saw evidence that the service carried out yearly health and safety checks. In addition, an external health and safety assessor audited the service and described it as having an outstanding safety performance. We looked at the most recent fire risk assessment where we saw that actions were required to ensure the service was safe and the risk of fire was minimised. The registered manager provided us with evidence that actions arising from this report were in the process of being taken.

Since the last inspection, the service reported a number of medicines administration errors to CQC. To reduce the risk of further errors, the registered manager had implemented daily and weekly medicine checks to ensure safe medicine storage and administration. Following our inspection, we received correspondence from the registered manager who provided us with an additional annual service audit that also looked at medicines administration. We could see that efforts had been made to reduce the number of medicines errors.

We also saw other good examples of audits being carried out. These included audits of training completed and annual service audits carried out by the provider's auditing team to ensure internal controls of the service provision.

Family members told us the service was well-led. They felt the registered manager and the staff team were helpful and very easy to approach. One relative told us, "The registered manager is very informative and they always get in touch with me about my relative. They are doing a good job." A second family member said, "My relative gets very good quality of life there, the main thing is the communication. They always inform me about everything."

The registered manager was supportive of the staff team and promoted an open and transparent culture within the service. Staff members were encouraged to contribute to the service's development as well as work towards their own professional growth. For example, we saw evidence of staff taking part in the review of weekly shift patterns and undertaking file audits as an opportunity to become involved with management duties.

Staff knew what was expected of them and they all said they felt supported by the registered manager. One staff member said, "You wouldn't have asked for a better boss, he gets his hands dirty and steps in straight away if needed." A second staff member said," We support each other. The registered manager does the work himself and asks what he can do to help."

The registered manager promptly addressed any staff training gaps and performance issues. We saw evidence of discussions about individual performance taking place in one to one and staff meetings or by email.

External health professionals told us they had a very good experience of the service and they thought it was "one of the best homes they visited".

The provider had up to date policies and procedures, which were available to staff on the provider's intranet system.