Ordinary Life Project Association(The)

Ordinary Life Project Association - 17 Berryfield Road

Inspection report

17 Berryfield Road
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27 July 2016

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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 the 20 and 27 July 2016 and was unannounced. At the previous inspection visit which occurred in December 2013 all standards inspected were met.

Three people were currently living at the service which is registered to provide accommodation for up to four people with learning disabilities.

A registered manager was in post. 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.

The person we spoke with said they felt safe living at the home and staff made them feel safe. Staff said they attended bi-annual safeguarding of vulnerable adults training. They said the procedures were updated to reflect recent changes. The staff we spoke with had a clear understanding of the safeguarding of vulnerable adults procedures. They were able to describe the types of abuse and the actions they must take.

Risks were assessed and staff were knowledgeable on the actions they must take to minimise risks. Staff told us risk assessments were discussed at team meetings and were developed by the registered manager. They said there was an expectation they read the risk assessments and sign to indicate their agreement with the plan of action.

Staffing levels were being maintained with agency and permanent staff. Staff said the same agency staff were used to ensure people had continuity of care. The rota in place showed two staff were on duty throughout the day and one member of staff at night.

Medicine systems were safe. Medication administration records (MAR) chart were signed by staff to indicate the medicines administered. Protocols were in place for medicines administered "when required" (PRN).

Staff were supported to develop their skills and their performance was monitored. Staff attended essential training as identified l by the provider and specific training to meet the changing needs of people. One to one meetings were regularly held with the line manager and at these meetings concerns, training and personal development was discussed.

People made decisions and Deprivation of Liberty Safeguards (DoLS) application to the supervisory body for people subject to continuous supervision.

People were supported with their ongoing health care needs. Reports of healthcare visits were maintained and demonstrated people had access to specialists and had regular check-ups, for example optician and dental check-ups.

The two people we asked told us the staff were kind and caring. We saw staff interact with people and where people became agitated we observed staff used a calm approach to prevent any escalations. People were supported with their activities programme which including outings with keyworkers and to attend clubs.

Support plans were person centred and included the person's ability to meet their needs and how staff were to assist them. For example, Daily routine plans described the person preferred times to rise, menu planning, activities and how staff were to assist them. Support plans were signed by the person to show their agreement. The person we asked told us records were kept about them.

Systems were in place to gather people's views during tenant meetings. Questionnaires were used to seek feedback for visitors. Systems and processes were used to assess, monitor and improve the quality, safety and welfare of people. There were systems of auditing which ensured people received appropriate care and treatment.

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

The staffing levels were being maintained with permanent, relief and agency staff. Sufficient levels of staff were deployed to meet people's needs.

Safe systems of medicine management were in place. Staff signed medication administration charts to show they had administered the medicines. Protocols for administering "when required" medicines were developed and included the purpose of the medicines.

Staff knew the procedures they must follow if there were any allegations of abuse.

Risks were assessed and staff showed a good understanding of the actions needed to minimise the risk to people.

Is the service effective?

Good

The service was effective

People were able to make day to day decisions. Mental Capacity Assessment were carried out to ensure people had capacity to make decisions about their care and welfare.

Members of staff benefitted from one to one meetings with their line manager. Staff said the training delivered increased their skills to meet people's changing needs.

People's dietary requirements were catered for at the home.

Is the service caring?

Good

The service was caring.

People received care and treatment in their preferred manner which respected their human rights.

Members of staff were respectful and consulted people before they offered support.

We observed positive interactions between people and staff.

Is the service responsive?

Good

The service was responsive.

Support plans reflected people's current needs and gave the staff guidance on how to meet them.

No complaints had been received from relatives or members of the public for investigation since the last inspection.

People attended clubs, participated in household tasks and one to one outings with their keyworker was organised.

Is the service well-led?

Good

The service was well led.

Systems were in place to gather people's views.

Members of staff worked well together to provide a person centred approach to meeting people's needs.

Quality assurance systems to monitor and assess the quality of service were in place and protected people from unsafe care and treatment.

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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 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 20 and 27 July 2016 and was unannounced.

The inspection was completed by one inspector. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.' We also reviewed information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with two people, one member of staff, an agency worker and the registered manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for two people. We also looked at records about the management of the service

Good

Is the service safe?

Our findings

One person told us they liked living at the home. Another person told us they felt safe living at the home and the staff made them feel safe. The agency staff on duty on the first day of the inspection visit told us the procedure for safeguarding vulnerable adults from abuse. They listed the types of abuse and told us that any allegation of abuse would be reported to the home's registered manager and to the agency manager. If these concerns were not taken seriously then they would report their concerns to senior managers and to the lead authority for safeguarding. A permanent member of staff we spoke with said the organisation had recently updated the safeguarding people from abuse procedure. They said "I would report the incident to the registered manager. Report it [abuse] then it will be dealt with. No matter how trivial."

Arrangements were in place to manage risks to people's health and welfare. A member of staff said risk assessments were developed by the registered manager. They said risk assessments were discussed at staff meetings and staff were expected to read and sign the risk assessments. This was to indicate their agreement with the risk assessment. Risk assessments were developed for people at potential risk and for the environment to ensure the safety of people living at the service and for the staff.

Where people were at risk of falls, risk assessments were developed. For example, one person was assessed as medium risk of falls outside the home. The preventative actions listed were for staff to have the home's mobile when they were not in the service, for the person to be accompanied by staff and for them to be referred for specialist input.

Risk assessments on managing difficult behaviours gave staff with guidance on how to respond to specific behaviour. For example, staff were to remain calm, they were to allow the person to regain previous composure and to ask other people to move from the vicinity of the incident.

Health and Safety risk assessments were in place which included fire safety, domestic appliances and food safety. Within the risk assessments the level of risk was rated for example, low, medium and high. The control measures to minimise risk were listed and for food safety the risk assessment included staff attending training, maintaining records of temperatures and ensuring perishable foods were not outside the expiry dates.

Evacuation and contingency plans listed the utilities, operating instructions and emergency contact details. Emergency evacuation procedures gave staff guidance on how people respond to the sound of fire alarms, the individual's ability to walk unsupported and to follow instructions to leave the property. Also included were the relocation arrangements. People and staff were to relocate to the residential home next door in the event of a fire at the home. The actions to minimise the risk included testing of equipment and training of staff.

One person said sometimes they asked for staff to spend time with them and "sometimes they [staff] had time to sit and chat." Another person told us they liked to know the staff that were on duty. Staff told us there were two full time support worker vacancies and staffing levels were being maintained with relief and

agency staff. On the inspection days there were agency staff working at the home. An agency worker told us they worked regularly at the home and knew the people at the service. The rota in place showed there were two staff on duty during the day and one member of staff slept in the premises.

Medicine management systems were safe. Medication administration files had a photograph of the person to ensure their identification. Within the medication file there were profiles and a support plan for each person which listed the name of medicines prescribed, when required (PRN) medicines and homely remedies. The purpose of the medicines, side effects and administration directions were included in the support plans and profiles.

Protocols were developed for PRN medicines. For one person PRN protocols were in place for administering pain relief and for anxiety. PRN protocols for pain relief included the directions and the maximum dose that can be administered safely. The protocol for anxiety included the triggers to behaviours exhibited and stated the actions staff must take before they offered PRN medication. For example, strategies included cancelling activities if the person became tearful and suggesting alternative activities such as going for a walk.

Medication administration records (MAR) were signed by the staff to show that medicines were administered. A record of medicines no longer required was maintained and the record was signed by the pharmacist or their representative to indicate receipt of the medicines.

Good

Is the service effective?

Our findings

Staff said training was good. They said the training programme was organised by the training officer and courses were available monthly. The training courses available to staff included refresher training in the safeguarding of vulnerable adults, medicines management and Prader Willi Syndrome. Training courses specific to the needs of people were delivered in-house. For example, food hygiene and fire safety.

Staff said one to one meetings took place with their line manager. The registered manager told us the structure for one to one meetings. They said one to one meetings were conducted by the registered manager and the senior support worker. The senior support worker carried out the one to one meetings with support workers. New staff and senior support workers had one to one meetings with the registered manager.

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.

The person we asked told us they made decisions and these included planning their meals. A member of staff told us that people at the service made their own decisions. For example if they should receive the flu vaccines. People's preferred method of communication was used to assess their capacity to make decisions. For example, for one person the MCA assessment was in pictures and words for flu vaccine to ensure they understood the decisions and consequences for not having the vaccine.

This member of staff said "we make sure they [people] understand about making decisions. For example locking kitchen cupboard". MCA assessments dated 17 September 2015 were in place for locking cupboards and the fridge. The person was assessed as having capacity to make agreements for staff to manage their access to food because of their medical conditions. The two other people had signed an agreement stating their understanding for locking parts of the kitchen and how to access these cupboards and fridge when this person was in the home.

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 application 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.

People living at the home were subject to Deprivation of Liberty Safeguards (DoLS) for continuous supervision. DoLS applications to restrict people's liberty were made to the supervisory body for approval. MCA assessments for door alarms were in place to prevent one person from undertaking activities that may cause them harm. Risk assessments were in place for staff and one person to carry out checks of their

bedroom. Staff were to request consent and the action plans gave staff guidance if the person refused.

One person told us they "sometimes lost their temper" and the staff response was to suggest they go to their bedroom. Behaviour support plans included a traffic light system to code the levels of behaviour. For example, green for usual behaviour, amber for becoming upset and red for anger. For one person pain or staff not understanding was identified as a trigger and the action plan was for staff to suggest relaxation activities and to give the person time. The plan identified the people who were at risk when difficult behaviours were exhibited and the action staff must take if the behaviours escalated. A member of staff explained the types of difficult behaviours some people could exhibit at times. They told us the actions needed to ensure situations did not escalate and how to ensure other people in the home were kept safe. For example, staff ensured other people were not in the vicinity if the behaviours were to escalate and once the person was calm the staff discussed the incident with the person.

We observed an incident where one person became frustrated and shouted when undertaking an activity. The member of staff calmly suggested the activity was terminated and gave the person time and space to regain their previous composure.

One person told us they liked the food and another person told us they devised their own menus and prepared their meals. This person also told us they had separate storage facilities for their food.

People were supported to plan their meals. We saw a good range of fresh vegetables and fruit, tinned and frozen food. One person prepared their menu, they had separate storage facilities and prepared their food and refreshments. Menus prepared by the other two people were in picture format. While there were parts of the kitchen that were locked agreements were in place and the people not affected were able to access these parts at all times.

One person told us they were accompanied by staff on their healthcare appointments. A member of staff said health action plans were in place and usually staff arranged appointments. Individual healthcare files included the professionals involved in the care of people. Reports of visits showed people had regular GP visits as wells as dental and optician check-ups.

Good

Is the service caring?

Our findings

The two people we asked told us they liked the staff and the staff were kind. A member of staff told us the people at the service were able to "say the things they liked or wanted". They said the staff had a clear understanding of people and how to interpret behaviours. For example, when staff made suggestions of possible activities and the person was reluctant to participate they were slow to prepare for the activity. Another member of staff said "we get to know people's likes and dislikes. People are not forced, they are respected as individuals. It's all about trust and getting people to trust you [staff]. They [people] then get to know they [people] can come to you [staff]. It's all about good communication and respect. I know one person likes the curtains drawn and coffee table where it is (close to the sofa in the lounge). It may look untidy but what is the big deal. It's the little things that are important."

The person we asked told us their views about the home were gathered. They said at tenant meetings they discussed "what I like to do. "One person invited us into their bedroom. We saw the person was helped to decorate their bedroom. This person said they had chosen the colour of their bedroom. We saw the personal belongings and photographs reflected the person's taste and personality.

Daily routines plans gave staff guidance on how people liked their care and treatment to be delivered. For example, the morning routine plan for one person included their likes, their ability to manage aspects of their care for themselves and how the staff were to assist them. The actions from the staff included how the person's rights were to be respected. For another person their daily routine plan included their particular characteristic on their dressing preferences.

People were supported to maintain contact and links with their family and friends. One person we spoke with said their family was welcome at the home. Family contact support plans listed the names of family and friends in regular contact with the person, how these relationships were maintained and the assistance required from staff to maintain them. For example, for one person joined family members of holidays.

People's rights were respected by the staff. The person we asked told us their bedroom was lockable and they had a key for their bedroom. They also told us the staff always knocked before they entered their bedroom. A member of staff said "People were treated equally and we try to respect people's rights. We follow policies and procedures and we try to meet their [people's] goals.

Good

Is the service responsive?

Our findings

The person we asked said they had a care file and that records about them were kept. A member of staff said support plans were put together by the staff. They said the registered manager monitored the support plans to ensure the information needed was included. For example, the information needed by agency staff to meet people's needs. On the first day of the inspection the agency worker on duty told us support plans were available for them to read.

Support plans were developed to reflect how people wanted their care and treatment to be delivered. Support plans were audited by staff to ensure the information on meeting people's needs was documented. Where shortfalls were found in the support plans an action plan was developed. For example, action plans were developed to provide the clarification needed on health care needs and included was the manner in which other staff were to be informed about the changes.

Daily routine plans described people's daily activities and preferred routines which included the person's signature to show their agreement with the plan. Within the support plans were the person's preferred times to get up and to retire, their personal care needs, menu preferences and their participation in household tasks. For example, f one person's care plan included information on their ability to manage parts of their care and the actions needed from the staff to meet their care.

Personal support plans listed the person's capacity to consent to care and how staff were to assist the person with their care needs. For example, for one person their support plan included their preferences, the level of support needed from the staff and decisions made by the person regarding their personal care needs.

Independent living skills support plans for one person included their ability to undertake tasks. For example, laundry, preparing meals and household chores, such as cleaning their bedroom and some areas of the home.

An agency worker told us there was a checklist of tasks to be completed and there was a handover of information when their shift began. Individual diaries were used to record the times when people woke up and went to bed, appointments and their outcomes and activities undertaken. A quick relief file was in place for bank and agency staff which included people's profiles, important things to know about people and key information.

On the first day of the inspection we observed two staff support people to participate in activities. One person was accompanied by staff to the "Monday and Wednesday" club and another person had arranged with their key worker to go on a day out.

One person told us they attended clubs twice weekly and the staff went with them. Another person told us their activities programme for example, attending clubs and going on day trips. A pictorial plan of household tasks was in place that people undertook which included emptying the dishwasher and changing the sheets.

They also told us that when they were at home they played online games and did puzzles. A member of staff told us people made decisions on their activities. They described the person's activity programme for example, one to one time with the person, visits to clubs and at weekends visits to coffee shops.

A member of staff said people approached the staff or registered manager with their concerns. The complaints procedure in place was in pictures and words. There were no complaints received since the last inspection.

Good

Is the service well-led?

Our findings

Feedback about the service was gathered from people, visitors and from staff including bank and relief staff. The two people we asked said their views about the service was gathered at tenants meetings. Tenants meetings were held monthly and minutes of a meeting held in July 2016 were in pictures and words. Within the minutes the people present and the areas of discussion were included. For example the people living at the service attended and they discussed activities, areas of concern and information was shared.

Questionnaires were completed by visitors and by relief and agency staff. The agency staff that completed the questionnaires in April and May 2016 stated the service was "excellent, well run, and delivered well thought out care".

Team meetings were held regularly and the minutes of the meeting held in June 2016 detailed the agenda followed. For example, risk assessments, referrals for new admission, the roles delegated to staff , updating the statement of purpose and the people living at the service were also discussed.

The agency worker on duty during the inspection visits days told us the team was good and the staff worked well together. They said everybody pulled their weight. A member of staff employed at the home stated "we work well as a team. We complement each other's strengths and weaknesses. We try to accommodate each other which benefits the people living at the service."

The registered manager told us there were challenges with managing two services. They said this service ran smoothly and there was daily contact with each service which included visits or telephone contact. It was also stated the recruitment of new staff was in progress and flexibility of shift pattern was to be part of their employment.

Quality assurance arrangements in place ensured people's safety and well-being. Monthly self-assessment forms were completed by the registered manager. The registered manager told us where shortfalls were identified an action plan was put in place on how standards were to be met. They said central management received copies of the self-assessment and the findings were discussed at central management meetings. Internal audits were undertaken to assess and monitor the quality of the service. For example, medicine and support plans.

Quality assurance visits were undertaken by a quality assurance team which included an area manager, Human Resources (HR) and the Chief Executive to assess the standards of care and treatment were assessed . At the most recent visit all areas reviewed were met.