The Drive Care Homes Limited

Glover House

Inspection report

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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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 25 and 26 August 2016 and was unannounced. Glover House provides accommodation and support for up to eight people who may have a learning disability and autistic spectrum disorder. At the time of the inspection three people were living at the service. People had access to two communal lounge areas, a dining area, kitchen, shared bathrooms and a large well maintained garden. Each person had an ensuite shower in their bedroom. Glover House was last inspected on 16 May 2014 where no concerns had been identified.

The service had a newly appointed registered manager in post. They had previously been the deputy manager of the service and had registered with The Commission in July 2016. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Some of the language used in people's records was not dignified or respectful. The registered manager had identified this as an area which needed to improve and had booked some staff on to a report writing course.

Staffing was sufficient and flexible to meet people's needs; staff had time to respond to people's needs in an unrushed way. People were protected by the service using safe and robust recruitment processes.

There were safe processes for storing, administering and returning medicines. Medicines were administered by trained staff who were competency checked by the registered manager. Medicines were regularly audited to maintain good oversight.

Accidents and incidents were recorded and audited to identify patterns and the registered manager used this as an opportunity to learn and improve outcomes for people.

Appropriate checks were made to keep people safe. Safety checks had been made regularly on equipment and the environment.

The service was good at responding to people who needed help to manage their health needs. People were supported to access outside professionals and the service was adaptable when a person's needs changed.

Staff received supervision and appraisal to support the development of their role and attended staff meetings to share knowledge and information.

Staff had appropriate training and experience to support people with their individual needs and demonstrated a good understanding of people.

The registered manager demonstrated a clear understanding of the process that must be followed if people were deemed to lack capacity to make their own decisions and the Mental Capacity Act (MCA) 2005. The service ensured people's rights were protected by meeting the requirements of the Act.

Staff demonstrated caring attitudes towards people and showed concern for people's welfare. When people required to be supported with their anxieties staff did this in a patient and compassionate manner.

People had care plans which were detailed and informative. Care plans gave clear descriptive information which was easy to understand. Robust guidance was available for staff to follow to help support people manage their behaviours.

People were supported to take part in activities which were suitable for their individual needs and had the opportunity to discuss activities they wished to undertake in the future.

Staff said they felt well supported by the registered manger and were able to talk to them at any time. There were good processes in place to ensure people's daily needs were met and important appointments or events were not missed.

People were encouraged to express their views and provide feedback so the service could continuously improve.

The provider strived to continually improve the service to improve the lives of the people. Quarterly internal audits were conducted by a senior manager to identify areas which were in need of improvement.

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.

There were enough staff to support people and meet their individual needs.

People received their medicines safely.

There were detailed risk assessments which were person centred.

Accidents and incidents were recorded and audited to identify patterns.

Recruitment processes were in place to protect people.

Is the service effective?

Good

The service was effective.

Staff had received the training they required to be able to support people with their needs.

Staff said they felt well supported by the registered manager and were able to approach them at any time if they required help. Staff received supervisions and appraisals.

People's health needs were responded to promptly and people were supported to access professional healthcare when they required this.

Is the service caring?

Requires Improvement

The service was not always caring.

Some of the language used in people's records was not dignified or respectful.

Staff cared about the welfare of people and adapted to their changing needs.

Staff were respectful of people's private space and asked for

permission before entering their bedrooms or engaging in conversation with them.

People were treated with respect and dignity.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed, informative and person centred.

There was a complaints procedure available for people should they be unhappy with any aspect of their care or treatment.

People were offered varied activities to meet their individual needs and interests.

Is the service well-led?

Good

The service was well-led.

The registered manager had good oversight of the service and there was a clearly embedded culture, staff had good attitudes.

Systems for accountability had been established which meant people's immediate needs had been responded to.

People's feedback was sought so improvements to the service could be made.

Glover House

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 the 25 and 26 August 2016 and was unannounced. The inspection was conducted by one inspector. Before our inspection we reviewed information we held about the service, including previous inspection reports and notifications. A notification is information about important events, which the service is required to tell us about by law. We reviewed the Provider Information Return (PIR) and used this information when planning and undertaking the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

During the inspection we spoke with two people, one visitor, six staff, the registered manager, and the provider. Before the inspection we received feedback from four healthcare professionals. Some people were not able to express their views clearly due to their limited communication, others could. We observed interactions between staff and people. We looked at a variety of documents including three peoples support plans, risk assessments, activity plans, daily records of care and support, three staff recruitment files, training records, medicine administration records, and quality assurance information.

Good

Is the service safe?

Our findings

A healthcare professional said, "I have no concerns regarding the care and support service users are receiving from their support workers".

Staffing was sufficient and flexible to meet people's needs. Four staff were available between 7.00am until 9.00pm, at night there were two wake night staff. The registered manager covered any shortfalls if there were not enough staff to cover shifts, drive the company vehicle or support the activities people attended outside of the service. Throughout the day and evening people were allocated at least one staff member to provide continuous support. People were responded to quickly when they asked for assistance and staff had enough time to engage with people in an unhurried and meaningful way. There was an on call system covered by the registered manager should staff require guidance or support at any time. There was a rota displayed within the service using photographs, so people knew who was going to be on duty.

People were protected by the service using safe and robust recruitment processes: Employment gaps had been explored, and Disclosure and Barring Services (DBS) checks made. These checks identified if prospective staff had a criminal record or were barred from working with adults. Other checks made prior to new staff beginning work included health fitness assessments, references and photographic identification to ensure staff were suitable and of good character.

There were safe processes for storing, administering and returning medicines. People had individual assessments around how they liked their medicines to be administered and staff that administered medicines were trained to do so. The registered manager and team leader competency checked any staff that dispensed medicines to ensure good practice continued. They were also responsible for ordering new stock and returning any unused medicine. Regular audits monitored errors, temperature checks to ensure safe storage of medicines had been completed and occasional medicine (PRN) protocols were up to date. If people were unable to verbally request PRN pain relief medicine there was clear guidance for staff to follow in the person's care plan to recognise the physical signs they may display.

Some people could display behaviours, which were physically and verbally challenging. People had behavioural guidelines in their care plans to help manage incidents. Some people required physical intervention to re-direct their behaviour, prevent them from harming themselves and others around them. All staff had completed specialist training to support people safely at these times. If people were prescribed PRN medicine to help manage their behaviour rigorous protocols for administration were in place and people only received prescribed medicine as a last resort. Accidents and incidents were recorded and audited to identify patterns and the registered manager used this as an opportunity to learn and improve outcomes for people.

A staff member said, "I've had safeguarding training, I would know how to report outside, we have a policy". Staff were aware of their responsibilities in relation to keeping people safe. They knew how to whistle blow and report any concerns to their manager and also to external agencies, such as the local safeguarding team or The Commission. Staff were able to describe how to raise safeguarding concerns and who they

could report concerns to outside of the organisation. As well as a general safeguarding and whistle blowing policy there was a separate policy that staff could follow if the safeguarding concern related to the practice of the registered manager.

People had their own individual risk assessments according to their needs. Risk assessments had been completed to support people to remain safe. Risk assessments included information about the risk area, potential risks and control measures in place. There were environmental risk assessments to help reduce the impact of harm to people. People had individual personal emergency evacuation plans (PEEPs) that staff could follow to ensure people were supported to leave the service in the most appropriate way in the event of a fire. Fire evacuation drills were conducted so staff understood how people's PEEPs would be put into practice. Appropriate checks were made to keep people safe. Safety checks had been made regularly on equipment and the environment. This included electrical, fire doors, emergency lighting, fire escapes, first aid equipment, carbon monoxide monitoring, fire alarms, and water checks.

The provider responded quickly to areas of the service, which were in need of repair and maintenance. One person had been unwell, which had resulted in their behaviour becoming more challenging; incidents had resulted in damage to the environment and premises. The service employed a maintenance worker for three days of the week. During the inspection the maintenance person came to repair areas of the environment, which had been damaged including fire doors and glass panels.

Good

Is the service effective?

Our findings

A staff member said, "I have received training in autism, and Prader-Willi syndrome (Prader-Willi syndrome (PWS) is a rare genetic condition that causes a wide range of problems. These may include a constant desire to eat food driven by a permanent feeling of hunger, learning disabilities and behavior problems). We get face to face training. The manager is super, I've learnt so much. They have empathy for the work and understand the service users. They make sure we get training and they get on with the staff". Staff were encouraged to gain qualifications in health and social care while working at the service. 13 staff had obtained a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ)) level 2 or above. Diplomas are work based awards that are achieved through assessment and training. To achieve a Diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

All staff completed mandatory training in the form of face to face, DVDs, workbooks or e-learning. Mandatory training included; first aid, fire, food safety, infection control, Team Teach (de-escalation strategies to manage behaviour which could be physically challenging), and medicine training. Additional training was offered to staff in specialised areas such as epilepsy, Prader-Willi syndrome, challenging behaviour, bipolar awareness, Makaton (Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech), Autism awareness, and nutrition and diet. Staff demonstrated the appropriate skills and knowledge to support people with their needs. They were able to describe how they would respond to different situations which may arise for example, what steps they would take if a person's behaviour was physically or verbally challenging. A staff member said, "We do Team Teach but only if needed, restraint is always a last resort, we use distraction techniques".

Staff received formal supervision every six weeks and an appraisal each year which were conducted by the registered manager. The team leader had completed training in delivering supervisions. The registered manager was competency checking them through observational supervisions with the view of delegating some of the staff supervision to them in the future. The registered manager said they had conducted most of the staff appraisals when they had taken up their new role as registered manager. This had been useful and had given them a clear idea of the staff member's progression within the company. They were able to agree future training needs and discuss any issues the staff may need support with.

People were supported to receive appropriate treatment from outside health professionals including, psychiatrists, neurology, the learning disability and mental health nurse and the opticians. One person had epilepsy and had seizures; protocols were in place should the use of rescue medicine be necessary. Staff demonstrated a good understanding of the action they should take if the person had a seizure. Appointments were documented and followed up and staff communicated with the rest of the staff team any information, which may need to be shared to support the person following appointments attended.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 with the registered manager. They demonstrated a clear understanding of the process that must be followed if people were deemed to lack

capacity to make their own decisions. 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 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. Three people were subject to a DoLS to deprive them of their liberty and the provider was working within the principles of the Act. There was recorded documentation which showed how the service had responded to meet the requirements of this law and the needs of people.

One person had a specialised dietary requirement, which staff were aware of and catered for. Risk assessments had been made to manage the person's behaviour around food so meal times could be as least stressful for the person as possible. Staff recorded the food people had eaten to track if their tastes had changed which was particularly useful if a person found this difficult to verbalise. Other people shared a menu and staff understood the non-verbal communication people would display if they did not want a particular meal and an alternative would be offered. People were offered snacks in between meals such as biscuits, fruit, fruit loaf, and yogurts. One person liked to eat particular food associated with their cultural background; this was catered for and regularly offered to the person.

Requires Improvement

Is the service caring?

Our findings

A staff member said, "The people here are lovely, it's important to know how to communicate with people, we have communication passports".

Some of the language used in people's records was not dignified or respectful. An example of this was a person's guidance around managing their meals. The documented stated, 'When (person) is unsettled they can "play up" around what they want to eat, particularly at breakfast time. They will throw their breakfast expecting that staff will make them a cooked breakfast'. Another example was a person's key worker recording sheet which stated, 'If (person) "behaves", you can get (item) as a treat sooner'. This showed that people were sometimes treated like children rather than adults. This is an area which requires improvement. The registered manager said they had identified this was an area that some staff needed more training around as English was not their first language and had booked four staff to attend report writing training the following month.

Throughout our visit people came and went as they pleased and were always supported by staff according to their assessed needs. People were spoken to in a dignified and respectful manner, it was apparent that people felt confident and comfortable in their home and that the staff were easily approachable. A person and two staff members sat in the garden together chatting in an unhurried, relaxed and sociable way. Another person sat with staff listening to music they enjoyed.

People were encouraged to express their views and make their own decisions. For example, one person was supported to attend a health appointment once a week. Staff said the person did not like staff to be present whilst they attended this appointment. Staff respected this choice and waited for the person outside until their meeting was complete. One person was asked if they would like to speak to the inspector during the visit but declined. Staff explained to the person that if they changed their mind this was fine and it was their choice.

Consent was obtained from people before staff acted on their behalf. For example, one person had signed a document in their care plan to consent for staff to call their GP to visit them if they were unwell, obtain their prescriptions for them and arrange accident and emergency examinations if required. During the inspection a person had a seizure; staff responded appropriately and closed doors to other rooms to maintain the person's privacy. Staff asked for permission before going into people's bedrooms. This demonstrated staff maintained respect and dignity for people.

People were supported to maintain relationships with relatives and other individuals who were important to them. One person's relative visited them several times a week and other people were supported to visit their family at home. If people needed help with decisions which were complex they were supported to access independent advocacy services.

People were shown concern; the provider came to the service unannounced to check up on a person who had been recently ill. The registered manager said, "The provider is hands on and involved. I told them

about the person who is unwell and they have been phoning to check up on them". Staff understood the person well and explained how their behaviour had been out of character due to them feeling unwell. The person was being closely monitored and referrals had been made quickly to the GP to address the person's current condition.

Good

Is the service responsive?

Our findings

A healthcare professional said, "They do act quickly, the care plans were updated and are good. They react well, never had any problems with staff. The manager is taking it in the right direction". A staff member said, "People need to go out and do things to refresh their minds. Everyday people can do something; they can do bowling and swimming. I think more variety in activities would be good".

People's care plans were detailed and informative. Within people's care plans were pen portraits, information about their history, information about the person's routines and preferred communication methods in the form of a communications passport. Care plans also contained individual behaviour guidance and information about how staff could support the person in different situations. Care plans gave clear descriptive information which was easy to understand. Care plan files contained a 'Care plan audit tool' which was completed monthly by the registered manager. This ensured people's plans were kept up to date and reflective of their current care and support needs.

Each person was allocated a key worker and co-keyworker who were responsible for conducting weekly key worker sessions. The purpose of the sessions was to allow people to have the opportunity to feedback what was working well for them, how things could improve and what action was required to achieve this. People's religious preferences had been highlighted within the care plan. One person's family had expressed a wish for the person to follow their faith by attending church. Although the person had not shown an interest to do this staff had revisited this with the person and reassessed if their preference had changed. The recent evaluation in the person's care plan said, '(Person) has still not shown an interest in attending church. Their cultural needs around food are met and they visit their relative'.

People's individual preferences and needs were supported in a person centred way, and people were given information in a suitable format. An example of this was the information board which was used to display what staff were on duty throughout the day and night and what daily activities had been planned. Each person had their own section on the board. Two people's information included pictures and easy read information, one person's only contained written information. Staff were aware of the importance of communicating in a specific way with people and were able to describe words, which could trigger a person to become anxious and upset. This information was well reflected in the person's care plan and demonstrated people were treated individually according to their needs.

People were encouraged to practice and develop their life's skills. One person's occupational therapist had left simple guidance for them to follow with support from staff to make smoothies in the form of a step by step picture diagram. The occupational therapist had arranged to attend the next staff meeting to talk to staff about the person's development. Another person took charge of their own personal money. The registered manager had made an agreement with the person about the weekly budget they would stick to, to ensure they did not run out of funds. A risk assessment had been implemented so staff understood how to support the person with their finances. The registered manager said this was important because it helped the person become more independent.

People were supported to take part in activities which were suitable for their individual needs and had the opportunity to discuss what they would like to participate in or if they would like to visit particular places. One person volunteered at a local park and attended 'Art at the farm' and sensory sessions at the Rare Breeds centre. Another person had requested a visit to a zoo, but was undecided as to which one they wished to visit. Their key worker was reviewing this regularly with the person to support them to come to a decision at their own pace. Activities were well thought out and assessed for suitability. For example, two people could not cope well in crowded places so activities were planned to take this into account. People were offered educational and occupational opportunities and peoples decisions were respected if they declined to take part.

The service responded to complaints appropriately and had robust systems in place; an easy read format was available for people who may need it. When concerns or complaints were made these were recorded and follow up action taken and recorded. Some people understood the complaints procedure; others relied on staff to identify if they were unhappy through their body language and behaviour. There was simple description, which gave information about who people could talk to and how their complaint would be handled. The easy read complaints policy gave people information about who to contact outside of the service if they were unhappy with the response given or action taken by the provider.

Good

Is the service well-led?

Our findings

The provider said, "One of the biggest challenges is filling beds with the right people. We want people to be happy that's our priority". The registered manager had good oversight and direction of the service; they said they felt well supported by the senior management team. There were well established aims, objectives and a clear vision. They said, "I wanted staff to talk to me, it's the downfall of any manager if staff can't talk to them. We have informal chats, when I took over I had been deputy so knew them and they were very receptive".

There were good processes in place to ensure people's daily needs were met and important appointments or events were not missed. Handover sheets were used by staff to ensure all daily duties had been completed and people's needs had been met. Shift leaders were responsible for organising tasks for each staff member and ensuring the shift ran smoothly. Staff maintained good communication with one another by the use of a communication and shift leader book, which summarised key information from the shift. A staff member commented, "My main role as team leader is checking health and safety checks, auditing medicines, rotas and working shifts. I'm training at the moment with the manager to do supervisions. I've learnt a lot, I'm still learning and getting more experience. There's good communication and good team work". Systems for accountability had been established, which meant people's immediate needs had been responded to; staff were clear about their responsibilities.

The provider strived to continually improve the service to improve the lives of the people. Quarterly internal audits were conducted by a senior manager to identify areas which were in need of improvement. The last internal audit was completed in June 2016, the audit looked at the quality of the service people were receiving and what areas could be improved. The audit had highlighted that the fire risk assessment had not been reviewed at the appropriate time, and a recommendation was made that the carbon monoxide monitor should be checked weekly as opposed to monthly. The registered manager had taken action and had completed the recommendations. The provider had also employed an external consultancy company to conduct a quality monitoring audit; the provider had taken steps to improve the service following the recommendations found during this audit, which included improvement to the staff recruitment files. The registered manager conducted their own internal audits, such as daily medicine checks, monthly care plan reviews and health and safety audits completed weekly and monthly.

People were encouraged to express their views and provide feedback so the service could continuously improve. This was achieved through the weekly key worker sessions; house meetings had been offered, but people found keyworker sessions to better meet their needs. People were offered questionnaires to provide written feedback about the service they received. One person commented that they did not like to be referred to as a service user (when staff spoke about people in general) as it confused them so requested staff should call people by their names. The registered manager reminded staff about the importance of doing this whilst maintaining confidentiality.

The staff had regular team meetings and outside professionals were invited to attend. During the team meeting in June 2016 the psychologist nurse came to speak to staff about a person's behaviours and how

they could deal with this effectively. This had proved to be a valuable learning experience for staff who were able to discuss openly about some of the challenging behaviour they had to manage consistently as a team. The nurse was able to provide advice and guidance so staff felt more confident in meeting the person's needs.