Hightown Housing Association Limited

The Crossings

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

Summary of findings

Overall summary

This inspection took place on 7 and 8 August 2017. This is the first inspection carried out at the service since the provider transferred to a new provider. Their registration with the Care Quality Commission was completed in October 2016.

At the time of the inspection The Crossings was providing accommodation and care for three adults with learning disabilities including one person who had additional physical disabilities. The service had a registered manager in place. 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.

Prior to the inspection we responded to concerns about low staffing levels by visiting the service unannounced. We found there to be sufficient staff on duty to support people safely.

We were told by the registered manager they had experienced difficulties in guaranteeing sufficient staff were available to work, following the resignation of a high number of staff. Given there was a small team working in the service, this had a large impact. Work had been undertaken and was on-going to recruit suitable staff to work in the service. The registered manager took appropriate steps to ensure suitable people were employed to support people using the service. We observed suitable numbers of staff were present in the service during the inspection.

Staff were trained to administer medicines safely, we found records and practice were up to date and accurate. Risks to people's safety had been assessed and care plans gave detailed guidance to staff on how to provide appropriate care to people.

Staff were supported to carry out their role to the required standard. Staff attended training, and received supervision and appraisals. Staff meetings were available for them to discuss the service, and issue or any improvements that were necessary.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The service was

operating within the principles of the Mental Capacity Act 2005(MCA).

People were supported to be involved in making day to day decisions about their care. Where people needed support with food and drinks this was provided. People's health was monitored and where people needed extra support from medical professionals this was arranged.

We observed staff to be kind and caring towards people living in the home. They knew people's needs well and were responsive and supportive. People were respected by staff and their privacy and dignity was maintained.

People were encouraged to participate in activities they enjoyed. These were reviewed to ensure they were still appropriate and enjoyable for the person.

Feedback was sought from people and their relatives. This assisted the registered manager to ensure where improvements could be made, they were. Quality assurance checks were carried out, and where improvements to the service were identified, these were completed.

There was an open and transparent culture in the service, they were clear that the challenges faced by staff shortages would be rectified as soon as possible. The registered manager made themselves accessible to people, staff and relatives to ensure contact with people was always available.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's safety and wellbeing had been considered by the service and steps had been taken to ensure that any risk of harm had been assessed.

The provider had systems in place to ensure checks were carried out prior to candidates being offered employment. This minimised the risk of unsuitable candidates working with people.

People were protected from harm, as staff knew how to protect people from abuse and who to report concerns to.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and on-going support through regular meetings on a one to one basis with the registered manager or senior staff.

Staff had an understanding of the Mental Capacity Act 2005 (MCA). This helped to protect people's human rights.

Staff ensured people received assistance from other health and social care professionals when required.

Is the service caring?

Good

The service was caring.

People were supported to maintain relationships with their families.

We observed how staff cared for people and found it to be appropriate, respectful and courteous.

Is the service responsive?

Good

The service was responsive.

Each person had their own detailed care plan. People received person centred care and support.

People and their families were involved in the planning of their care and support.

The service identified people's needs and provided a responsive service to meet those needs.

Is the service well-led?

Good

The service was well-led.

The service listened to the views of people using the service and others and made changes as a result.

The registered manager and senior staff provided effective leadership and management.

There were clear visions and values for the service.

The Crossings

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 announced inspection took place on 7 and 8 August 2017. We gave short notice as we had received information the service were short of staff. We visited the service unannounced on the 6th August to ensure there were sufficient numbers of staff in place, which there were. We informed the staff we would be returning the following day to carry out the inspection. This was because the location was a small care home for adults who may have been out during the day; we needed to be sure that someone would be available to assist us with our inspection.

The inspection was carried out by one inspector. Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

We did not ask the provider to complete 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.

During the inspection we carried out observations of care. Not everyone living in the service was able to discuss their care with us. Because of this we carried out a short observational frame work for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During the inspection we spoke with one person living in the service and two relatives. We also spoke with five staff including the registered manager, the regional manager, a support lead (equivalent to deputy manager) a mobile support worker and permanent support worker.

We looked at care records for three people. We examined recruitment documents for two staff and reviewed the medicine documentation for three people. We also reviewed records relating to the running of the home, for example audits and health and safety checks amongst others.

Good

Our findings

The staffing level in the service had been assessed as requiring two staff during the day and two staff throughout the night. During the night one staff member would be asleep and one awake. We had recently received information telling us the service was short of staff, especially at the weekends. As a result of this information we visited the service on Sunday 6 August 2017. The service did not know we were coming. We found there were the correct numbers of staff on duty to meet the needs of the people living in the home. We returned the following day to carry out the inspection.

Over the two days of the inspection there were sufficient numbers of staff on duty. We discussed the concerns raised with the registered manager. They explained a large percentage of staff had left the service in a short period of time. This had resulted in a high usage of agency staff, bank staff and staff working overtime. The provider had recently introduced the role of mobile support worker to the workforce. These were support workers who were assigned to work regularly for a short period of time at services that were facing staffing difficulties. Other systems had been put in place to support staff who found they were lone working. This included a buddy system, where a senior staff member would make contact at regular intervals to ensure the staff and people living in the home were safe.

Through discussions with staff, relatives and a person living in the home, it was apparent there had been difficulties around the staffing levels at The Crossings. Comments include "I think they have managed well under the circumstances, they have had a change of company, staff have left it has been really difficult. They have come so far with the resources and staff. They are not blinded, they know there is still progress to be made."; "We have had so many changes, our concern was about the lack of continuity caused by the staffing problems….It seems to be very settled now." and "I think they have been very honest about how things have been here and trying to get staff, it will improve. They have had a hard time…they seem willing to get the staff, only time will tell, fingers crossed." Recruitment was on going in order to fill the staff vacancies. Two new staff had recently started their employment and were being inducted into the service. The registered manager and the support lead had worked hard to remedy the situation.

We discussed further with the regional manager how the registered manager and support lead faced problems with locating extra staff when staff did not turn up for work at short notice. For example, on one occasion recently, there was no staff available to remain awake during the night at a weekend. The sleeping in night staff had to be awake twice during the night to check on the welfare of the people they were caring for. The following day they were working a long day (7am until 10 pm.) at another service. The regional manager told us they would discuss with the provider how the systems for registered managers and senior

staff could be improved to further enable them to access staff when shortages occurred.

We recommend the provider ensures effective systems are in place to ensure sufficient staff are provided to safeguard people's safety.

Medicines policies and procedures were available to ensure medicines were managed safely. Medicines were stored securely in a locked cupboard in each person's room. Staff had been trained in the safe handling, administration and disposal of medicines. The registered manager told us most of the staff working at The Crossings had been trained to administer medicines to people. The staff had their competency checked to ensure they were aware of their responsibilities and understood their role. In addition to this, each member of staff had three direct observations of medicine administration to determine if they were competent to be the lead person to administer medicines, a second staff member checked they had carried out the task correctly.

We checked the records of medicines against the stock held in the home and found these to be correct. Audits had been carried out so errors could be identified quickly and any remedial action could be taken to protect people's health and wellbeing.

The registered manager understood their responsibility to ensure suitable staff were employed. We looked at the recruitment records of two staff members employed at the service. Recruitment records contained the relevant checks including a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any past convictions that may prevent them from working with vulnerable adults. References were obtained from previous employers as part of the process to ensure staff were suitable and of good character. Gaps in employment histories were investigated.

People's rights were upheld. One person told us they felt safe living at the home. Two relatives described how reassured they were that their loved one was being looked after safely. Staff were aware of how to identify safeguarding concerns and the reporting procedure to follow. They were also aware of the whistleblowing policy and how to obtain advice and support if they felt they needed to disclose concerning information about the service.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. These covered areas such as moving and handling, personal care and fire risk assessments. The risk assessments were guidelines for staff on how to manage the risks. These were reviewed regularly. Care plans gave detailed guidance for staff on how to support people with activities of daily living and identified how to reduce the risk of harm. For example, when supporting a person with a mobility aid.

Environmental risk assessments had been completed. This ensured the environment was safe for people and staff. These included, for example, risk assessments for dealing with snow and ice, lone working, moving and handling. Each person had an individual personal evacuation plan in place and fire systems were checked and serviced. A business continuity plan provided staff with information about what to do in extreme circumstances such as failure of utilities and bad weather.

All accidents and incidents were recorded. Records were checked to ensure that any actions which could prevent a repetition of an incident were taken. This helped minimise the risk of harm to people.

Overall the home appeared clean and tidy. We noted some areas that required more thorough cleaning and informed the registered manager. They told us they were going to ask staff to complete the cleaning of pipes and ensure this was included in the cleaning schedule. Staff knew how to minimise cross infection. We saw

they washed their hands at frequent intervals and there were sufficient supplies of gloves and aprons available at all times. We saw staff had completed training in this area and staff we spoke with demonstrated a good understanding of infection control procedures.

Good

Our findings

One person told us the staff supported them with things they wanted to do and the things they needed to do. For example, they supported them with their medicines and supported them to access the community. Relatives told us the staff appeared to be knowledgeable and skilled to carry out their roles.

When new staff commenced employment they received induction training, this included the completion of training in the areas the provider deemed to be mandatory. For example, health and safety, moving and handling and safeguarding amongst others. The registered manager informed us all new staff were required to complete the care certificate. The care certificate was developed jointly by Skills for Care, Health Education England and Skills for Health and is the minimum standards of care training that should be covered as part of the induction training of new care workers. The care certificate is based upon standards health and social care workers need to demonstrate competency in.

The registered manager told us new staff members had shadowed other care workers to enable them to learn from established staff. Staff received on-going training to ensure their knowledge and skills remained up to date. Records showed most staff training had been completed and was up to date. For example, fire training, moving and handling and safeguarding. Where this was not the case, training had been booked. Staff told us they felt they had received good quality training and enough to give them confidence to carry out their role.

Staff had received regular one to one supervision meetings. These were recorded and kept in staff files. The registered manager told us supervisions occurred every six week. However, if staff wished to discuss an issue or idea with the senior staff they did not have to wait until their scheduled supervision session to do so. The registered manager and /or the support lead would make themselves available to them. Records showed the scheduled supervision was detailed and comprehensive. The areas discussed included safeguarding concerns, personal development, and work performance. Staff told us they found supervision useful, one staff member told us "It keeps us up to date, we discuss what has worked and what didn't work. We can sort things out."

Staff were also supported through staff meetings, these were held regularly and gave staff the opportunity to feedback any suggestions or ideas of how the service could be improved. It gave the senior staff the chance to discuss any forthcoming changes that were happening at the provider level and any changes necessary within the service to improve performance.

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 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. Where restrictions were in place the provider had received authorisation from the local authority. This meant the restrictions had been reviewed and the local authority agreed they were the least restrictive and in the person's best interest. We saw where people were not able to make decisions for themselves, mental capacity assessments had been completed and best interest meetings had taken place. These ensured professionals were acting in the person's best interest. Staff had received training in MCA and demonstrated a basic understanding of MCA and DoLS.

Where possible people were involved in making day to day decisions about their lifestyle and care. For example, one person could decide how they spent their time, what they wanted to eat and when they wanted to have their meal, and they had the option to assist staff in household chores. For other people, they were able to indicate to staff if they were happy to wear the clothes staff chose for them and express whether they liked the food being offered to them. Staff knew people's needs well, and were able to discuss with us how they encouraged people to be as independent as possible given their own individual abilities.

People were supported to eat a healthy diet, and where assistance was required with eating and drinking this was provided. Each person had their own dietary needs. For one person they needed a pureed diet and thickener added to drinks to ensure it was the correct consistency to prevent choking. Staff were well informed on how to do this, information related to the process of thickening drinks was attached to the inside of the kitchen cupboard for this person. This was used as an aide memoire. One person was at risk of weight loss, their weight had been monitored. They had fallen below their ideal weight. The registered manager told us they were introducing high calorie foods and drinks to encourage weight gain. People were offered choices of meals during the weekly menu planning session. Staff told us they used pictures of food and their knowledge of people's likes and dislikes to put together a menu for the week. If on the day a person did not want the food on offer, and alternative was provided.

People's health was monitored, they had access to external professionals such as GP's, speech and language therapist and physiotherapists. People were supported to attend hospital appointments when needed. For one person who had diabetes, they were supported to manage their own health needs and attended regular podiatry and optician appointments to assist them to remain healthy.

Good

Our findings

Relatives told us they felt the service was caring. They told us "The staff always sit and chat to them [people]. They [people] are always very clean and tidy." They commended the attitude of the registered manager and told us they were a good role model for staff.

We observed staff to be attentive and caring towards the people living in the home. They were gentle in their approach and informed people of any actions they were going to take before doing so. For example, we observed a staff member asking a person's permission to take them to their bedroom. Conversations between staff and people was comfortable, and people appeared to enjoy the company of staff. This was demonstrated through smiling and relaxed body language. Staff had built positive relationships with people.

Staff treated people with understanding, kindness, respect and dignity. Each person's permission was asked before we were allowed to access their bedrooms. Staff understood the benefits of encouraging people's independence. One staff member told us "It is letting them do what they can do for themselves, encouraging them to keep their skills even if it takes longer. The more that is taken away from you the less you must feel about yourself." Another told us "We don't want them to feel undermined; we don't want them to lose the confidence to do things."

Care plans reflected people's preferences, for example, in one person's care plan it stated they preferred to take their medicines on top of a spoon of yogurt. The care plan also described how when being supported with teeth cleaning, the person may push the staff's hand away from their mouth to indicate they wanted them to stop. This assisted staff to provide appropriate care in line with people's preferences.

People's privacy and dignity was maintained. Staff closed doors and curtains when supporting people with personal care. One staff member told us "We protect their modesty, it is about thinking about what you are doing. When you are taking someone to their room, you need to explain to them what you are doing before you do it." When asked how they showed people respect they told us "It is about respecting people's wishes and thinking about how they feel and what they may be thinking. They may not be able to respond verbally but it is about us respecting them as a person."

Staff understood the individual communication needs of people at The Crossings. Communication was enhanced by the use of hand signs for one person. Diagrams were displayed in the person's room of what each sign meant to the person. The use of one word accompanied the hand sign. This was simple and

effective in allowing staff to communicate with the person. For one person a smile indicated they were positive about the subject matter, for example if they wanted to join in an activity. Facial expressions were interpreted to understand the preferences of people. Staff understood when people may have been in pain or uncomfortable through the expression of noise or facial and body language indicators. Staff told us they would try various options such as offering food or drink to establish what the cause of the discomfort may be. If they were still unsure they called the GP to establish if there was a physical cause which could be treated. The service ensured that people has access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. For another person in the service, they had read their care plan and agreed that the contents were accurate and up to date. They felt comfortable discussing with staff their needs and felt staff responded positively.

People's right to family life was encouraged. Relatives and friends were able to visit at any time. Relatives told us they telephoned the home out of courtesy to make sure their loved one was not going to be out at the time they planned to visit. They told us they visited weekly and were always made to feel welcome. Where relatives were not always able to visit people in the home, staff supported people to visit their relatives.

Good

Our findings

Each person's needs had been assessed. Following the assessment risks were identified and were recorded in care plans. The care plans detailed individual needs and preferences and how staff were to support people. They included areas such as personal care, food and nutrition and moving and handling. For one person information included accessing the community and maintaining independent contact with their family members.

Changes to people's needs were identified promptly and were reviewed with the person or their relative and the involvement of other health and social care professionals where required. Each person's care file was reviewed regularly. If any changes to their health were identified the care plan and risk assessment were updated. A relative informed us they were invited to participate in reviews of their loved one's care and felt their opinions were taken into account and listened to.

Any changes to people's care were discussed during handover, staff meetings or through the use of a communication book. Changes were recorded in the person's care plan. This was to ensure staff were kept up to date with people's needs and appropriate care was provided.

One person we spoke with indicated that they were happy living in the home and with the staff that supported them. From our observations we saw staff spent time with people and engaged with them throughout the day. One person told us they felt the staff were responsive to all of their needs and if anything changed with their care needs, the staff always supported them and were happy to discuss any changes in support required.

People were assisted to participate in activities. People were provided with the opportunity to partake in activities they enjoyed. For example, one person was having swimming lessons as they had expressed a desire to do so. We spoke with the support lead, who was conscious that some people had participated in the same activity for many years. For example people attended the Gateway Club. This is a social club for adults with learning disabilities and their families. We were told for one person it was understood they enjoyed attending this club and had done so for a long time. However, staff noticed this person's body language indicated they were not enjoying attending the club. During the observation the person was seen to make numerous attempts to leave the building, this indicated they were not happy. As a result they were no longer encouraged to attend. Other activities included attending day services, going for walks and participating in sensory activities in a community setting. An annual holiday was enjoyed by people with staff support. One person was supported with their employment and leisure pursuits. People's diverse needs

were accommodated as care was provided to support people's individual needs.

The provider had a complaints procedure and policy in place. At the time of the inspection there had been no formal complaints made. Staff knew how to deal with complaints. Relatives told us they didn't know how to make a formal complaint, but this did not worry them as they would speak directly to the registered manager. They felt comfortable speaking to the registered manager and had confidence that any concerns would be addressed.

Good

Our findings

As part of the quality assurance process, feedback was sought through a number of ways from people, their representatives and staff. Staff told us they were able to feedback ideas or improvement through supervision sessions, team meetings, and resident meetings or through general discussion with the senior staff. We saw these meetings were effective. For example, one person told us they had addressed a concern with the registered manager through the residents meetings, which were held regularly. The person explained that they did not like to have the bathroom door locked when they were in the bathroom. Staff supported the person to design a sign which the person could use to indicate the bathroom was occupied when in use but could remain unlocked. This provided the security the person wanted without the anxiety of having the door locked. Relatives told us they felt comfortable speaking with the registered manager, and were happy to feedback any concerns or ideas they had with them.

A number of quality assurance checks were undertaken to ensure the safety and quality of the service being provided. Peer audits were carried out in the service by senior staff from other services managed by the provider. Areas they covered included health and safety checks, fire safety, care plans and incidents and accidents amongst others. Where actions were required to improve the service, these were documented and the peer auditor checked the progress at the following audit.

The manager was registered with the commission in May 2017. Staff and relatives spoke positively about management. Staff told us they felt they could discuss any concerns they had with the registered manager or the support lead. Comments from relatives included "[Registered manager] is approachable; she will spend 10 to 15 minutes chatting to us each time we come. She has been one of the better ones. It comes across that she loves her job. It is good for the staff to see that." Staff told us how communication between the staff team and the management was good. They said "If something isn't right we talk about it and they [management] change things and fix things. In the team meetings we talk about how things need to be done, we give our opinions. If someone is doing things wrong, we help each other to understand how to do it right."

Staff appeared to work well as a team, and were supportive of each other. Staff told us the registered manager and the support lead were always available to answer any questions or issues staff may have. The registered manager told us for one person assistance was provided for them to visit their relative at home. The registered manager sometimes undertook this task as it offered the relative an opportunity to discuss with them directly how the person's care was being provided and any concerns the relative may have.

It was clear there was a strong value base around providing person centred care to people using the service and enabling them to reach their full potential through maximising their independence. Staff told us "The best thing about this service is we are giving people choices, they can do what they want, if they want to have a lie in they do that." Another said "They [staff] are dedicated to the clients, that is really important and they do want to do the best they can for them." From our observations we could see people were treated equally and as individuals. Their needs were met and support and care was tailored to them as individuals.