Azure Charitable Enterprises

Hexham

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 28 July 2017 and was announced. This was to ensure someone would be available to meet with us and show us records.

Hexham is a registered location for Azure Charitable Enterprises, which provides support and a wide range of services to people with learning disabilities in their own homes. On the day of our inspection there were 16 people using the service, 11 of whom were receiving support with their personal care.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

We last inspected the service in July 2015 and rated the service as 'Good.' At this inspection we found the service remained 'Good' and met all the fundamental standards we inspected against.

At this inspection we visited the office and two of the houses where people were receiving care and support from staff.

Accidents and incidents were appropriately recorded and risk assessments were in place. The manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

People were supported in a safe environment. Health and safety checks and infection control audits had been carried out. Appropriate arrangements were in place for the safe administration and storage of medicines.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff. Staff were suitably trained and received regular supervisions and appraisals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care specialists.

People who used the service and family members were complimentary about the standard of care at

Hexham. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person-centred way. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs.

The provider had an effective complaints procedure in place and people who used the service and family members were aware of how to make a complaint.

The provider had an effective quality assurance process in place. Staff said they felt supported by the management team. People who used the service, family members, staff and visiting health and social care professionals were regularly consulted about the quality of the service via meetings and surveys.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Hexham

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 28 July 2017 and was announced. One adult social care inspector took part in this inspection.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff.

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 used this information to inform our inspection.

During our inspection we spoke with three people who used the service and two family members. We also spoke with the registered manager and four members of staff.

We looked at the care records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Good

Is the service safe?

Our findings

People who used the service had completed easy to read questionnaires about whether they felt safe, whether they knew who to tell and whether they knew what hate crime was. These showed that people felt safe using the service. Family members told us their relatives were kept safe. They told us, "I think she's very safe" and "Very safe. She's well looked after."

There were sufficient numbers of staff on duty to keep people safe. We discussed staffing levels with the manager and staff. Staffing levels depended on the individual needs of the people who used the service. For example, two members of staff were required to support some of the people in the community, however, other people were more independent and could go out without the support of staff. The registered manager told us agency staff were sometimes required to cover staff absences, however, most absences were covered by the provider's permanent staff. Staff we spoke with confirmed this and told us, "We are very flexible" and "We help each other out [covering shifts]".

The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed new staff to ensure they were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), two written references and proof of identification. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

Accidents were appropriately recorded and untoward incident forms were completed for any incident involving a person who used the service. All records of accidents and incidents were sent to the provider's head office and discussed at monthly management meetings. Risk assessments were in place for people who used the service and included communication, behaviour, living environment, hot water, using wheelchairs and getting up during the night. These described the potential risk, who might be harmed, the level of risk, measures put in place to reduce the risk, and the new risk level once the measures had been implemented. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

Health and safety checks were regularly carried out at each home where support was provided and monthly infection control audits were carried out to ensure people were living in a clean environment, and risks from infection were minimised.

The provider had a 'Safeguarding (adults and children at risk) policy, which defined what abuse is, the different types of abuse, roles and responsibilities of staff, procedures for dealing with allegations of abuse, and information on useful legislation. We found the manager understood safeguarding procedures and had followed them, statutory notifications had been submitted to CQC and staff had been trained in how to protect vulnerable people. Staff had also completed questionnaires to check their knowledge of safeguarding. These were used to identify any gaps, which were discussed at team meetings and additional

training provided if required.

We found appropriate arrangements were in place for the safe administration and storage of medicines. The provider had a medication policy in place and weekly audits were carried out by staff. Any discrepancies were recorded and investigated, and appropriate action taken by the manager.

Staff had received training in the administration of medicines and received regular observations in the work place. Medicines were stored in secure cabinets in people's own homes and people had completed medicines support plans with staff that recorded people's understanding about the medicines they were prescribed and the level of support required to take them.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. People who used the service told us, "They [staff] take me shopping", "I'm well cared for and well looked after" and "Staff help me get dressed and go in the shower." Family members told us, "I've got admiration for the staff", "I think the staff on the ground deserve a medal", "We are very lucky we've got such good staff" and "It's excellent. I have no worries whatsoever."

Staff were supported in their role and received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace.

Records we looked at showed that staff mandatory training was up to date. Mandatory training is training that the provider deems necessary to support people safely and included first aid, moving and handling, safeguarding, fire safety, food hygiene, health and safety, mental capacity, medication, and infection prevention and control. Staff received additional training that was relevant to their role. For example, end of life care, epilepsy awareness and dementia. All staff had also completed a qualification in health and social care at level two or higher. New staff completed an induction and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

People who used the service were supported with their dietary needs and had food and drink support plans in place. These described people's abilities with preparing a shopping list, shopping for food, preparing a meal, food storage, cleaning up after a meal, and specific dietary needs. For example, one person had been referred to their GP due to poor diet. The person's support plan described how they would choose unhealthy options if they were left to choose their own food so staff were to support them in this area. The person was weighed monthly and had a food diary, where staff could document what food and drink the person had consumed throughout the day. Staff were advised in the support plan to prompt and remind the person about healthy eating.

Some of the people who used the service had difficulty communicating. Each person had a communication plan, which described how the person communicated, what they wanted staff to know, a guide to things the person said and what they meant, and a guide for helping the person communicate. For example, "Have patience", "Explain words that I don't understand", "Prompt me to explain further" and "Don't talk down to me." This enabled staff to support people with their communication needs.

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. We checked whether the service was working within the principles of the MCA and found the registered manager had a good understanding of their legal responsibilities with regard to the MCA and DoLS. Mental capacity assessments had been completed for people and best interest decisions made for their care and treatment where applicable.

Care records we looked at were signed by the person who used the service to say they agreed with the content and permission had been given by the person for health and social care professionals to view care records.

People who used the service had 'Hospital passports' in place, access to healthcare services and received ongoing healthcare support. The aim of the hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health if they are admitted to hospital. Care records contained evidence of visits to and from external specialists including GPs, dentists, opticians, chiropodists and practice nurses.

Good

Is the service caring?

Our findings

Family members told us people were well cared for. They told us, "[Name] is very well cared for", "They have a really good way of working with her" and "For [name] it's very individualised. She has individualised care."

We visited people in two of the homes where support was provided. Staff asked people's permission for us to look in their bedrooms and a person who was being supported gave us a tour of their home. Bedrooms were individualised and people told us how they had been involved in making decisions about their furnishings and the décor of their bedrooms and the home.

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and saw and heard how people had a good rapport with staff.

People's care records described how staff were to promote dignity and respect people's privacy. For example, "Once [name] begins getting dressed, staff can give [name] five minutes of privacy", "Staff are never to go into the bathroom with [name] when she is attending to personal care" and "Staff to wait in passage to give [name] time and space to finish [in the bathroom]." Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

Care records described how staff supported people to be independent. For example, "[Name] will be prompted to prepare the clothes that she wishes to change into after her shower", "[Name] can dress and undress herself", "[Name]'s independence is to be promoted as far as is possible when shopping" and "[Name] can put laundry in the washing machine but requires staff support to select a programme and run this." We observed one person was vacuuming the lounge when we visited their home. The manager told us how one person had been supported to move into their own flat due to them becoming more independent. Staff we spoke with told us about this person and how they still received support from staff but the number of supported hours had been reduced and the person had a more independent lifestyle. This demonstrated that staff supported people to be independent and people were encouraged to care for themselves where possible.

The provider had an advocacy policy in place to ensure people were able to get appropriate help and support when they needed it. Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. None of the people who were using the service at the time of our inspection had advocates, however, we saw a person who had used the service in the past had been supported in making decisions about their end of life care and what they wanted to happen in the event of serious illness.

The provider had a policy in place for end of life care to provide staff with guidance on how to support people with their wishes. We discussed this with the manager who told us end of life was not routinely discussed with people who used the service as it was a sensitive subject but discussions would take place with family members and care managers if required, and a funeral plan was in place for one person who

used the service.

Good

Is the service responsive?

Our findings

People's needs were assessed before they started using the service, and care records were regularly reviewed and evaluated.

Each person's care record included important information about the person including their preferred name, details of their diagnosis, contact details for their GP, care manager and next of kin, and any hobbies or interests. Care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account.

Support plans included communication, behaviour management, personal hygiene, work, recreation and leisure, living environment, food and drink, finances, personal relationships, and concepts. Support plans included guidance for staff on how to support the person in a particular area and if a risk was identified, a risk assessment was put in place.

For example, one person required support with their personal care and had a support plan in place. The person did not like to bathe so staff were instructed to prompt the person to bathe daily. The person was able to attend to their own personal care but required regular prompts from staff such as to wash their hands and face when required, ensure clean towels and clean clothes were to hand, and to change their clothes when needed.

People had 'Goal plans', which were targets the person had been set to achieve. For example, to carry out tasks independently or go on a holiday. These described what the goal was, steps taken to ascertain whether the goal was realistic and achievable, an agreed plan with the person of how the goal would be achieved, and details of when and how the goal was achieved. People also had long term outcomes, some of which were to support the person become more independent. For example, one person's long term outcome was to become more independent in the kitchen and included steps towards using the dishwasher independently. Monthly meetings took place between people and their key workers to discuss their goals and outcome steps, and any progress was recorded.

Daily records were maintained for each person who used the service. Records we saw were up to date and included information on the person's sleep pattern, diet, activities, and any issues. Staff maintained handover diaries, where they documented important information to be handed over to the next person on shift.

We found the provider protected people from social isolation. People had 'Work, recreation and leisure' support plans in place that described needs and abilities. For example, when they were out in the community, meeting family and friends, travelling on public transport, and going out for meals. One of the people who used the service worked part time in a local café, whilst others attended voluntary placements in charity shops. One person told us how they enjoyed visiting a local charity organisation and made cards and calendars to sell in shops. They told us they had enjoyed visits to museums, shopping trips and holidays. Another person showed us a papier mache elephant they had made at an art class and told us

they enjoyed going to a local disco. Staff told us, "We work with them to do whatever they want" and "They can do pretty much whatever they want."

The provider had a complaints and compliments policy and procedure. People who used the service were made aware of how to make a complaint via an easy to read version of the policy and complaints was a standing agenda item at house meetings. We looked at complaints records and saw there had been three recorded complaints in the previous 12 months. Each record included a copy of the initial complaint, details of the investigation and action taken, and copies of letters sent to complainants informing them of the outcome. All the complaints we saw had been appropriately dealt with. This meant the provider had an effective complaints procedure in place.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. We spoke with the manager about what they thought was good about their service and any improvements they intended to make in the next 12 months.

The manager had developed a 'Support services newsletter' that had recently been produced and sent to all the homes where support was provided, and to family members and relevant social care professionals. This provided information on the service, staff, events, training opportunities and a 'Recognition roundup' where staff had been recognised for their achievements.

The manager attended the provider's managers' meeting every month. This included an update on policies and procedures, updates on the provider, a review of staffing and recruitment, training, and a review of accidents and incidents.

The service had good links with the local community. These included charity organisations, a local social group where people had the opportunity to spend time with each other and carry out activities such as arts and crafts, and local cafés and shops.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring people's personal information could only be viewed by those who were authorised to look at records.

The service had a positive culture that was person centred and inclusive. Family members told us, "The staff, team leader and the manager communicate well", "It's a fantastic service" and "It's a good team." Staff we spoke with felt supported by the management team. They told us, "The support here is second to none", "They [management] are really good", "There's always someone at the end of the phone" and "Lots of support."

Staff were regularly consulted and kept up to date with information about the home and the provider. Staff meetings took place regularly in each house where people were supported, and team leader meetings were held once per month.

We looked at what the provider did to check the quality of the service, and to seek people's views about it.

Team leaders carried out monthly audits at each of the homes were people were supported. These included checks of care records, daily notes and diaries, finances, medication, meeting minutes, menu planning, health and safety, and fire safety. Any identified issues were recorded in action plans. For example, health and safety checks during one week had not been recorded at one of the homes. We saw this was actioned and the record signed to say it had been completed. The manager audited the records to see if any further action was required.

The manager also carried out regular visits to the homes, for example, to review financial records and full service visits were conducted by the manager at least once per year.

Annual surveys took place for people who used the service, family members, staff, and health and social care professionals involved with the service. Family members were asked to comment on the professionalism, skills and abilities of staff, communication, whether any concerns had been dealt with appropriately and whether they were generally happy with the service. People were asked how well they were supported with their needs, their social activities and employment opportunities, dietary needs, whether they felt safe, and whether they were happy overall with the support they received. The majority of responses were positive, and the results were analysed and made available to the people, family members and professionals. House meetings took place monthly at each home where people were supported. This gave people the opportunity to raise issues, plan rotas for domestic chores and discuss maintenance and the décor of the home.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.