Raynsford Limited

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

Overall summary

The inspection took place on 29 June 2015 and was unannounced.

Harrington House can accommodate up to 12 people who live with a learning disability or who have mental health needs. At the time of the inspection there were 12 people receiving care and treatment.

At the last inspection on 16 September 2014 we asked the provider to take action to make improvements in how they notified us of significant events and in how they managed and checked stocks of medicines. The provider told us they would meet this action by November 2014. During this inspection we found these actions had been completed.

There was a manager in post who was not yet the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

People were provided with personalised care which meant they were at the centre of any care planning and decisions made about them. The service's main aim was to help people live a full and meaningful life and to achieve their goals and aspirations. Where people required more support, because they had complex needs, staff made sure they had access to all the help they needed. People who lacked mental capacity were protected because staff made sure their care and treatment was delivered in their best interests.

People's personal risks and environmental risks were managed in order to keep them safe. Risks were not seen as a hindrance to ensuring people lived their lives in the way they wished to. Where needed, strategies were put in place and people's risk were managed in the least restrictive way possible. People were helped to recognise their goals and aspirations and given support to achieve these. They were given opportunities to express their views and make day to day and longer term choices and decisions. There were sufficient staff to provide personalised care and to support people in activities and social events of their choice. People's medicines were managed safely. People were provided with a choice of meals, drinks and snacks and given appropriate support to maintain a healthy intake.

People were cared for by staff who had received appropriate training. In most cases staff had additional knowledge and experience specific to the needs of those they supported. Staff competencies and on-going training needs were monitored and met by the manager and provider. People's health care needs were met and they were support to attend health care appointments. Where needed referrals were made to appropriate health care professionals to help meet people's needs.

Staff were caring and compassionate and maintained people's dignity and privacy. They made sure people were cared for and helped them to feel secure. Staff used different methods to communicate with people and they made sure people were listened to, however difficult it was for a person to express themselves. Staff knew people well and were able to help people avoid situations which caused distress. Any distress exhibited was quickly responded to. People were supported to maintain friendships and their right to private life and family life respected.

The service was well-led and both the manager and provider had arrangements in place to monitor the quality of care and support people received. Information about people was kept secure and only shared with appropriate and relevant people. People's views about the service were sought and these combined with any concerns or complaints received were listened to, taken seriously and used to improve the services provided.

Summary of findings

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 were protected against risks that may affect them because health related and environmental risks were monitored, identified and managed.

Arrangements were in place to make sure people received their medicines appropriately and safely.

People were protected from abuse and their human rights were upheld.

There were enough staff to meet people's needs and staff recruitment practices protected people from those who may cause them harm.

Is the service effective?

Good

The service was effective. People received care and treatment from staff who had received training and who were supported to meet people's needs.

People's rights were protected under the Mental Capacity Act (2005) because staff adhered to the legislation.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

People had access to health care professionals when they needed it. People were supported to attend health related appointments.

Is the service caring?

Good

The service was caring. People were supported by staff sensitively and patiently. They were treated with dignity and respect.

People were encouraged to be as independent as possible developing skills which reflected their lifestyle choices and future aspirations.

People were involved in the planning of their care. Staff had a good understanding of their communication needs and how to support them to express their views and needs.

Is the service responsive?

Good

The service was responsive. Records kept about people's care, support and treatment were kept secure and were kept up to date. Care plans were personalised and the care delivered was in line with people's care plans.

People were supported to take part in activities and social events of their choice. They were supported to maintain friendships.

People were involved in making decisions about their care and treatment.

There were arrangements in place for people to raise their complaints and concerns and to have these listened to, taken seriously and addressed.

Summary of findings

Is the service well-led?

Good

The service was well-led. The manager provided strong leadership and support to people who lived in the home and to the staff who cared for them.

People were encouraged to be involved in the running of the home.

There were established quality assurance systems in place which enabled the manager and provider to monitor the quality of care provided and drive improvements.

The manager and staff were open, willing to learn and worked collaboratively with each other and other professionals to ensure people's needs were met in the best possible way.

Harrington 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 29 June 2015 and was unannounced. It was carried out by two inspectors.

Before the inspection We looked at information forwarded to us by the service about significant events. We reviewed information shared with us by local commissioners.

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 to us.

We spoke with seven people who lived at Harrington House and six members of staff including a representative of the provider. We reviewed five people's care records which contained care plans, risk assessments, mental capacity assessments and best interest decisions. We also reviewed a selection of medicine administration records. We reviewed the recruitment records of two members of staff. We also reviewed a selection of records relating to the management of the service. These included a selection of policies and procedures, quality monitoring audits, staff training and staff competency records. We reviewed the current management actions plan and provider's quality monitoring report. We found the service's registration certificate was on display and the employer's liability insurance certificate was in date. We attended a meeting where staff going off duty handed over information to those coming on duty.

Good

Is the service safe?

Our findings

People, who were able, knew how to raise concerns or issues. They also said they would raise concerns on behalf of other people living in the home who were unable to express their views. A person described how concerns they raised with the provider had been dealt with. They said they "felt more secure" and that "staff had supported me". Another person told us "Staff tell me to be careful on the roads". They said they had talked to staff about staying safe when out and about in their local community. They had a mobile phone which they used to keep in touch with staff.

People were supported to keep their money and valuables safely. The manager confirmed one person who kept their own cash card knew not to share any confidential information with people.

Staff had received training in safeguarding people and knew how to recognise abuse and how to manage allegations of abuse. Staff were aware of how to share relevant information with external agencies who also had responsibility to protect people.

People were supported to take risks, enabling them to be as independent as they could be, whilst minimising any known hazards. A member of staff described "positive risk taking" for one person and how this had "allowed her to be herself, but be safe and happy". This had allowed this person to manage their own money and lead a more independent life without staff support. Risk assessments had been developed to highlight any known hazards. Strategies for each individual person had been developed and recorded about how to keep them safe and to prevent harm. Accidents and incidents were recorded and the manager confirmed they analysed these to assess for any trends or emerging themes. They would then make sure strategies were put in place to prevent these happening again or make referrals to other health care professionals. For example, after an increase in falls a referral for one person was made to the falls clinic and for a review of the equipment they used. Staff said, "Risks do not prevent people from developing independence."

Occasionally people became upset or anxious and staff needed to support them to manage their emotions. Clear guidance was provided about what upset people for example, a noisy environment or wanting to go out. Staff understood people well and knew how to help them to regain a sense of calm. Any incidents were recorded and monitored to assess whether strategies needed to be reviewed. Staff had completed the relevant training to manage such situations and were registered to complete further training recommended by the local placing authority. Staff confirmed they rarely used physical intervention.

People's medicines were managed safely. Medicines were securely stored and excessive stock was not kept. People received their medicines in private and they were dispensed directly from the medicines cupboard. This avoided unnecessary transportation of medicines around the home. People's medicine records were well maintained. All staff who administered medicines had completed training to be able to do this safely and to have an understanding of the medicines they were administering. Medicines were reviewed by health care professionals to ensure people were not taking unnecessary medicines or inappropriate doses.

People were protected from those who may not be suitable to care for them. Staff recruitment records demonstrated robust recruitment processes in place.

There were enough staff to meet people's needs. Extra staff were on duty on the day of the inspection so that people could be supported to go swimming. Staff told us this was a usual occurrence when community based activities were planned. Additional funding had been applied for in the case of one person in order for the staff to be able to provide additional one to one care. This person had complex needs and required additional time spent with them to ensure their safety. In order to keep the person safe the provider had already provided additional care hours prior to the outcome of the application.

Good

Is the service effective?

Our findings

People commented, "Staff looking after me are really good", "Staff are really good". One person told us they felt staff understood them and looked after them well.

People were supported by staff who had been trained to meet their needs. All staff had completed training in basic subjects which enabled them to carry out their role safely; mandatory training. For example, safe moving and handling, fire safety, infection control and nutrition. These trainings were regularly updated. The majority of staff held a recognised qualification in care such as the National Vocational Qualification (NVQ). This meant they had completed modules of study and been assessed in various areas of care. Several staff had also completed more specific training in relation to people's needs for example, management of epilepsy, dementia care, autism awareness and stroke care. Staff had also received regular one to one support (supervision) from the manager. The manager was also aware of and had plans to implement the new Care Certificate (a set of standards introduced to support all new care staff deliver care to a recognised standard). Existing staff were completing various competency/knowledge tests in order for the manager to identify gaps in knowledge and to plan staffs' future training.

The Care Quality Commission has the responsibility to monitor the implementation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). People's care records provided evidence of their capacity to make decisions about their care and support. A section entitled "How I make decisions" provided confirmation of their assessment in line with the MCA. Staff had completed training on the MCA and were able to describe how some people had fluctuating capacity to make choices. They had an understanding of the processes involved to ensure decisions made on people's behalf were done in their best interest and were made lawfully. A person had asked staff to "help me with more complicated decisions" and another person had said, "Explain things in a way I can understand". The manager was in the process of also improving this documentation. One person had appointed a lasting power of attorney to make decisions on their behalf should it be needed in respect of health and welfare. Evidence of who held what type of power of attorney was recorded. This ensured staff were aware of whom to involve and discuss people's care and treatment or their finances with.

Where appropriate the manager had made referrals to the local County Council to ensure people were not deprived of their liberty unlawfully. The manager took advice and guidance from the local County Council's MCA and DoLS team if she was unsure if a person's liberty was being deprived and a referral was needed.

People were supported to eat and drink and maintain a healthy nutritional intake. People said they chose what to have on the menu each week. A book provided a photographic prompt for people to help them make food choices. Easy read recipes had also been produced. Menus were displayed for people to see and to remind them what was on offer. People could have alternatives to the main menu if they wished. Staff said they shopped with the people from Harrington House on a daily basis for fresh items from local shops. People were helping to grow some vegetables and fruit. One person said they really enjoyed helping in the garden. People helped staff to produce their meals using some fresh ingredients. The manager explained people had been helped to understand what a healthy diet consisted of. If people had particular dietary needs these were highlighted in their care records. For example, one person was at risk of choking and needed their food to be cut up. They also used special crockery and utensils. They were observed using these at lunch and tea time.

For one person living with diabetes staff had purchased special jams, biscuits and substitute sugar. They successfully managed their diabetes through their diet. The manager confirmed staff had completed diabetes training. Another person enjoyed their coffee but could not remember how much they had already drunk. It was their choice to have staff remind them as the day went on. People chose to have their meals when they wanted them and where. One person liked to have their meal after others had finished theirs. People had access to drinks and snacks throughout the day.

People had health action plans and were supported to attend annual health checks. Any appointments with health care professionals were recorded and the outcome of the appointment was recorded to prompt staff and people to follow up when needed. People had individual

Good

Is the service effective?

hospital assessments providing information about their medical history and health care needs. These were ready to accompany them to hospital should they be needed. People had access to specific health checks when needed, for example, regular eye and foot care for people who were diabetic.

Good

Is the service caring?

Our findings

People amiably chatted with staff whilst working alongside each other in the kitchen. People had positive interactions with staff who treated them with kindness and sensitivity. Staff were patient responding to people's repetitive questions in a good-natured way. Staff were attentive to people's needs, for example offering to wipe their face gently when they had eaten or had a drink. Personal care and support was provided discreetly. A person told us, "Staff are really kind" and "Staff are really friendly and helpful".

People's personal histories and backgrounds had been explored with them when developing their new care plans. Staff said, "This increased our awareness and understanding of people." This process had also given people the opportunity to reflect on their aspirations and future goals.

People had been involved in developing their new care records. Part of this process included identifying "What people like and admire about me". Comments ranged from "my sense of humour" to "I am clean and tidy". A person told us, "My personal file is in the office, I have discussed my needs, my aims and my goals for the year." People had also identified routines important to them to help them remain calm and happy. Staff had a good understanding of these and were observed spending time with people who preferred to stay in their room encouraging them to use communal areas when others were out of the home.

People had communication profiles which explained how to interpret their behaviour and expressions. Staff used sign language, symbols and easy to read information to help people to express themselves. A person showed us their communication book and a personalised tool which used photographs and pictures to help them describe their needs and emotions. People were given time and space to express themselves, staff did not rush them supporting people at their own pace. When people were upset or anxious staff reassured them helping them to become calm by using distractions such as offering a drink or a walk.

People were encouraged to be independent. Taking responsibility for household tasks such as cooking, cleaning, washing up and setting tables. People were thoroughly engaged with these jobs taking pride in their duties. One person was being supported to develop the skills to help them move into their own home. Another person described how they went out to a local shop independently. People's care records clearly highlighted what they could do for themselves and what they needed help with.

People's spiritual and cultural beliefs were highlighted in their care records. Some people liked to go to a place of worship with their friends. Where people had preferences about the gender of staff providing their personal care these were respected. People were supported to maintain personal relationships and their privacy was valued. People had visitors at times to suit them and their individual routines.

People were supported to access local advocacy organisations. Information was displayed in the hall. People's care records also identified under what circumstances they would need an advocate, for instance when making decisions about moving from the home.

People were treated respectfully and with dignity. Staff had a good understanding of their needs and how to support them to manage their emotions. One person's care plans prompted staff to "get to know and respect who I am". Another person told us how staff supported them through a really difficult time and that staff had told them "You have been really brave." Staff prompted people how to behave and when not to "hug" strangers. They also guided people about appropriate manners in an encouraging way.

Good

Is the service responsive?

Our findings

People were involved in the planning and review of their care wherever they were able. Some people had signed their care records confirming their involvement. People told us they talked with their key workers (named member of staff) about their care needs. People's care records were personalised and identified how they wished to be supported with their personal care and support to develop life skills. Staff said, "People are put first" and "We support people individually". A section in the care plans, "All about Me" provided staff with information about people's backgrounds, history and interests.

One of the manager's key visions had been to introduce a "holistic approach to care". They said, "Care is often done to people and it's not always what they want". They explained people were only able to achieve their goals and aspirations if the support they received was truly tailored to their needs. In order to put this in to practice within an effective timescale the manager had persuaded the provider to invest in the help of a consultant. Their role had been to review the information held on each person, to carry out one to one sessions with people to learn about their life histories, what was important to them, what their aspirations and goals were, where their skills sat and to formulate personalised care plans from this. In this process the person was "seen as the expert on how they experience their health condition" and the care plans had to reflect that. This was still work in progress with some people. These care plans then directed staff and enabled them to identify what support the person really required and wanted to lead a better life.

For some people their routines were extremely important to them. There was evidence staff had been able to help one person to develop strategies to cope and adjust their routines so they did not impact on their lifestyle or well-being. For example, being able to wash and change their clothes each day without feeling a loss of control. Another person with memory problems wished staff to talk to them about their past rather than the here and now. Staff were observed using this strategy to engage with them and encourage them to socialise with other people. Some people liked to remain in their bedrooms and staff were observed checking on them at intervals throughout the day in order to prevent social isolation and to ensure they were okay.

People said they enjoyed a range of activities. They liked to go to social clubs to meet with friends and to the college to learn new skills. Some people needed the support of staff to access activities in their local community such as swimming or the gym. They had planned trips out for the day as well as holidays. People told us, "I like living here, I go trampolining and into town with the other residents and staff" and "Staff help me to keep up with my activities which helps me get out and about more". The manager had recognised that through some of the activities people had formed friendships with people over several years and it was important that they were supported to maintain these.

People were aware of how to raise issues or make a complaint. An easy to read complaints procedure, using plain English and pictures, was displayed in the hall. People said, "I talk to staff if I have a problem" and "If I had any problems I would talk to the manager or [name of person]". One person told us they had talked about concerns with staff and said "I feel more happier, it's really nice living here." Concerns had been raised by a relative who felt they had not been effectively communicated with regarding an aspect of their relative's care. This had been treated as a complaint by the manager, investigated and the relative spoken with. A plan of action to ensure better communication with the relative was put in place. A person who used the service had recorded their dissatisfaction in relation to a particular issue. The manager explained they had taken this seriously and had approached the person to see if they could resolve the issue. This resulted in adjustments being made which the person had been satisfied with.

Good

Is the service well-led?

Our findings

A member of staff explained that since the manager had been working in the home the atmosphere had been calmer. They said "People like her and we are encouraged to put our ideas forward."

The manager provided strong leadership in a quiet and inclusive manner. Staff felt encouraged and supported by her. The manager had skills and qualifications which enabled her to implement change and to support people psychologically. The manager's aim was to empower people to be more involved in decisions about their future. They said, "I do not work for (name of provider), I work for the people who live here". One of their key visions was to improve people's lives by supporting them to be as independent as possible and to move then forward as far as their capabilities would allow. They explained that goals and ultimate outcomes would vary for different people. They said for one person this could possibly lead to living independently and for another more support in their current setting for their complex needs. They explained their main challenge in doing this was a lack of external funding available to people.

The manager promoted this approach by having regular meetings with people who lived in the home and the staff. Where needed communication was tailored to an individual person's needs. A relatives meeting was planned but several relatives had been spoken with on a one to one basis. Regular one to one support sessions with staff helped the manager communicate their visions and values and identify what support staff needed to be able to put these in to practice. The manager told us they were very well supported by the provider's representative who visited the service on a very regular basis and who supported their aims and visions. Staff told us they felt confident in talking over concerns or issues with either the manager or provider representative. The provider's representative told us their close involvement with the service enabled them to have a good relationship with people who live in the home, the manager, staff and to monitor staff values and behaviours.

The manager told us they expected staff to be honest and transparent in all their dealings. Both the manager and provider's representative were aware of the new regulation under the Health and Social Care Act 2008; Duty of Candour where if mistakes are made these are openly admitted, discussed with the person involved and resolved.

The manager attended manager meetings within the provider's group where ideas and best practice were discussed. They were studying for advanced qualifications in leadership and had access to mentorship and supervision from people who were promoting and delivering current best practices. They had just completed a course provided by the local County Council which prepared managers for registration with the Care Quality Commission. Advice was at hand through the provider for staff employment and disciplinary issues.

The views of people and other interested parties were sought about the services provided. Questionnaires had recently been sent out to people who used the service, relatives and visiting professionals; in an appropriate format where needed. Eight out of 20 had so far been returned. We were told the feedback had been positive. This would be eventually collated with actions devised for making improvements to the service or to address specific ideas or comments. The plan was to also send questionnaires to staff. The manager told us the feedback and proposed actions would be shared with those who lived, visited and worked in the home.

Arrangements were in place to monitor the quality of care and service's provided. This was done by the manager through completion of various audits, checking of staffs' competencies, observation and by seeking feedback from people. The outcome of which was shared in a report to the provider's representative. The representative also carried out their own monitoring checks. Action plans were then devised by the manager and provider representative to address identified shortfalls or to plan improvements. These actions were signed off when completed by the provider representative. We saw examples of these.

The provider met the requirement for informing the Care Quality Commission about significant events that effect people who use the service.