The Brandon Trust

Alma Grove

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

The inspection took place on 16 March 2018 and was announced.

Alma Grove is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The provider is registered to accommodate up to four people living with learning disabilities. People were supported with personal care needs. At the time of our inspection four people were living at the service. Each person had needs relating to personal care and daily living.

Alma Grove is managed by The Brandon Trust, a national organisation that provides social and health care services.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 25 November 2015 we rated the service Good.

At this inspection on 16 March 2018 we found the service remained Good.

People received their medicines as prescribed and had regular access to healthcare professionals when needed. Medicines were ordered, stored and administered safely and in line with national guidance.

People were cared for by dedicated, attentive and enthusiastic staff. The care team were well trained and the registered manager and team leader ensured each individual remained up to date with the latest care standards. We saw during our observations people were happy and had access to recreation and activities important to them.

We were unable to speak to more than one person due to the nature of people's health conditions. However, we saw evidence people were happy, well cared for and had involvement from their relatives when they wanted it.

Where people's needs changed staff demonstrated a proactive and comprehensive response to enable them to adapt the service and their care strategies. This included working with the multidisciplinary healthcare team to coordinate holistic, individualised care.

Environment and fire safety management was comprehensive and the building was kept safe through

regular health and safety inspections. However timely action was not always taken in response to fire risk assessment recommendations. Not all areas of the home were consistently clean and free from dirt and dust. The registered manager said they would immediately implement improvements to address this.

The provider understood their responsibilities under the Mental Capacity Act (2005) and ensured they had consent before providing care. Where people's mental health needs increased, the care team had involved appropriate specialists and undertaken extensive additional training to make sure they could continue to deliver a high standard of care.

The service was well led. There were effective systems in place for governance and quality assurance, including information sharing and learning opportunities between managers and a rolling programme of audits. Staff told us they were well supported and had access to on-going, specialist training and development opportunities.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service deteriorated to requires improvement.

Staff had not acted on requirements from fire risk assessments and the provider did not provide recommended fire safety training. Not all areas of the home were cleaned regularly and there were areas of dust and dirt. Checklists for the first aid kit were ineffective and had not ensured the contents were regularly replaced.

Is the service effective?

Good

The service remained good.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Good

The service remained good.

Is the service well-led?

Good

The service remained good.

Alma Grove

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.

The comprehensive inspection took place on 16 March 2018. We gave the service 24 hours' notice of the inspection visit because the location was a small care home for adults who are often out during the day. We needed to be sure that they would be in.

A lead inspector, a second inspector and an expert-by-experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had a background in providing care for people with learning disabilities.

Before our inspection we looked at all of the information we held about the service. This included notifications from the provider. Notifications contain information about certain changes, events and incidents affecting the service or people who use it that providers are required to notify us about.

The provider had completed a Provider Information Return (PIR) in December 2017. The PIR is a form that asks providers to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection visit we spoke with one person who used the service. We spoke with the registered manager and care workers on duty. We also spoke with a clinical psychologist who was working with the care team to support a person. We observed how people were being cared for and supported.

We looked at the care records for two people who lived in the home and medicine administration records for all of the people living there. We also looked at the quality assurance systems and feedback from people using the service.

We looked at two staff recruitment files, records of staff training and supervisions, records of complaints and incidents and other documents relating to governance and quality assurance. We checked how medicines were managed and carried out a visual inspection of fire safety equipment, escape routes and emergency documentation.

At the end of the inspection we gave feedback to the registered manager. Following our inspection, the registered manager sent us additional information we had asked for.

Requires Improvement

Is the service safe?

Our findings

People's medicines continued to be managed in a safe way. Staff understood how to ensure people had their medicines as prescribed. They were able to tell us the route, method, dose and time of the administration of people's medicines.

People's medicines were stored safely and according to the manufacturer's recommendations. Staff completed records and obtained a receipt when unused medicines were returned to the dispensing pharmacy.

Staff recorded when people received their medicines. When people had taken their medicines, staff recorded this on medicine administration records (MARs). Each person's MARs were checked for their completeness. Records showed that staff completed the MARs and there were no gaps in them. People had PRN protocols in place to ensure people continued to receive their medicines safely when taking these medicines. PRN or 'as when' medicines were made available for people when this was required. People had medicine risk assessments that included the name of the medicines, any allergies to medicines and whether there were any issues related to the medicines that staff should be aware of.

The registered provider reviewed the quality of MARs. Audits of medicines helped to reduce the number of errors and staff administered medicines safely to people. We reviewed the medicine audits and found these had not found concerns in the administration of medicines.

The registered provider had a medicines policy, which provided staff with guidance on how to safely manage people's medicines. The policy detailed the safe processes to use for the administration, storage, disposal and ordering of medicines. The policy followed best practice guidance from the Royal Pharmaceutical Society: The handling of medicines in social care which provides advice and guidance for staff on medicine administration for people living in care homes.

People continued to be protected from risks associated with their health and well-being. Staff identified known risks and used this information in management plans. The risk management plans guided staff to manage those risks to keep people safe. Staff assessed all areas of people's lives, including health, mental health, mobility, eating and drinking and road safety needs. We saw examples were staff clearly recorded risks. For example, one person had a food intolerance and another person did not have road safety awareness. Each risk assessment detailed the risk and clear guidance for staff and the actions they should take to manage them.

There were enough suitably trained and qualified staff to provide safe care to people. The registered manager and team leader planned staffing levels to ensure people were cared for safely and had enough support to take part in activities important to them. We looked at the staff rota for the previous two months and saw there were no gaps in cover and night shifts were staffed by a sleep-in member of staff and an on-call individual. The provider operated a staff bank and the team leader ensured there were no unfilled shifts by using care staff from the bank in the event of sickness or holidays within the permanent team. Bank staff

had the same training as permanent staff and knew people well. The home had recently recruited to care staff positions.

The registered manager had adjusted the staff rota to accommodate individual needs. For example, one person preferred one to one time during the day and liked to be left alone at night and in the early morning. To accommodate this, the manager assessed the person for safety needs and adjusted staff rotas.

Staff managed fire safety in the home through bi-weekly fire drills, weekly fire alarm tests and by completing fire training. Each person had an up to date personal emergency evacuation plan that considered their mobility and level of understanding of an emergency. However, not all actions from previous fire risk assessments had been completed. For example, a fire risk assessment in May 2016 found there was no fire action notice by the alarm call point in the kitchen. This was not in place at the time of our inspection and the recommended review of the risk assessment should have taken place in May 2017 although there was no documented evidence of this. The fire risk assessment also found staff did not have practical fire extinguisher training. However, the provider did not offer this. Although actions from the last fire risk assessment had not all been completed, or were prevented by the provider's policies, staff had documented a good standard of local actions to maintain fire safety. For example, they had repaired upholstery to ensure it remained intact and completed more detailed personal emergency evacuation plans (PEEPS) after a simulated evacuation found one person did not respond to an alarm as expected.

Environmental safety was maintained by the local authority, who owned the building. We saw monthly health and safety assessments had been completed consistently and were up to date, with actions taken for maintenance.

Cleaning chemicals were stored in line with the Control of Substances Hazardous to Health (COSHH) Regulation (2002). This meant staff stored chemicals in locked cupboards and maintained a record of the items kept on site.

The home was generally clean on the day of our inspection but some areas needed more attention to detail. For example, there was ingrained dirt on the wall tiles in one bathroom and cobwebs on windows on the first-floor landing. We spoke with the registered manager about these at the time of our inspection. They addressed these immediately and said they would review cleaning checklists with staff to improve standards.

People were protected from the risk of abuse. Safeguarding training was mandatory for all staff and was up to date at the time of our inspection. Each member of staff was trained to complete safeguarding notifications and to contact the local escalation team if they had any safeguarding concerns. Staff had reduced the number of safeguarding alerts in the home in the previous two years by implementing strategies that helped them reduce risks to individuals. For example, one person liked to spend time outside and watch people and traffic go by. To reduce risks to the person whilst ensuring their independence, staff implemented discreet visual checks to periodically check on their safety.

The registered manager represented the home and the provider on a pan-London safeguarding board. This enabled them to share experiences and learning related to safeguarding with other managers and care teams as a learning strategy.

Staff had prepared quick grab cards for use in an emergency. This meant bank staff and emergency services had access to essential information to support people in an emergency. A first aid box was in situ and staff had up to date first aid training. In addition, they had documented weekly checks on the first aid kit.

However, we found each item in the box had expired. Some items, such as three bandages, had expired nine years previously, in 2009. This meant staff had not completed safety checklists accurately. The first aid box also contained body creams that had expired and were not labelled for an individual person.

There was evidence of documented health and safety checks, including for gas and electricity and hot water and water flushing tests. The home had last undergone a full Legionella assessment in October 2017. Legionella is a type of bacteria that can live in areas connected to a mains water supply but that is not used regularly. A check for this bacterium means the service manages the risk effectively.

The provider had procedures for recruiting new staff to make sure they were suitable. These included checks on their identity, eligibility to work in the United Kingdom, employment history and references from previous employers. The provider completed Disclosure and Barring Service checks and had a process for risk assessing staff who had criminal convictions. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. These assessments were discussed and agreed at senior management level to ensure people using the service were safe. All staff took part in an induction which included assessments of their competency and suitability.

The registered manager ensured applicants spent time with people who lived in the home. For example, after interviews each applicant met with people and spent recreational time with them in the communal areas of the home. The registered manager observed how applicants interacted with people and how they responded as part of the selection process to ensure they were suitable to work with people.

Good

Is the service effective?

Our findings

People's needs were assessed and staff provided care and support to meet those needs. Before living at the service people had an assessment of their needs. Assessments covered all aspects of the person's life. This included their abilities, areas in which they needed support, likes, dislikes, physical, mental and social care needs. People and their relatives were able to contribute to assessments and planning. This meant that people's views, opinions and wishes were taken into account in the development of their support plans.

Staff provided people with information in line with the NHS England Accessible Information Standard. For example, people had information presented to them that used symbols and signs and in an easy read format. The Accessible Information Standard makes sure that people with a disability or sensory loss are given information in a way they can understand.

The care team had worked with a speech and language therapist to review the nutrition and hydration needs of a person whose mental health needs had changed. This enabled staff to reduce the risk of choking and aspiration while preventing malnutrition and dehydration. The training and nutritional guidance prepared for staff was individualised to the person's needs and demonstrably aimed to maintain the person's independence and choices as much as possible. This included keeping eating and drinking enjoyable for the person.

Staff worked to specialist guidance issued by multidisciplinary teams about when to contact them for further assessments or changes in a person's condition they should be aware of. For example, the speech and language therapist instructed staff to contact them whenever they noticed specific changes in a person's eating and chewing habits.

The care team continued to work with community and professional partners to ensure people's needs and choices were met through the use of established standards and evidence-based guidance. Where a person's needs changed, staff readily engaged with appropriate teams to ensure their skills, knowledge and competencies were updated. This included a bespoke training programme delivered by an occupational therapist to help the care team continue to meet the needs of a person whose mental health deteriorated and became more complex. Training included standards and guidance from the College of Occupational Therapy, the British Psychological Society and the World Health Organisation measures of wellbeing.

Care staff used tools to assess pain, including for a person whose ability to communicate and express themselves was changing. This included visual and verbal tools and monitoring of pain behaviour.

Staff had completed bespoke dementia training delivered by a community learning disabilities and epilepsy specialist nurse and by a clinical psychologist. This helped them to provide care for a person who had developed dementia whilst living in the home. As the home did not routinely provide dementia care, staff undertook this training to enable them to continue to meet the person's needs and to ensure they did not need to find alternative accommodation for them. Following the training, care staff worked to an ongoing action plan to increase their ability to provide effective care. This included implementing fluid monitoring

charts and to monitor the person's mood to inform care planning with a psychologist. The theoretical elements of the training were evidence based using international research and understanding of dementia, it's progression and treatment.

People continued to be cared for by a staff team with the competencies and professional expertise to meet their individual needs. Staff recognised when additional or more advanced training would help them to better meet people's needs and the registered manager arranged this accordingly. For example, staff had undertaken training in 'specialist person management' that enabled them to plan care proactively rather than reactively. Staff told us this had helped to reduce people's anxiety and stress because they could anticipate and predict their moods and needs and plan in advance for this. All staff had completed training in Makaton and staff had developed a detailed understanding of the communication needs of each person.

Care staff delivered care only with the consent of each person. This was included in Mental Capacity Act (2005) training and included the promotion of each person's right to make individual choices. Staff understood the principles of best interests decision-making and included this in their daily support of people. In all cases staff delivered care and support based on least-restrictive options.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). All staff had up to date training in DoLS and followed the provider's policies to ensure each person's best interests were met.

Staff had worked with people to ensure their health needs and preferences were considered when planning services. This included a 'plan for life' that helped staff identify if a person was experiencing pain or another change in their condition that required referral to a clinician.

Each member of staff had completed an appraisal in the previous year. Staff we spoke with told us this was a useful process to reflect on their achievements and the registered manager supported them to identify development goals for the year ahead. The registered manager and team leader used a programme of ongoing professional development to support staff in documenting progress and supervision meetings and observations, which occurred at least monthly.

Each person had an individual one-page profile that included personal information to help staff provide effective care. This included details of how each person liked to be addressed and supported.

Staff provided a pictorial menu to help people contribute to meal planning and preparation. People could choose their own meals on the day or work with staff to plan ahead. Staff supported people to eat out at cafes and restaurants whenever they wanted and established routine meals in the home, such as Sunday lunch. This helped people to have scheduled sociable time together each week. Staff supported people to making grocery shopping lists and to choose healthier options when planning their meals and snacks as part of an overall focus on health promotion.

Staff recognised the balance between enabling people to make their own decisions and choices and providing support for healthier living. For example, one person did not like to eat whole fruit although their GP had recommended staff encourage them to do so. As an alternative staff found the person enjoyed fruit smoothies and prepared these using a range of fruits to support their health and tastes.

Good

Is the service caring?

Our findings

People were encouraged to provide their views on the quality of care they received. Surveys were in a format that people could understand using symbols and signs people could recognise. The survey was also available online so people could complete it with the support of staff if required.

The analysis from the survey showed that people were satisfied with the quality of care. We spoke with one person who said they were happy and satisfied with the care and support they received.

The care team had implemented a philosophy of care as part of their training to provide care to a person who had developed dementia. This supported the team to understand the person's changing mental health and to predict stressors for them. For example, the team identified they needed to provide an environment that was free from time pressures, expectations that could lead to the person feeling a sense of failure and a consistent approach to care. Care staff prioritised the happiness, comfort and security of the person without expecting them to learn new skills.

Staff recognised the deteriorating mental health of a person who had lived in the home for a long time had an emotional impact on other people. To ensure they remained happy and positive, the care team introduced dementia as a casual topic of discussion to acclimatise people to the subject. They discussed the condition with people to help them better understand why one of their friends was behaving out of character and unpredictably. Staff also ensured this made people feel safe and not distressed by the behaviour they witnessed.

People decided the level of involvement and interaction they wanted with family members, which staff respected. For example, some people liked to see their relatives on special occasions and another person wanted to see them more frequently. Staff maintained contact with family members at a frequency agreed by people and in line with their mental capacity. Staff supported people emotionally and recognised when some types of communication with relatives caused them distress. To address this, they worked with relatives to ensure contact was always in the best interests of the person.

From our observations and discussions with staff it was clear they understood people's needs and supported them to express themselves. In addition, staff had supported each person to complete a social profile that detailed how they liked to participate in the running of the home and the delivery of their care. The profiles also included details of how staff could support them by providing constructive practical guidance during daily routine tasks and when staff should offer to intervene with help.

The registered manager and team leader assessed how staff delivered care with compassion, kindness and dignity through observational supervision. They used criteria such as showing warmth and making appropriate eye contact to identify areas of good practice and where staff may be able to make improvements.

During our inspection we saw positive, friendly and caring interactions between staff and people who lived

there. Staff demonstrated their understanding of each person's routine and preferences. For example, they knew one person liked to take a bath with a drink at a specific time and helped them to prepare for this when they became anxious about the time.

We spoke with a health professional who told us they were pleased by the warmth and compassion staff had demonstrated during a training session to help them prepare more advanced care for a person. They said it was clear staff had each person's best interests at heart and that they genuinely cared for them. They also said the standard of care staff provided was thoughtful and focused on the person's long-term needs in addition to their immediate day to day needs.

Good

Is the service responsive?

Our findings

Each person had a care plan that was personalised to their individual needs. Care plans detailed people's needs and the support required to meet them. When people needed additional support with their personal hygiene needs this was recorded along with the support they needed to meet this need. Care plans also recorded the social activities people enjoyed doing. For example, one person enjoyed travelling on public transport, another person enjoyed listening to music and going to the library.

People were able to participate in activities they enjoyed and attended day activities in their local community. They took part in music and craft activities. Other people enjoyed going out in their local area to local shops and museums with the support of staff. Staff supported people to follow their own interests and participate in activities that were meaningful to them.

People had six monthly reviews of their needs to ensure their care was appropriate. We reviewed a person's care record that showed a recent change in their health. We saw that their care records were updated to reflect this significant change in their health. People's risk assessments were also updated. This meant that staff had accurate information about people to ensure that their individual needs were met.

The care team had been proactive in anticipating the changing needs of a person whose mental health was changing and showed signs of deteriorating. They carried out research on the person's existing mental health conditions and identified potential causes of their change in behaviour. To ensure they could continue to provide care to the person, the care team engaged with community mental health specialists. Staff had implemented new activities that helped to meet the person's needs and reduce their anxiety, including a 'rummage bag'. The care team had worked with an occupational therapist trainer to ensure this was a safe and appropriate resource to use for the person. This meant people were cared for by a team who had the skills, abilities and foresight to anticipate their changing needs and take proactive steps to meet them.

People in the home had lived there for over 20 years. Staff had built developed tested techniques and strategies to continually meet their individual needs and monitored this on a regular basis. For example, staff had asked each person if they still enjoyed living there and living with each other. This was part of a housing assessment pathway that staff could use to identify alternative accommodation if any person wanted to leave.

The care team were planning future modifications to the home to ensure the environment would remain accessible and homely for one person. This resulted from multidisciplinary care meetings in which the team identified the person would find it increasingly difficult to use stairs in the future. To plan for this the team had reviewed the layout of the home and planned to relocate the person to another bedroom on the ground floor of the home. This would ensure they continued to live in a familiar place with improved accessibility.

People received support from staff when they needed to attend healthcare appointments, including when they needed urgent or emergency care. This included the use of a 'hospital passport'. Staff ensured these

were kept up to date and took them with people when they attended hospital.

People had access to holidays and staff facilitated these safely with advance planning and risk assessments. People had travelled outside of the UK for holidays, which staff had fully escorted. Staff ensured each person was supported to go on holidays important to them that did not present risks to their health or well-being. For example, one person had wanted to go on a beach holiday but their health prevented them from travelling abroad. Instead staff researched a UK location that had the facilities they wanted and took the person there instead.

Staff had supported one person to apply for and obtain their first passport when they expressed a desire to go on holiday for the first time. One person enjoyed travelling on public transport and learning about it, which staff facilitated.

People had access to a furnished garden and the registered manager had employed a gardener to ensure this remained in good condition and safely accessible by people.

Staff reduced the risk of social isolation among people by supporting them to engage with local projects and organisations, such as bowling and snooker groups. As part of their work to ensure people were engaged with the community and local services, staff acquired a taxi service who had drivers trained to provide services to people living with learning disabilities. This enabled one person to maintain their independence as they were able to travel by taxi whenever they wanted, despite mobility issues that prevented them from using public transport.

Good

Is the service well-led?

Our findings

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was responsible for three other homes in the local area. We looked at how they managed their time and leadership capacity and found they spent time in the home at least every two days. A team leader was in post who led the home on a day to day basis.

People received a service that was monitored and reviewed. The registered provider strived to improve the service by completing a regular evaluation of the service. The registered manager monitored and reviewed the quality of care provided to people. The registered provider had a quality assurance programme. The quality assurance process gave staff the responsibility to audit the service to ensure it was of a good standard. For example, staff reviewed safeguarding records, safeguarding training and the arrangements for managing risk appropriately.

The quality of care records, quality of food and the home environment were also reviewed and monitored. We found the care records accurately reflected people's needs and recent changes in their care had been included in their care plans.

Each member of staff was required to review aspects of the service. Staff assessed whether the service was safe, effective, caring, responsive and well-led. As part of the review staff provided supporting evidence that reflected the judgements made. Following the staff audit an external manager reviewed the service and evidence and assessed the quality of the care provided. Records showed that the service provided a good standard of care and any actions planned following the review had been taken to resolve them.

The care team had worked closely with multidisciplinary colleagues to respond to the changing needs of a person who they knew well. The registered manager acknowledged that the person's deterioration had potential to impact the morale of staff. To address this, they ensured staff were able to support each other and to coordinate care together. In addition, the multidisciplinary team provided on-going support and the clinical psychologist offered to arrange a reflective debrief for the team to discuss their feelings and concerns.

The registered manager had implemented improved governance and quality assurance systems following a quality assessment from the provider. This included more frequent meetings with other managers to share learning and a bi-monthly quality inspection based on the fundamental standards of care. The registered manager used meetings with colleagues to review complaints, incidents, safeguarding issues and other areas of quality, care and compliance.

The Food Standards Agency rated the home as a maximum five stars in a January 2018 food hygiene

unannounced inspection.

The provider had an overarching vision and strategy, which staff were aware of and felt they contributed to. They described pride in helping people to fulfil their potential through daily support and encouragement. This was the key focus of staff, who described each person's happiness and outcomes as the most important role of the service.

Staff told us they felt supported by the registered manager and team leader and told us they were happy with their work-life balance.

Behavioural characteristics and values were part of the provider's care planning and staff supervisions and were a framework for care observations. This enabled the registered manager and team leader to assess care against the provider's quality standards and to provide support to staff within a quality framework.