Valeo Limited

Alpha House - Huddersfield

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 unannounced inspection of Alpha House took place on 6 November 2018. Alpha House 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. Alpha House accommodates three people with learning disabilities in one building. Two people live in shared accommodation whilst another has self-contained facilities within the building. There were three people using the service when we visited.

The service is in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At the last rating inspection in February 2016, the service was rated Good. At this inspection we found the service remained Good. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

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.

Staff understood their responsibility to report any concerns and were aware of the action to take if they suspected abuse had occurred. People were supported to manage their risks by staff who were aware of the need to protect people from avoidable harm. There were sufficient numbers of staff available to meet people's care and support needs. The provider recruited staff safely.

People received their medicines as prescribed. Medicine stocks tallied with those determined by the medication administration record. The environment was maintained and generally clean but some areas were in need of attention. Systems were in place to monitor infection control.

Staff had the skills and knowledge to carry out their roles and were supported by a system of induction, relevant training, one-to-one supervision and appraisals.

Staff understood their responsibilities under the Mental Capacity Act 2005. People's capacity had been assessed and when required best interest's meetings had been held and recorded.

People had a choice of meals and were supported to maintain a balanced diet in line with their choices, preferences and any healthcare needs. People's health was assessed and monitored. Staff took prompt action when they noticed any changes or decline in health. Staff worked closely with health professionals and followed guidance given to them to ensure people received safe and effective care.

Staff maintained people's dignity and encouraged choice and independence. Staff supported people to maintain friendships and relationships. People's friends and family could visit when they wanted and without restriction.

People were encouraged to follow their interests and develop daily living skills. There were a range of activities which took place within and outside the home.

Information about how to complain was displayed in the service. People and their relatives were asked their opinions of the service and responses were collated to form action plans. Staff meetings were held regularly and their feedback valued. Staff told us that they felt supported by the registered manager and that the service was a good place to work.

Audits were in place to monitor the quality of the service people received. The registered manager reviewed any recorded accident and incidents. These were analysed to identify any patterns or trends and plans were put in place to reduce the risk of them happening again in the future.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

Further information is in the detailed findings below.

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**

Alpha House - Huddersfield

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 inspection took place on 6 November 2018 and was unannounced. The inspection was undertaken by one adult social care inspector.

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 reviewed the PIR and other information we held about the service. This included feedback from the local authority and past reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with two staff members and the locality manager. We spent time observing how people were supported, as people required support to communicate. We looked at three care records and medicine administration records. We reviewed three staff members' recruitment, training and supervision records. We also checked records relating to the management of the service including quality audits and health and safety management records. We checked the building to ensure it was clean, hygienic and a safe place for people to live.

During our inspection, we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

At the last inspection we found the service was effective and awarded a rating of good. At this inspection we found the service remained good.

Due to the complex nature of people's conditions we were unable to hold conversations with individuals, but we did receive thumbs up gestures from people who used the service.

Staff we spoke with told us that they had received training on keeping people safe from abuse and avoidable harm and were able to give us examples of the different types of abuse. One member of staff we spoke with said, "If I suspected that anyone was being abused, I'd go to my line manager and report it. If I wasn't satisfied I would go to an external agency."

We saw that staff acted in an appropriate way to keep people safe and were knowledgeable about the potential risks to people. One member of care staff we spoke with told us that they assessed risks continually, and gave us examples of being aware of risks when supporting someone out in the community. They told us that people's risk assessments were fluid and needed to be updated whenever the need arose. We saw people's risk assessments were completed whenever there were changes in their circumstances, as well as, on a regular basis. This demonstrated that staff were aware of the risks that each person might be susceptible to.

People could be confident they were supported by staff who were appropriate to work within care because recruitment practices were safe. Potential new staff completed an application form and were subject to an interview. Following a successful interview, references were sought and Disclosure and Barring Service (DBS) checks were carried out. These checks helped to ascertain if applicants were suitable to work with people at risk. Staff confirmed they did not start work until recruitment checks had taken place. Staffing levels met the needs of people living at the home. Staff told us additional staff were in place to support various activities people chose to do. Staff told us they felt that staffing levels were appropriate to meet people's needs. We observed throughout the inspection visit that staff responded in a timely manner to people's request for support.

Staff were clear of their responsibilities for recording and reporting accidents and incidents. We saw the registered manager reviewed and signed off all accident and incidents reports and actions were put in place to prevent reoccurrence where possible.

Fire risk assessments, personal emergency evacuation plans (PEEPs) and safety checks were in place and monitored regularly. We saw the service regularly reviewed environmental risks and carried out safety checks and audits. Safety equipment was regularly checked, serviced at appropriate intervals and repaired when required. One staff member conducted the weekly fire alarm and emergency test during our inspection.

People received their medicines as prescribed and medicines were managed safely. Staff were trained and

their competency was assessed in the safe administration of medicines. There were protocols in place for 'as required' medicines so staff knew when to administer such medicines to people. We reviewed the medicine administration record (MAR) sheets and saw staff had signed them with no gaps. Appropriate codes were used where people had not taken their medicines, for example, where a person had refused their medicines or when people were away from the service.

Medicines were stored in a locked cabinet in the office and only staff had access to it. The room temperature was monitored to ensure the effectiveness of medicines were maintained. Unused medicines were returned to the pharmacist in line with the provider's procedure. The registered manager carried out regular checks and audits on medicine stocks to reduce the risk of misuse and to rectify any errors immediately, although the audit tool was basic. For example, it did not cross reference medicines stocks with administration records. We checked medicine stocks and they tallied with records. We discussed the medicines audit with the locality manager who committed to improving the robustness of the tool. We also noted the medicines cabinet and the carpet in the medicines room would benefit from cleaning. Again, the locality manager told us this would be actioned immediately.

The service had adequate procedures to reduce the risk of infection. Staff had received training in infection control and food hygiene. They knew to use personal protective equipment (PPE) where required, such as gloves and other items of clothing that protected them and people from the spread of infection. The service was clean and well maintained.

Good

Is the service effective?

Our findings

At the last inspection we found the service was effective and awarded a rating of good. At this inspection we found the service remained good.

The service assessed people's needs before they moved into the service. A staff member told us this enabled the service to establish what level of support people required and helped the service appropriately plan people's support. Care needs assessments covered people's physical, mental health, behaviour, medicine management, communication, nutrition, social activities and personal care needs. The staff member further explained that the service continued to assess people's needs on an on-going basis through observation and input from relatives and relevant professionals such as GP's.

Staff had received appropriate training and had the skills they required in order to meet people's needs. A staff member we spoke with told us, "We receive lots of training, we really value it." Another member of staff we spoke with said, "We have a lot of refresher training." The locality manager showed us meeting minutes where service policies and CQC key questions were discussed and resulted in a quiz. Staff told us they found this beneficial.

Staff told us they had regular supervision meetings and an annual appraisal with their line manager to support their development. A member of staff we spoke with told us, "We have regular supervision. We get a chance to share opinions, ideas, say how we feel and to set personal goals."

The home had systems in place to promote communication within the team. Handover meetings took place and a shift rota was in use outlining the staff on duty, the shift leader, tasks to be completed and who was delegated for tasks and supporting individuals with their care, appointments and activities. The home had a communication book in use where staff were informed of key changes within the service. This prompted them to refer to individuals care plans and risk assessments. Regular team meetings took place to keep staff updated on key issues within the service. Staff were expected to sign to say they had read and understood revised documentation, guidance and policies. Staff told us they felt well informed and worked well as a team.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 provider was working within the principles of the MCA. Staff had all been trained in the MCA and understood their responsibilities in enabling people to make their own decisions and respecting their choices. One staff member said, "It's so important to promote choice and independence." We saw that people's relatives and relevant professionals were involved in making best interest decisions for

people where it was established that the person was not capable of making that decision.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS protect the rights of people who may require their liberty restricted lawfully in order to protect them from harm. Where required, the registered manager submitted DoLS authorisation applications to the local authority and completed all necessary processes in line with the legal framework, to ensure they did not deprive people of their liberty unlawfully. At the time of our inspection, people were on DoLS and the conditions of authorisation were being met.

People's care plans included a health action plan which outlined their health needs and the support required. People had access to a GP, dentists and opticians. A detailed record was maintained of the outcome of appointments and any subsequent follow up. Each person had a hospital passport in place which outlined individual's needs and key people involved with individuals. This ensured key information was available in the event of a person needing a hospital admission. A member of staff said, "A bonus of people being here for a long time is that we, as staff, can see any minute changes and act quickly to make appropriate referrals or changes.

People's care plans outlined nutritional risks and the support they required with their meals. The menu plan was agreed with people. Staff were responsible for cooking the meal and people were encouraged to participate. They were aware of people's likes, dislikes, specialist diets and risks. Records were maintained of meals eaten and people who required it had their fluid and weight monitored.

Good

Is the service caring?

Our findings

Care staff we spoke with told us that not all of the people they supported were able to verbally communicate how they preferred to receive their care and support. A member of staff we spoke with told us that if people were unable to communicate verbally they used gestures and behaviours, which were well documented within their care plan.

People were supported by a consistent team of staff which ensured continuity and enabled people to get to know the staff. Observations reflected that people were comfortable and relaxed in staff's company. Each person was addressed using their preferred name. Staff were respectful to and immediately answered all the requests from people and fitted their own tasks around the needs of the people living at the home. Staff spoke to people in a kind and respectful manner and people responded well to this interaction. They recognised when people needed reassurance and provided this in a positive manner. There was a light friendly atmosphere, with positive engagement between staff and people.

Throughout the inspection we observed positive engagement between staff and the people they supported. Staff were kind, gentle, patient and engaging. They provided people with good eye contact and used appropriate touch to provide reassurance and encouragement.

Staff knew what made people happy and relaxed and how people expressed their distress. Staff provided people the comfort and reassurance they needed by following guidance stated in their support plans. For example, one person showed their distress or unhappiness by indicating toothache. Staff knew to pay attention to their needs and provide reassurance. One staff member told us, "As a staff team, we know people's likes and dislikes and the support plans detail them."

People's privacy and dignity was promoted. Staff were observed knocking on people's doors prior to entering. People's bedrooms were personalised and reflective of their likes and interests. Staff called people by their first names and were discreet when talking to people about their personal care.

The provider had policies, guidance and systems in place to promote people's confidentiality in line with the data protection act. The provider was aware of the General Data Protection Regulation (GDPR) and people's records were kept secure.

Good

Is the service responsive?

Our findings

At the last inspection we found the service was responsive and awarded a rating of good. At this inspection we found the service remained good.

An assessment was carried out prior to admission, to identify each person's support needs. Care plans were developed outlining how these needs were to be met. Involving people in this assessment helped to ensure support was planned to meet people's individual care preferences. Risk assessments had been completed and care plans were in place to make sure people stayed safe and well. We saw that care plans and risk assessments had been reviewed to make sure they were up-to-date. We saw that each person had a record of all interactions of care and support over a 24 hour period.

Each person had a person-centred plan which gave clear information about their background, histories, family, social networks, preferences, personalities, habits, qualities, likes, dislikes, their goals, routines, social and family support and what was important to them. For example, one person's care plan described the importance of their daily routines and that deviation from the routines may cause anxiety.

Activities were personalised and based on individual's interests. One member of staff told us how the staff team continued to work with people to maximise the activities people experienced. With support from staff it was clear that people were developing their skills and confidence. For example, one person regularly enjoyed bus journeys alone.

The registered provider had a policy and arrangements in place to deal with complaints. They provided information on the action people could take if they were not satisfied with the service being provided. There were no recent complaints recorded, although we did see appropriate mechanisms in place for timely investigation of any complaints received.

At the time of the inspection no one was receiving end of life care, however care plans contained information from people's families about people's end of life wishes.

From April 2016 all organisations that provide NHS care or adult social care are legally required to meet the requirements of the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information they can easily read or understand to support them to communicate effectively. Information about the service was available to people using large text where they had poor eyesight, and in an easy read format where appropriate. We saw that people's care plans, activities plan and the service's complaints procedure were available in pictorial, and easy read formats to make them more understandable to people.

Good

Is the service well-led?

Our findings

At the last inspection we found the service was well led and awarded a rating of good. At this inspection we found the service remained good.

There was a registered manager in place who managed staff who understood their roles and responsibilities in providing effective care to people. The registered manager complied with the requirements of their CQC registration including submitting notifications of significant events at their service. They also displayed the last CQC rating of the service at the home and on the provider's website. The registered manager was supported by senior care staff. The senior staff member we spoke with was experienced in delivering care and support to people, and providing direction to staff.

Since our last inspection changes had been made to the management structure. The registered manager was now also registered for another home within the organisation. One staff member said, "It means they are not here all the time, but the other home is local so it's not too bad."

The registered provider attempted to consult with people and their relatives about the service. We saw the most recent questionnaire from 2018 which had just been completed. Unfortunately, there had been no responses from relatives. However, the communication book and care plans showed regular contact, discussion and information sharing with relatives. The questionnaire for people was pictorial for ease of use and covered areas of the service such as, activities, safety, staff, complaints and the environment. The responses had been collated and were predominantly positive with people indicating their happiness with the service provided. The locality manager told us some areas of the questionnaire would be discussed with the registered manager to investigate and resolve, if possible. For example, one response stated the person wanted more hours.

Staff we spoke with told us the registered manager provided them with the support, leadership and direction they needed, although the staff questionnaire responses were mixed. Of the five staff responses, four rated support from the registered provider as poor. The locality manager told us they would investigate the reasons and themes behind the responses and an action plan would be devised to ensure change happened.

The registered manager regularly held meetings with the staff team to discuss issues regarding people's care and other matters relating to the running of the service. Staff told us meetings were also used as opportunities to receive support, discuss ideas and share learning. All the staff we spoke with demonstrated they understood their roles and responsibilities and the aims and objectives of the service.

A senior staff member informed us they worked closely with partner organisations to develop the service they provide. They told us how they attend meetings with the local and healthcare professionals to identify areas for improvement and care provision in the future.

Staff told us that they understood the whistle blowing policy and how to escalate concerns if they needed

to, via their management team, the local authority, or CQC. Prior to our visit there had been no whistle blowing notifications raised at the home.

A number of effective auditing systems were in place. This included dignity and respect, risk assessment, infection control, finance and care plans. There was also a comprehensive audit undertaken by an internal quality team. The internal quality audits focused on the Key Lines of Enquiry that we look at during an inspection.