Aspire Living Limited

# Aspire Living - 1-2 Markyes Close

## Inspection report

1-2 Markyes Close
Ross On Wye
Herefordshire
HR9 7BZ

Tel: 01989769035

Date of inspection visit:
29 June 2016

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27 July 2016

## Ratings

| Overall rating for this service | Good |
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|---|---|
| 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

1-2 Markyes Close is located in Ross-on-Wye, Herefordshire. The service provides accommodation and care for up to nine people with learning disabilities. On the day of our inspection, there were nine people living at the home.

The inspection took place on 29 June 2016 and was unannounced.

There was a registered manager at this home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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.

People's individual safety needs were known by staff and these were regularly reviewed. Consideration was given to ensuring people were safe, but also to promoting their freedom. There were sufficient staff to support people safely. People received their medicines from trained and competent staff. Staff provided explanations to people when supporting them with their medicines, and people's preferences were taken into account in the way they took their medicines.

People were supported to eat and drink, and meals were presented in a way which would be appetising and appealing for them. People were encouraged to make choices about their meals. People received specialist input from a range of health professionals to ensure that their health and wellbeing needs were met. Where people's liberty was restricted, this was done in accordance with the principles of the Mental Capacity Act.

People enjoyed positive relationships with staff and had their own keyworkers to support them with their communication needs and making their views known. People were involved in meetings about their care and support in ways which were inclusive for them. People had access to independent advocates to ensure they were involved in decisions about their care. People were treated with dignity and respect.

People's needs were assessed and reviewed to ensure they received all the support they needed. People were encouraged to set personal goals and were supported to achieve these. Staff knew people well and knew when people were unhappy and how to respond to them. Relatives and health professionals knew how to complain and make suggestions, and were confident their views would be acted upon by staff and the registered manager.

The registered manager created an inclusive atmosphere for people and staff and involved them in the running of the home. The registered manager encouraged staff to involve people in their local community. Staff felt supported in their roles and that the registered manager was approachable. The registered manager and provider carried out regular audits and quality assurance measures to ensure people received a high quality level of care. The registered manager and provider had values for the service, which were known and shared by the staff team.

## 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 is safe.

People's risk assessments were known and followed by staff. People's freedom was encouraged, whilst maintaining their safety. Staff knew how to recognise and report abuse or harm. People received their medicines safely and as prescribed by their GP.

### Is the service effective?

Good

The service is effective.

People were supported by staff who were subject to on-going and tailored training and development. People were supported with their eating and drinking needs and creative ways of making people's meals appetising and appealing were used. People were supported to maintain good health and had access to a range of specialist health professionals.

### Is the service caring?

Good

The service is caring.

People were involved in decisions about their care and support, and in ways which were inclusive for them. People enjoyed caring and respectful interactions with staff. People's individual communication needs were known and staff used a range of approaches to ensure people's views were heard.

### Is the service responsive?

Good

The service is responsive.

People's needs were assessed and were reviewed. Where there were changes to people's health and wellbeing, these were responded to. People were supported to set and achieve personal goals and aims. People enjoyed varied social and leisure opportunities. There was a system in place for capturing and responding to complaints, suggestions and feedback.

### Is the service well-led?

Good

The service is well-led.

The registered manager demonstrated an inclusive approach and sought to find ways of involving people in decisions about their home. Staff and relatives benefited from an approachable registered manager. The registered manager had established links with the local community for the benefit of people. Staff knew how to report abusive or unsafe practice, and were confident action would be taken.

# Aspire Living - 1-2 Markyes Close

**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.

We made an unannounced inspection on 29 June 2016. The inspection team consisted of one 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. This information helped us to focus our inspection.
We contacted the local authority before our inspection and asked them if they had any information to share with us about the care provided to people; they did not have any matters of concern.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required to send us by law about important incidents that have happened at the service.

We spent time with five people who lived at the home. We spoke with the registered manager, two senior staff members, three support staff and two relatives. We looked at three records about people's care, which included risk assessments, health information and guidance from health professionals, and capacity assessments.
We used the Short Observational Framework for Inspection (SOFI) because people were unable to communicate with us verbally, so we used different ways to communicate with people. SOFI is a specific way of observing care to help us understand the experience of people living at the home.

Good

# Is the service safe?

## Our findings

Due to the complex health needs of people living at the home, we were unable to ask people whether they felt safe, and what feeling safe meant to them. We looked at how staff kept people protected from avoidable harm and abuse. Staff told us they had received training about keeping people safe from harm and abuse and they knew about different types of abuse, and how to report these to the local authority. We saw that where staff had concerns about people's safety, these had been reported to the registered manager. Where appropriate, the registered manager had subsequently notified the local authority and the CQC.

We looked at how individual risks were managed. We saw that risks associated with people's individual care and support needs had been assessed, and that there were individual risk assessments in place in relation to areas such as mobility, road safety, choking and personal care. The risk assessments included information about particular areas staff should be vigilant of, and how best to support people. We saw that the risk assessments were kept under review and updated to reflect the most up to date position. For example, an occupational therapist had recently recommended a new hoist for a person. The risk assessment had been updated by the registered manager to say that staff were not to attempt to use the hoist until the occupational therapist had provided guidance on its use; staff we spoke with were aware the hoist could not be used at present. We also saw that where there was a high risk of harm to someone, action was taken to keep people safe. For example, one person was at risk when using the bath and as a result, a walk-in bath had been installed so that the person could bathe safely. Staff we spoke with were knowledgeable about people's individual risks and how to keep them safe. We looked at whether risk assessments took into account promoting people's freedom. We saw that one person had difficulties with road safety and had a health condition which caused sudden and unexpected falls, but they enjoyed visiting their family and going out socially. Staff had recently obtained a bus pass for the person and made sure that one member of staff accompanied them when going out so that they could enjoy their freedom, but remain safe. The registered manager told us that concerns had been raised about people using their kitchen area due to health and safety risks. The registered manager told us that they had reviewed this and were of the view this approach restricted people's freedom unnecessarily. The registered manager told staff that people should be able to access their kitchen, but with staff supervision and support where necessary. We saw that people were supported when using their kitchen area.

We spoke with the registered manager and senior staff about how they ensured there were sufficient staff to keep people safe and accompany people who needed staff support when in the community. We saw that staffing levels were determined according to the needs of people living in the home. On the day of our inspection, there were seven staff on duty. Staff told us that this was the usual number of staff, and that the staffing levels meant they could support people safely. One member of staff told us, "The staffing levels mean that we can spend time with people and support them properly. We don't have to rush them when we are helping them with their hoists. It means there is a relaxed atmosphere for people and that we don't end up making mistakes". We saw that there were sufficient staff to provide support to people on an individual basis where required, and people were able to go out and enjoy their freedom, with staff support. The registered manager told us that agency staff were used to cover shifts when staff members were on leave or

unwell, but that this was occasional and only agency staff known to the home were used. The registered manager told us, "There are some agency staff members who have being coming here for a long time, so it is like using our own staff". Staff members told us before they were allowed to start work, checks were completed to ensure they were safe to work with people. Staff told us references and checks with the Disclosure and Barring Service (DBS) were completed and once the provider was satisfied with the responses, they could start work. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people.

We looked at how people received their medicines. Due to people's difficulties with swallowing and the risk of choking, people's individual support needs had been assessed and staff supported people to take their medicines accordingly. For example, some people were assessed as needing assistance with swallowing medicines. People's tablets were given in lemon curd, jam, yoghurt or marshmallows, depending on their preference. We observed that staff explained to people the food contained medicine and they stayed with people to ensure the medicines had been safely swallowed. One person's medicine was in liquid form as this was the safest way for them to ingest it. We saw that one person had been assessed by a health professional as needing to sit in a specialised chair when they had their medicines, and for 20 minutes afterwards. We saw that staff ensured this medical guidance was followed, and they explained to the person the need for them to remain in the chair. We asked staff how they knew when people wanted or needed their 'as required' medicines. Staff knew the specific circumstances in which 'as required' medicines should be used. Staff told us that they looked for signs to suggest the person was in pain or discomfort. For example, one person's gel had been applied that day as the person had appeared stiff and uncomfortable in their movements that morning. Staff had all received medication training, and their on-going competency in this area was routinely checked by senior staff and the registered manager to ensure people received their medicines safely and as prescribed.

Good

# Is the service effective?

## Our findings

Due to people's complex health needs, they were not able to tell us whether they thought staff had the necessary skills and knowledge to support them. Relatives told us staff knew and understood people and were quick to refer to other health professionals when people were unwell. We observed that staff had the knowledge and skills to support people. For example, staff knew when people wanted food or drinks. Staff also recognised people's different emotional states, such as feeling distressed, and knew how best to support individuals.

Staff told us the induction and training they received enabled them to support people. Two new members of staff told us how useful the induction had been to understand the needs of people living at the home. One member of staff told us, "The moving and handling training was excellent. We got to experience being in a hoist and being moved so that we could experience what it is like for people". Another member of staff told us how important the medication training had been for them as they had not administered medicines before, and the training gave them the knowledge and skills to make them feel confident. Staff told us that they could request additional training where they felt this would make them more effective in their roles. One member of staff told us they had requested more training on epilepsy, and another member of staff told us they had requested training on diabetes as there were people living at the home with that condition and they wanted to be able to support them. Staff told us, and we saw that, they communicated regularly with each other. One member of staff told us, "It works so much better when everyone knows what they are doing and when they share information. We are lucky as that is how we all work, here".

We looked at how people were supported with eating and drinking and how a balanced diet was maintained. We saw that people's support needs in relation to eating and drinking were known by staff. Where people had difficulties with eating, drinking, and swallowing, people had been referred to Speech and Language Therapy (SaLT). Staff knew the SaLT recommendations for individuals and we saw that this information was in people's care plans and was followed by staff. We saw the registered manager had sourced some "Lush not Mush" moulds so that people who needed their food blended could have it remoulded into recognisable shapes. One person preferred their food to be blended and not moulded, so staff ensured this person's food was presented in the way which would be most appealing to them. We saw that people were offered as many choices as possible with their food and drink options. Staff had taken photographs of meals and used these as aids to ascertain people's views. Staff also used a tablet device to look at photographs of food to show people and see whether the foods appealed to them. We observed the lunchtime meal and saw that people were supported with their needs regarding eating and drinking. People were offered choices as to where they wanted to eat. For example, staff asked one person if they would prefer to sit next to the window. We observed that staff had time to support people and the meal was not rushed. Staff offered people hot and cold drinks throughout the course of the day and ensured people had enough to drink with their meal to help them to swallow their food.
People were weighed monthly to check whether anyone was at risk of being under or overweight. Where people's weight was in an unhealthy range, medical input had been sought from GPs and dieticians. Where there were concerns about people being at risk of malnutrition, food and fluid monitoring charts were in place and fortified foods were provided.

We found that people had access to healthcare professionals and were supported to maintain good health. People had their own monthly health recording books, which provided information for health professionals about areas such as sleep, appetite and mood. We saw that people were supported to access a range of health professionals, including occupational therapists, district nurses, chiropodists and psychiatrists.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA.

We looked at how the MCA was being implemented. Staff had a good understanding of the Act. One member of staff told us, "You can't just make decisions about that person, you have to involve them and people who are important in their lives". Where people lacked capacity to make certain decisions, meetings were held with the person, relatives and health professionals to ensure staff acted in that person's best interests. For example, we saw that a best interest meeting had been arranged for one person regarding medical tests a health professional needed to carry out. The person did not have the capacity to agree or disagree to this, but staff knew the person would be distressed by the procedure. The meeting was due to take place with the person, their family, staff and a health professional and an Independent Mental Capacity Advocate (IMCA). An IMCA is someone who helps people with communication difficulties make their views known and represents people when decisions are being made about them. Staff and the registered manager told us that IMCAs had previously been arranged for people. We saw people's care plans reflected this.

At the time of our inspection, every person living at 1-2 Markyes had been assessed in respect of their individual care and support arrangements and the registered manager had made DoLS applications accordingly. We reviewed a sample of these applications and saw that each application was specific to individuals' requirements. For example, one DoLS application was about a specialist chair and the need for the person to sit in it when eating and taking medicines, and another application was about a person not being able to leave the home unaccompanied. Staff we spoke with knew why DoLS applications had been made for people and were able to explain to us the individual reasons for the applications. The registered manager had implemented a tracking system for DoLS applications and authorisations so they could ensure people were not unlawfully being deprived of their liberty.

Good

# Is the service caring?

## Our findings

We observed that people enjoyed positive and caring interactions with staff, which was reflected in what relatives told us. One relative said, "[Person's name] Likes living there, likes the staff and is settled". Another relative told us they were always welcome to visit their relative and had been given the code to the door so that they could come and go freely. Staff we spoke with spoke enthusiastically and affectionately about the people they cared for. One member of staff told us, "I absolutely love it here. You spend all your time with people. It's not at all regimented. The staff here all really care about the people who live here and if something is wrong, we want to know what it is and how we can make life better". Another member of staff told us they had previously worked at the home as an agency staff member, but had decided to become a permanent member of staff. They told us, "It was always my favourite place to come as agency staff. The staff are so friendly, the atmosphere is great and the people who live here are really happy". We saw that staff knew how people liked to be addressed, whether that was by a nickname or a different name and they used these names when speaking to people. The bedrooms we saw were all personalised according to people's preferences. For example, one bedroom was themed on the football team the person supported. There was a keyworking system in place in the home. A keyworker is a member of staff who takes a lead role in working with a person to understand their preferences, changes in health, social and emotional needs, and in communicating with relatives and health professionals. Every person living at Markyes Close had two keyworkers. Keyworkers we spoke with had an in-depth knowledge of people. One member of staff told us, "I love keyworking, it is so rewarding".

We looked at how people were involved in decisions about their care. We saw examples of approaches used to involve people in meetings, such as care plan review meetings and best interest decision meetings. For example, the registered manager had introduced "Terms of Reference" boxes for people. We saw that these boxes were decorated to reflect people's interests, and contained items which were important to them. One box was designed like a tool box as the person was interested in DIY. Another box had a music theme and contained CDs the person liked. The boxes were used in review meetings so that the person would feel relaxed. The registered manager told us, "We use the boxes so that people can be present in the meeting and feel comfortable, rather than just taking the approach of there is no point in them being in the meeting. If we are talking about a person, I believe the person should be present".

Staff we spoke with told us about the importance of trying different communication methods with people, and spending time trying to get to know their preferences and views. One member of staff told us, "We never just say they can't understand. Here, we say let's try and find a way to help them to understand". Another member of staff told us, "We have to be creative and think of new approaches". Staff were able to explain to us how individuals expressed different emotions, such as discomfort or unhappiness. We saw this information was recorded in people's care plans and that new information was added when there were any changes to people's communication needs. Staff were able to explain to us the importance of independent advocates for people who needed assistance with making their views known. We saw that one person at the home currently had an independent advocate in place, and that an advocate was being arranged for another person.

Staff told us they promoted people's independence. We saw that people were encouraged to help with food preparation wherever possible. One person had made chocolate cornflake cakes with a member of staff in the kitchen, and we saw that some people had grown their own fruit and vegetables in the garden which were used in people's meals.

We saw that people's privacy and dignity were considered by staff, and people were treated with respect. For example, the registered manager told us that an occupational therapist had recommended reigns for one person to assist them with walking. Staff and the registered manager had tried these, but felt they were not dignified for the person when out in the community. Also, they appeared to cause the person distress. Therefore, these were no longer used. We saw that this information was reflected in the person's care plan. One member of staff told us, "We give people the respect and dignity they deserve. We don't write people off here just because they are unable to speak" The registered manager and the provider were the appointed dignity champions for the home. Their role included educating and informing staff about dignity and respect, and acting as a point of contact for people or staff if they had any concerns about people not being treated with dignity and respect.

Good

# Is the service responsive?

## Our findings

One person had recently moved into the home, and we looked at how their needs had been assessed and what consideration had been given to their interests, likes, dislikes and personal goals. We saw that an initial assessment had taken place with the registered manager, the person and the person's carer. The registered manager told us how important this was. They told us, "When [person's name] moved in, it meant we knew what was important to them and how we should support them". For example, the assessment explored how important it was for the person to eat their breakfast in their pyjamas, then get dressed afterwards. Any change to this routine would result in the person becoming distressed. Staff were aware of this and ensured they respected the person's routine.

We looked at how staff responded to people's changing health and wellbeing needs. During the course of our inspection, we saw that a senior member of staff contacted the district nurses regarding a concern staff had raised regarding one person and a sore area on their skin. Staff told us that they had concerns regarding another person's health, and they had discussed the concerns with each other and with senior staff. As a result, the person had been monitored over a period of three days so that a complete picture of changes to their health and behaviour could be established. Following this, medical attention had been sought and the changes to the person's health had been shared with the GP and used to inform which tests would be carried out. Staff told us how important it was to respond to people's needs and be alert to any changes. One member of staff told us," People here cannot tell us what is wrong. None of us ever presume or assume we know what is wrong. Instead, we have to investigate concerns thoroughly and rule things out". Another member of staff told us, "It is a process of continual learning for us. We have to adapt as people's needs change". We attended a handover meeting in the afternoon. A handover is a brief meeting at the end of one shift and the start of the next. We found that people's individual needs were communicated between staff, and discussions took place about changes to people's health and wellbeing needs and what action should be taken.

We looked at how people were encouraged to maintain hobbies and interests, as well as develop new interests and explore different social opportunities. We saw that scrapbooks were used and completed with the person and the keyworker so that relatives and health professionals could see what the person had achieved and been involved in. We looked at two of the scrapbooks and saw they contained photos of a recent trip to a safari park, and people enjoying a visit from a donkey and its owner. One relative told us how much their relative enjoyed the different social events at the home. They told us, "There were three Shetland ponies there recently, which [relative] absolutely loved. They have lots of different trips and holidays, and there was a magician and a singer there recently". Staff told us that they obtained people's views on different leisure opportunities through 'trial and error'- giving people different opportunities and choices and finding out what they liked and disliked. One member of staff told us, "We never use people's disabilities as an excuse not to take them out and try new things".

We found that keyworkers were encouraged by the registered manager to explore people's individual goals with them and look at achieving these. The registered manager and staff told us that these goals were reviewed in keyworkers' monthly meetings with the registered manager. We saw that one person had

wanted to grow some tomato plants, and that their plants were in the garden. Another person wanted to watch a Premier League football match. It had been agreed with the person that their keyworker would support them to attend a local football match first so that they could experience that and make sure they enjoyed the experience before attending a larger football ground.

We looked at how the provider managed complaints and encouraged feedback. Although no complaints had been received in the last 12 months, we saw that there was a complaints system in place. However, no information was visible in the home for people, relatives and health professionals about how to complain or voice any concerns. We raised this with the registered manager and they rectified this during our inspection. We looked at how people were supported to raise any concerns, or make suggestions. Staff and the registered manager told us the keyworking system meant that staff knew people's individual communication styles well enough to be able to identify if someone was unhappy and then explore the reasons for that. Relatives we spoke to told us they were confident their concerns and feedback would be acted upon. One relative told us they had not been contacted by staff recently regarding an issue their relative had. The relative told us that had they been consulted, they would have been able to provide important information. The relative told us they raised this with the registered manager and felt confident this would not happen again.

Good

# Is the service well-led?

## Our findings

We were unable to ask people whether they knew who the registered manager was. Pictures of all staff members were displayed for people, including the registered manager. During the course of our inspection, the registered manager spent time with people and we saw they knew people well .Staff told us the registered manager spent regular amounts of time working alongside care staff and spending time with people. We asked the registered manager how they and the provider involved people in the running of their home. The registered manager told us the keyworking system was used to involve and include people, but that they also used their own observations and time with people to try and establish their views. For example, the registered manager showed us plans they had for the development of the lounge area as they had observed people seemed unsettled by the constant stream of staff and different visitors using the area as a way of reaching other rooms in the home.

Staff told us they felt supported in their roles by the registered manager and provider. One member of staff told us, "The manager is very helpful, and very knowledgeable." Another member of staff told us, "They are very approachable and I feel I could ask [registered manager] anything". Staff were also positive about the ways in which they were involved in the running of the home, and were able to make suggestions. One member of staff told us, "The staff meetings are really helpful. We discuss improvements we could make, and changes. Everyone gets heard. It builds a stronger team". We found the registered manager had made changes in the running of the home as a result of feedback from staff, and health professionals. We saw there was a designated medication room for staff. Staff told us that previously, medicines were kept in the office, which meant they were often distracted by phone calls and by people coming in and out of the room. The registered manager had listened to staff feedback and had implemented a medication room. Staff we spoke with were positive about this change. One member of staff told us, "It is so much better for everyone". Another member of staff told us, "It's all progressing forward with the new manager". We also saw that the registered manager had acted on feedback from health professionals, who had commented that they wanted separate and readily accessible medical information about people. As a result, the registered manager had introduced separate monthly books for people which contained health information and recorded any changes or concerns. Relatives we spoke with were positive about the changes the registered manager had made since joining the home. One relative told us, "They have really improved the home for people. There is a real homely atmosphere now, and people are offered lots of different opportunities".

The registered manager told us that the values of the service were to "provide person-centred care and make sure people are at the centre of everything we do". We spoke with staff who were aware of the values of the service and told us they were shared by the staff team. One member of staff told us, "Person- centred care was the main theme throughout all our induction training, and it is something which is reinforced in our staff meetings and 1:1 meetings". We saw this approach to people in our observations, and it was reflected by what relatives told us.

We looked at how the registered manager and provider monitored the quality of care provided to people, and how they ensured that people's safety, wellbeing and health were maintained. We saw that the registered manager carried out monthly audits in areas such as medicines, health and safety and people's

monies. The audits were used to identify any concerns. Where concerns were identified, we saw that these were addressed. For example, a fire safety audit had shown that the home's fire alarm system was not fit for purpose. The registered manager had discussed their concerns with the provider, and we saw that a new system had been installed. The registered manager and provider also carried out monthly reviews of any accidents and incidents in the home. This information was used to look at whether people's safety needs were being met, and whether additional support was required. The registered manager had been in their post for a period of six months and so had not yet carried out any annual questionnaires to ascertain the views of people, relatives, staff and health professionals. However, we saw there was a plan to implement these.

Since starting their role, the registered manager told us they had encouraged staff to establish links with the local community to promote social inclusion for people. We saw that two people had recently been supported by their keyworkers to apply for bus basses, and they were supported to use public transport rather than the home's own mini-bus. The registered manager told us, "When I started here, people were not part of their local community. Now, one person has joined the library, two people use public transport and people attend the community centre". On the day of our inspection, people were supported to go out into their local community.

Staff were aware of the provider's whistleblowing policy and the procedure to follow if they had any concerns, including any concerns about the registered manager or provider. This meant that there was a forum for staff to report any matters of concern. Staff told us they were confident that action would be taken in the event they reported any unsafe or abusive practice.