Innovation Care Limited

Prospect House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This was an unannounced inspection which took place on the 25 and 26 October 2016. Prospect House provides accommodation and personal care for up to nine people with a learning disability mental health needs and a sensory or physical disability.

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. The registered manager also managed another home owned by the provider in Herefordshire and divided their time between the two homes.

People had not been protected against the risks of employing unsuitable staff. Safe recruitment and selection procedures had not been followed. Staff had not received mental health training so they could effectively meet the needs of people diagnosed with this condition. Staff did not receive on going individual support to enable them to reflect on their roles and responsibilities. Quality assurance records were not available to evidence consultation with people or the support provided from the provider to the manager. The statement of purpose did not reflect all the needs of people currently living in the home.

People's care and support was individualised and monitored to make sure care records reflected any changes in their health or wellbeing. People had appointments with health care professionals and staff implemented their recommendations to keep people safe and well. People were supported to have a healthy diet and their medicines were managed satisfactorily. People's rights were upheld and staff understood their responsibilities to recognise and report abuse. People were encouraged to make decisions about their day to day lives in line with the Mental Capacity Act 2005. If needed best interests' decisions were made on their behalf involving people important to them. When deprivation of liberty safeguards were needed, the least restrictive practice was implemented and authorisations granted to keep people safe.

People enjoyed a range of meaningful activities which reflected their lifestyle choices and preferences. People used local facilities such as places of worship, the gym, the swimming pool and shops. There were opportunities to volunteer and attend college. People said they looked forward to special events which they shared with families and friends. They also liked to go on holiday in this country and abroad. People had positive relationships with staff and managers. They were relaxed in their company sharing light hearted

banter. They were treated with kindness and reassured when needed. Staff understood people well.

People talked to staff and managers about any problems or concerns. Their feedback had resulted in the kitchen being refurbished. Quality assurance systems monitored the environment and health and safety checks were carried out. Staff were confident any concerns raised under whistle blowing would be listened to and action taken as needed. They had access to training considered mandatory by the provider such as safeguarding, food hygiene, fire and first aid. The registered manager and staff said "We are like one big family" and "We are like a family."

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009 (Part 4). You can see what action we told the provider to take at the back of the full version of the report.

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 was not always safe. People were potentially put at risk of inappropriate care due to poor recruitment and selection checks.

People were supported by enough staff to meet their needs.

People's rights were upheld and systems were in place to reduce any risks to their safety or wellbeing.

People's medicines were administered safely.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not always receive the training they needed related to people's specific needs. Staff support through individual and team meetings was inconsistent.

People's capacity to consent was considered in line with the Mental Capacity Act 2005. Deprivation of liberty authorisations were in place for people deprived of their liberty to keep them safe.

People were supported to stay healthy and well through access to health care professionals. Their nutritional needs had been assessed and a balanced diet provided.

Is the service caring?

Good

The service was caring. People had positive relationships with staff and were treated with kindness and understanding.

People had access to advocacy services and kept in touch with those people important to them.

People were encouraged to be independent. People were supported at the end of their lives with dignity and respect.

Is the service responsive?

Good

The service was responsive. People's care reflected their

assessed needs, their likes and dislikes and routines important to them.

People took part in meaningful activities based on their interests and lifestyle choices.

People had a variety of ways in which they could express concerns. They were listened to and action had been taken in response to any problems they had.

Is the service well-led?

Requires Improvement

The service was not always well-led. The statement of purpose did not include information about all the service user types currently receiving a service. Quality assurance systems were not robust.

Improvements had been made in response to feedback by people.

The registered manager was accessible and approachable. Staff were confident about raising concerns.

Prospect House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 25 and 26 October 2016 and was unannounced. One inspector carried out this inspection. 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 also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

As part of this inspection we spoke with eight people using the service. We spoke with the registered manager, the acting deputy manager, four care staff and joined staff at a handover between shifts. We reviewed the care records for three people including their medicines records. We also looked at the recruitment records for two staff, three additional staff files, staff training records, complaints, accident and incident records and health and safety systems. We observed the care and support being provided to people. We used the Short Observational Framework (SOFI) for inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We contacted four health and social care professionals for feedback and spoke with commissioners from the local authority.

Requires Improvement

Our findings

People were potentially put at risk of receiving inappropriate care and support due to poor recruitment and selection procedures. Two new staff had been appointed without having checks made about their character and fitness to carry out their work. References had not been sent out in line with the provider's recruitment processes to verify why people had left previous employment and to assess their character, skills and knowledge. Applicants had supplied copies of their Disclosure and Barring Service (DBS) check and a record summarised the dates DBS checks had been received. A DBS check lists spent and unspent convictions, cautions, reprimands, plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. We shared a checklist of information to be kept for each new member of staff in relation to their DBS check and the acting deputy manager put this in place. Proof of people's identity, although checked, had not been evidenced in their recruitment records. Recruitment procedures did not ensure that all the relevant checks had been completed or recorded to evidence 'fit and proper' staff had been appointed.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Application forms provided a full employment history and confirmation of training which had been completed. Staff worked in the home once a satisfactory DBS check had been received. New staff confirmed they shadowed staff until they felt confident to work unsupervised. An induction programme was in place.

People were supported by enough staff to meet their needs. Staff said levels were flexible according to people's individual needs and the minimum of three staff could rise to five if needed. They also said the registered manager and acting deputy manager were always on hand if needed to help out. Systems were in place to support staff out of normal working hours. Staff said the core team had worked with people for a considerable time and their knowledge and understanding of people provided consistency and continuity. Staff had confidence if they had any concerns about the practice of colleagues they would be listened to and the appropriate action would be taken by management. The registered manager described how poor performance was dealt with and how staff were supported through training or supervision to reflect on their knowledge and practice. For example, additional medicines training would be offered if medicines errors were found.

People's rights were upheld. They were supported by staff who had a good understanding of their roles and responsibilities in relation to recognising abuse and raising concerns when necessary. Staff had completed

training in the safeguarding of adults. Safeguarding information was available including a copy of the Department of Health's safeguarding guidance, 'No Secrets'. The safeguarding policy and procedure did not provide any specific information about local safeguarding contact details or contact details of other organisations who should be contacted (such as the police). This was updated during the inspection. The registered manager described how they had raised a safeguarding alert on behalf of people living in the home when there were concerns about their safety. They had informed the Care Quality Commission (CQC).

People were advised about how to stay safe in their home and local community. Each person had a key fob with contact details about the local safeguarding authority. They had keys to their rooms to make sure their possessions were kept securely. People who were unsafe in the community on their own were supported by staff. The front door had an alarm fitted to alert staff if people, at risk if unsupervised outside of the home, had left the house. When people were at risk of taking goods without paying for them in shops they were monitored closely by staff. The registered manager described how the local police had visited the home to talk with people about their personal safety and the consequences of shop lifting. People had been supported to deal with the impact of one person's behaviour and staff described the actions they had taken to keep people safe. People's finances were monitored and audited to ensure balances were correct. Receipts were kept for any transactions and records were maintained.

People's safety within their home was assessed and any hazards had been minimised to keep them safe. For example, each person had a personal evacuation plan should they need to leave the house in an emergency. A summary of these was kept at the front of the house for easy access for emergency services. Risk assessments described how other hazards were minimised such as the use of the kitchen, going out with or without staff support and taking part in activities. Staff described how they worked with health care professionals when they had concerns about risks to people's health such as choking or moving and assisting. Staff followed guidance provided by speech and language therapists to reduce the risk of choking by ensuring food and drinks were of the correct consistency. Equipment had been provided for moving and assisting people such as a hoist and sliding sheets. Staff had been given training and guidance about the correct use of these. When people had been assessed as at risk of developing pressure ulcers they had been provided with an air mattress and staff monitored the condition of their skin closely, applying creams as prescribed.

People had accidents and incidents occasionally. These were recorded and monitored to assess if any trends had developed which needed attention or action to minimise risks to people. For example, an alarm had been fitted to the front door to alert staff if a person decided to leave the house. Staff were completing training in positive behaviour management and there was evidence they used distraction and diversion effectively to help people to become calmer, when they were upset or anxious. Monitoring records were used to assess any changes in people's wellbeing or any risks they faced.

People's medicines were administered safely. Each person had their medicines in a locked cabinet in their bedroom. One person told us they preferred to have their medicines in their bedroom and not from a medicines trolley in the dining room. They listed the medicines they took and said they liked staff to help them to take them. Another person had their medicines with their food. This had been advised by a health care professional and records confirmed this was done in their best interests. Staff had completed training in the safe administration of medicines. Their practice had been observed and they had completed questionnaires to check their knowledge. Medicine administration records (MAR) had been completed satisfactorily. Stock records had been maintained on this record. A member of staff had responsibility for checking medicines each week and following up any issues. This had been a recommendation from an inspection by their supplying pharmacy.

Requires Improvement

Our findings

People who had mental health needs were not supported by staff who had completed training specific to their needs. Staff had not done training in mental health or Schizophrenia which would help them to support and understand the needs of people who had moved into the home with these conditions. The registered manager said some training had been provided when a person with an acquired brain injury moved into the home but this person has since moved out because they were unable to meet their needs. Other people had recently been admitted whose primary needs were mental health. Staff confirmed they did not have the knowledge and understanding of mental health which they felt would equip them to support people effectively and to be able to respond to their individual needs. For example, what staff should do if the person's mental health deteriorated or if they had a crisis.

People were assisted by staff who had not been effectively supported in their roles. The acting deputy manager said meetings were scheduled with senior staff to discuss their roles and responsibilities. However the schedule could not be found during the inspection. Most staff had received two individual meetings (supervisions) with senior staff in 2016 and another meeting was being scheduled for November 2016 for all staff. Preliminary meeting forms had been sent to staff to complete in advance of this meeting. These gave staff the opportunity to rate their performance and reflect on their training needs. The registered manager said staff meetings were arranged and provided minutes of a meeting in July 2016. Staff did not receive levels of supervision or support to help them to carry out their roles and responsibilities. This could potentially impact on the care delivered to people living in the home.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff confirmed they had completed the care certificate and would then move onto the diploma in health and social care at level two. Staff told us they had completed refresher training when needed as well as some training specific to people's needs such as epilepsy and autism awareness. Staff who had been given key responsibility for certain tasks had been provided with training to equip them with the skills they needed before taking these roles on. For example, a member of staff had completed health and safety training before carrying out health and safety checks.

People were supported to make decisions about their care and support in line with the Mental Capacity Act 2005 (MCA). The 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. There was some inconsistency in the assessment of people's capacity to make decisions for themselves and a variety of different forms were in use. We discussed with the registered manager and the acting deputy manager the most effective method of recording people's capacity to make choices about their care and support and linking these with best interests decisions. It was evident people were making choices about their day to day care such as how to spend their time and what to eat or drink. The acting deputy manager discussed instances when people usually able to make decisions about their care and support might need help and guidance due to being unwell physically or mentally. They said this would be recorded and reflected in care plans and risk assessments. People had access to advocates if needed to help them with larger decisions such as moving home or hospital treatment.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Authorisations had been granted by the local authority and reviewed when needed. CQC had been notified when authorisations had been granted. The registered manager described how they looked for the least restrictive option when people's liberty was deprived. For example, using alarms instead of locking doors. People and those important to them were supported to make decisions about the support they received at the end of their life, if this was appropriate. Any "do not attempt resuscitation" (DNAR) orders had been signed by their GP and had been put in place in their best interests.

People who became unhappy or anxious were supported to manage their emotions. Clear guidance was in place, discussed with health care professionals, about the most effective way to support people when upset. Staff spoke confidently about how they used distraction and diversion techniques such as giving space, playing music or offering alternative activities. They were observed doing this during the inspection and people responded positively re-engaging with people and staff. Staff confirmed they did not use physical intervention.

People's nutritional needs had been considered and their care plans detailed their specific requirements. For example, one person needed to have their food pureed and drinks thickened. This was observed being done. They were involved in choosing the menu which reflected a balance of freshly prepared healthy meals with people's choices of "sausage or fish and chips". People were observed being offered a choice of meals, alternatives were always available. Good use was made of easy to read menus and recipes, using pictures and photographs, so people could make an informed choice about their preferences. People also enjoyed going out for meals and snacks. People were observed having drinks and snacks including fresh fruit whenever they wanted. Their weights were monitored and people at risk of malnutrition had access to milkshakes and fortified drinks to maintain their weight.

People's health and wellbeing was maintained through access to a range of health care professionals. Staff said they worked closely with the GP, community nurses and local health care professionals. Each person had a health action plan which provided an overview of their past and present health and medical needs. They also had a hospital assessment which provided a summary of their health, medical and communication needs which was available in case of emergency admission to hospital. There was evidence people's health care needs were being responded to appropriately. For examples, referrals were made to mental health professionals where there were concerns about changes in their mental wellbeing. Staff described how one person had been supported to manage their health appointments. They were encouraged to make their own appointments and attended these at times which suited them.

Good

Our findings

People were treated with kindness and compassion. They told us staff were "nice", "ok" and "good fun". People were observed positively interacting with staff, chatting amiably with them and sharing light hearted moments. Staff understood people well and knew how to soothe any anxieties or worries people might have offering them reassurance when needed. Distraction was used to help people become calmer using activities or resources they enjoyed. Staff commented, "We are like a family" and "We are here for the guys, they are really happy." Comments from relatives to the provider confirmed, "Staff are absolutely fantastic" and "The care at Prospect House is fantastic."

People's human rights were promoted. People were supported by their preferred gender of staff with their personal care. Each person's religious beliefs had been recorded in their care records and staff supported them to attend places of worship when they wished. People's right to a family life was respected and people were supported to keep in touch with those important to them either through visits, telephone calls or social events. Staff described how they made travel arrangements for one person to visit their relatives who lived some distance away. They co-ordinated these visits with a day trip for other people living in the home. People's personal information was kept securely and confidentially. Care records kept electronically were accessed by staff with individual passwords maintaining their security.

People's disabilities and conditions had been considered when planning their care and support. For example, one person had routines they liked to go through before eating, these were respected by staff and the person was not rushed. A stair lift had been provided for a person so they could remain in the bedroom they preferred. Another person needed support to access the community and facilities which provided access for people with a physical disability had been sourced including holiday accommodation which provided hoists.

People's personal histories provided staff with information about their life experiences and routines really important to them. People were supported to be as independent as possible in their day to day lives. For instance, arranging appointments with health care professionals, helping with chores around the home and deciding how to spend their time. Good use was made of easy to read material around the home to make sure information was accessible and could be understood. These documents used photographs and pictures to illustrate the text. They included the service user guide which described the services people received, menu plans and the staff rota. People had access to advocacy services when they needed them.

People were asked for their views about their care and support. They were observed talking with staff about

their day to day activities and planning future appointments and social engagements. The provider information return (PIR) stated, "Care plans are written in a person centred way to allow and encourage service users to undertake as much responsibility for themselves." People were encouraged to express their views about their care and support. They were observed questioning staff, being listened to and responded to appropriately.

People's dignity and privacy were respected. People had keys to their rooms which they were encouraged to take responsibility for. People were observed choosing where to spend their time; in the company of other people living in the home, in the garden or in their own rooms. Staff had completed training "which promotes dignity and respect" and were observed putting this into practice. Observation of staff during a handover confirmed they spoke about people professionally and politely. The PIR quoted comments from a relative; "Could not have wished for better care and support for [name]. The respect and dignity given her and the family could not have been better."

People were supported to prepare plans for the end of their life if this was appropriate. The registered manager described how a person, at the end of their life, had remained living at the home with the support of health care professionals. Plans had been put in place with their relatives to reflect their personal choices and wishes. Staff had supported other people living at the home to cope with their grief and held a memorial service at the home for those who did not wish to attend the funeral. Parents of the person commented about the "wonderful treatment" provided by staff.

Good

Our findings

People's care reflected their individual needs, aspirations and wishes for the future. Each person's needs had been assessed prior to moving into the home to make sure their care and support could be provided. The provider information return (PIR) stated, "As far as possible service users attend and contribute to the planning of their care. They are encouraged initially with a pictorial guide during an initial assessment." A person told us they talked with staff about their care records. We looked at one person's care plans which had been produced in an easy to read version using pictures and photographs to illustrate the text. People's care records were kept electronically and in a paper version. The paper versions had not all been kept up to date but changes had been made to the electronic records. Staff confirmed they worked with the electronic records updating daily records throughout their shift and making any changes to care records as they happened. People and those important to them were involved in formal reviews of their care.

People were encouraged to talk with staff about how they would like to live their lives. They had a relaxed relationship with staff openly talking about how they wished to spend their day or plans for the future. For example, going out shopping, getting ready for a social club or planning holidays for next year. People's learning support plans reflected these hopes and aspirations. The PIR stated, "Learning support plans are developed to assist, monitor and record outcomes of specific requests of learning or desires." People told us they had achieved their goals such as going on an aeroplane, going to concerts and having a job.

People's changing needs were monitored and action taken if needed to involve health care professionals. Staff said they sought the advice and guidance of health care professionals and incorporated their recommendations into peoples' care records. For example, ways of supporting a person to prevent them from choking and using equipment to support people with their moving and assistance needs. Staff said they communicated well as a team and any changes in people's needs were passed on ensuring a consistent approach.

People had access to a range of meaningful activities which reflected their interests and promoted community involvement. One person had a voluntary job helping at a local animal feeds outlet and others went to the local college. Social events were planned locally including using a gym, swimming pool, the cinema and classes such as Zumba and arts and crafts. The PIR stated, "Functions are organised within the wider community so as not to segregate the service users." The acting deputy manager described how people had formed their own social relationships at a pub they regularly used, enjoying spending time with other people using the facilities rather than staff. People were planning their Christmas party at a golf club to which family, friends and staff were invited.

A person told us, "I like it here, it's my home and we do lots of activities." Staff commented, "People have the freedom to do what they want to do" and "They bring up what they want to do and we try and arrange it." A relative told the provider, "They are never there, always out with clients, taking them on holiday or activities. Going out all the time." During the inspection people took part in horse carriage riding, box fit (fitness based on boxing), shopping, arts and craft and helped around their home. One person had responsibility for taking care of chickens in the garden. Another person enjoyed playing the drums and singing as well as doing live performances. Two people enjoyed trampolining and had taken part in a national event winning gold medals.

People knew how to raise concerns and said they would talk with staff if they had any issues. Each person had a copy of the complaints procedure in the service user guide and a copy was displayed in the home. People also attended house meetings when they could raise any concerns. In addition people met with their key workers to review their care and could also talk through any problems they might have. The registered manager shared with us complaints they had received from people living in the home and a meeting held to discuss these concerns with parents and a social worker. Robust records had been kept of the investigations and responses as well as the action taken.

Requires Improvement

Our findings

The primary needs of new people who had moved into the home were mental health. Others living there had a learning disability and this is what the statement of purpose reflected. The service was registered with CQC to provide services to people with a learning disability or autistic spectrum disorder, dementia, younger and older people, people with a physical disability and sensory impairment. The registered manager agreed to amend the statement of purpose and send this to CQC with a notification to add an additional service user band of mental health. This was received after the inspection and the service user band amended. In addition they said they would arrange training for staff in mental health and schizophrenia to update their skills and knowledge so they could effectively meet people's needs.

This was a breach of Regulation 12 of the Care Quality Commission (Registration) Regulations 2009 (Part 4)

Quality assurance processes were not robust. People's views were sought as part of the quality assurance process. Each year questionnaires had been sent out to people, their relatives, staff and health care professionals. This had been carried out in 2015 and was due to be started for 2016. The registered manager said the surveys and outcomes for the 2015 had been archived and was unable to access these. The provider regularly visited the service to monitor the quality of the service provided and to seek feedback from people and staff. The registered manager confirmed this had not recently been formally recorded and so there was no evidence of any discussions or actions taken in response to these visits.

People's environment was monitored to make sure it was well maintained. Audits had been completed to monitor the safety of the home, infection control procedures, fire and electrical systems as well as the risks of legionella developing. Staff had been delegated the responsibility of monitoring medicines administration, overseeing activities and management monitored accidents and incidents as well as complaints. The provider information return stated, "Staff and service users are able to raise ideas and concerns through house meetings, staff and senior meetings." The acting deputy manager reflected about improvements which had resulted from feedback by people living in the home such as the refurbishment of the kitchen.

The staff and the registered manager upheld the vision of the service to "give specific help required to develop skills necessary to lead a self-determining and fulfilling life". The registered manager said, "Their quality of life depends on what we do and we have to make it happen for them." People were exploring what they wished to achieve for the next year with staff including going on a cruise. The registered manager commented, "Staff go beyond what is required of them." An example of this was the acting deputy manager

who researched the use of a local gym in their own time. The registered manager reflected "We are like one big family."

People were observed spending time with the registered manager and acting deputy manager in the office and around the home. They were relaxed in their company and enjoyed light hearted banter with them. Staff said they found managers to be approachable and could keep in touch with them either face to face, by telephone or email. Staff said they would be confident raising concerns through the whistle blowing procedure. A member of staff confirmed, "He would look into concerns and deal with them, taking appropriate measures." The registered manager described how they had supported staff to develop their professional practice when concerns had been raised.

The registered manager was aware of their responsibilities with respect to notifying CQC of incident affecting people. They worked closely with health care professionals to maintain people's quality of life. Commissioners had inspected the service and issued actions for improvement which they said the provider had put into place. The registered manager had previously attended meetings with a local care provider. The acting deputy manager had only recently been appointed to post. Throughout the inspection they made changes to documents and downloaded information we shared with them to make improvements to the service.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The statement of purpose did not reflect the service being provided. The registered person had not informed CQC of revisions to the statement of purpose. Regulation 12 (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who use services and others were put at risk because all of the information required for new staff had not been obtained prior to employment. Regulation 19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive training and supervision to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)