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Imber House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Imber House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Imber is registered to provide personal care to a maximum of six people with a learning disability. At the time of inspection there were six people using the service.

The care service has been developed and designed 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.

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People and their relatives told us they felt safe living in the service and that staff made them feel safe. Risks to people were appropriately planned for and managed. Medicines were stored, managed and administered safely.

Checks were carried out to ensure that the environment and equipment remained safe. The service was clean and measures were in place to limit the risk of and spread of infection.

People and their relatives told us there were enough suitably knowledgeable staff to provide people with the care they required. Staff had received appropriate training and support to carry out their role effectively.

People received appropriate support to maintain healthy nutrition and hydration. They were supported to participate in preparing their meals according to their abilities.

People told us staff were nice to them. Relatives told us staff respected their family member's right to privacy and that staff supported people to remain independent. Our observations supported this.

People and their relatives were encouraged to feed back on the service in a number of different ways and participate in meetings to shape the future of the service. People and their relatives told us they knew how to complain.

People received personalised care that met their individual needs and preferences. People and their relatives were actively involved in the planning of their care. People were supported to access meaningful activities and follow their individual interests.

The provider created a culture of openness and transparency within the service. Staff told us that the provider was visible in the service and led by example. Our observations supported this.

There was a robust quality assurance system in place and shortfalls identified were promptly acted on to improve the service.

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?

Good

The service was safe.

Risks to people were identified, monitored and managed.

Medicines were managed and administered safely.

There were enough staff to meet people's needs.

The premises were safe and clean.

Is the service effective?

Good

The service was effective.

The service was complying with the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were supported to eat and drink sufficient amounts.

Staff had the training and support to deliver effective care to people.

People were supported to have contact with external health professionals such as doctors.

Is the service caring?

Good

The service was caring.

Staff were kind and caring towards people.

People were supported to be involved in the process of their care planning.

People were enabled and encouraged to be independent.

Staff upheld people's dignity and right to privacy.

Is the service responsive?

Good

The service was responsive.

People were supported to engage in meaningful activity inside and outside of the service.

People received personalised care.

People and their relatives were made aware of how they could complain.

Is the service well-led?

Good

The service was well-led.

The provider had a robust and effective quality assurance system in place capable of identifying areas for improvement.

People, their relatives, external professionals, and staff were given opportunities to feedback on the service.

The provider was visible and led by example. They engaged with other organisations to keep up to date with best practice.

Imber 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 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 comprehensive inspection was carried out by one inspector on 15 October 2018 and was unannounced.

Prior to the inspection we reviewed the contents of notifications received from the service. Services have to notify us of certain incidents that occur in the service, these are called notifications.

Some people using the service were unable to communicate their views about the care they received. We carried out observations to assess their experiences throughout our inspection. We spoke with three people using the service, two relatives, two care staff and the provider.

We reviewed three care records, two staff personnel files and records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. One person said, "Yes I am safe." Another person told us, "I feel safe." Another person nodded repeatedly when we asked if they felt safe. A relative said, "I have no concerns that [relative] is completely safe." Another relative commented, "I am pleased [relative] is there because they were not safe before [coming to Imber House]. Now I don't have to worry."

Risks were managed well by the service. Each person had a set of individualised risk assessments. These assessed the level of risk to the person in areas such as pressure care, malnutrition, falls or accessing the community. Where people were identified as at risk, there were clear instructions that staff could refer to in order to minimise the risk to people. Staff we spoke with were aware of the risks to individuals and how they could be supported to minimise these risks. The provider and staff had an understanding of 'positive risk' and care records assessed the benefits of taking some risks, such as promoting independence by supporting one person to work independently.

There were appropriate processes and procedures in place to protect people from the risk of potential abuse. There was a safeguarding plan in place for one person who had previously been financially abused and was vulnerable to this happening again. The staff we spoke with were clear about how this risk was minimised without restricting this person's ability to leave the service independently. For example, they ensured that the person was accompanied to withdraw money from the bank as this was a time in which they had previously experienced financial abuse. With the persons consent, they also ensured that staff dropped them off and picked them up from their place of work to reduce the risk of the person coming into contact with their abuser.

People told us there were enough staff to meet their needs and they were never alone unless they wished for privacy. One person said "Yes" when we asked them if there were staff around if they needed them. One other person nodded repeatedly when we asked the same question. A relative told us, "There always seems enough staff around. [Relative] is always tended to well." Another relative said, "When I visited there were quite a few [staff] around and everyone had someone with them." The provider assessed people's dependency and used this to calculate the number of staff needed to meet people's needs. The staffing level took into account the number of staff required to support people with activities inside the service and to access activities in the community.

Medicines were stored, managed and administered safely. We audited the number of remaining medicines against the number of medicines signed off as administered in Medicines Administration Records (MARS). We found that these indicated people's medicines had been administered in line with the instructions of the prescriber. There was an appropriate system in place to identify any shortfalls in medicines administration.

The environment appeared hygienically clean and the service was free of unpleasant odours. There were cleaning rota's in place which delegated duties between domestic staff. People were supported to carry out cleaning and tidying tasks according to their ability. We observed one person hoovering during our visit. Audits were carried out by the provider to ensure the cleanliness of the service and limit the risk of and

spread of infection.

There was an appropriate system in place to monitor the safety of the premises and monitor and manage environmental risks. Records demonstrated that the provider had an external company service the fire detection and prevention systems regularly. They also carried out tests of the fire alarms to ensure they remained in working order. After taking ownership of the service, the provider had independently identified that there were no fire alarms in the basement of the property and no fire door between the kitchen and dining room. Additionally, they had identified that there was not suitable lighting outside the property to expediate an evacuation of the building at night. They had taken action to resolve these issues and a recent visit from the fire officer confirmed there were no other areas for improvement.

The provider had an external company to risk assess and carry out checks on the water systems to look for the presence of legionella bacteria. Additionally, they carried out regular flushes of the water system and checked water temperatures to ensure the risk of the presence of legionella bacteria was reduced.

The provider ensured that appropriate testing was carried out of electrical appliances to ensure they remained safe for use and that safety checks were carried out on window restrictors. The provider had replaced a number of window restrictors after taking ownership of the service because they identified these were in a poor state of repair.

Good

Is the service effective?

Our findings

Care records demonstrated that people's needs were assessed and care planned taking into account best practice guidance.

Our observations and discussions with staff demonstrated they had the training and support to deliver effective care to people. Staff received training in subjects such as the Mental Capacity Act and Deprivation of Liberty Safeguards, safeguarding, food hygiene, health and safety, first aid, challenging behaviour, fire safety, infection control, care planning, medicines, learning disability, manual handling and equality and diversity. The providers training matrix confirmed that all staff were up to date with the providers mandatory training. Staff told us that the training they received was appropriate for the role and provided them with the skills and knowledge to deliver safe, effective care.

New staff were required to carry out all of the providers mandatory training before starting shifts and this was confirmed by a member of staff who had started working for the service on the day of our visit. Staff told us that they received an adequate induction when they started and this included carrying out shadow shifts to observe the support people required. New staff were required to complete the care certificate and one staff member was nearing the end of this at the time of our visit. The provider carried out competency assessments to ensure they could identify any areas for improvement in staff practice.

Staff told us that the provider was supportive and they felt able to speak to them about any concerns or issues they had. One staff member who had been working for the service since May 2018 told us that speaking to the provider was as easy as speaking to one of their family. Staff told us and records confirmed that they had regular supervision sessions with the provider where they could discuss any issues or training needs. The provider was rolling out annual appraisals shortly after our visit to set goals for staff in the coming year.

People were supported to eat and drink sufficient amounts. The support people required with eating and drinking was clearly set out within their care plans. Staff were aware of the specific support people required to eat and drink. People were supported and encouraged to participate in the preparation of their meals according to their ability and could access the kitchen to make snacks and drinks with staff support. Plans were in place to reduce risks to people when cooking and preparing meals. People were enabled to make choices about what they would like to eat and drink and they told us the food was good. One person said, "Nice food here." Another person nodded their head in agreement. When we asked what people liked to have for breakfast, one person said, "Porridge." Another person told us, "I have toast or cereal. I don't like porridge." This demonstrated to us that people were provided with meals that met their individual preferences.

People were enabled to access support from external health professionals such as doctors, dentists, opticians and psychologists. The support people required to visit these professionals was clearly set out in their care records. Staff supported people to visit these professionals in the community to promote their independence. There were hospital passports in place for each person using the service which set out their

needs and how they communicated. This meant that they could be provided with consistent care if they needed to be admitted to hospital.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People using the service had their capacity to make decisions and consent to their care assessed appropriately under the MCA. DoLS applications had been made to the Local Authority and authorised where appropriate.

Staff and the provider had a clear understanding of their responsibilities under the MCA and DoLS. Observations demonstrated that people were enabled to make day to day decisions according to their abilities. The service had carried out mental capacity assessments to assess people's ability to make specific decisions, such as a decision to live at Imber House or decisions which may impact upon their safety and welfare. People who were assessed as not having capacity to make some of the bigger decisions in their lives were still supported to make other decisions they could make. This promoted people's independence. Where people did not have relatives, who could help them with making decisions, the provider had arranged for these people to have advocates who could support and represent them.

We observed that the provider and staff asked for people's consent before supporting them with tasks or entering their personal bedrooms. For example, we asked if we could look in the bedrooms of people using the service. The provider went to ask people if they would be happy for us to look in their bedrooms and whether they would like to show us themselves. People had keys to their personal bedrooms and we observed that staff knocked before entering when the person was inside.

The service was decorated in a way which made it easier for people using the service to find their way to key areas. For example, each area of the service was decorated differently with different photographs on the wall so it was easier to differentiate between each room. There was signage on the doors to rooms such as the kitchen, toilet, lounge and dining room to make these easier for people to identify.

Good

Is the service caring?

Our findings

People told us that the staff were nice to them. One person said, "They are very nice." Another person said, "Yes" when we asked if the staff were nice to them. Another person nodded their head repeatedly and smiled when we asked this question. A relative told us, "The staff are so caring, really friendly and on a level with [relative]." Another relative said, "They were all so nice when I came to visit."

We observed that the interactions between staff and people using the service were kind and caring. Staff showed genuine interest in people's day and spoke with them about the pottery class they had just returned from. When one person showed a staff member what they had made, the staff member told them how good it was and called other people over to have a look. We observed staff talking with people about their individual hobbies and interests, such as one person's interest in a football team.

The service promoted people's independence, upholding their dignity and right to privacy. People's care records made clear what parts of tasks they could complete independently to reduce the risk of staff over supporting them. People were enabled to have privacy to carry out their own personal care if they were able and this upheld their dignity.

People and their relatives were supported to participate in the planning of their care. Care records clearly reflected people's views on their care and the views of their relatives or representatives. Easy read copies of people's care plans with pictures and large text had been created. The provider told us these were in place to show people so they could better understand what had been written about them. One relative told us, "I have seen the [care plans] and we were asked to participate."

Family members told us they were free to visit their relatives at any time without restriction. They told us staff were very accommodating when they visited and staff gave them private time with their relative.

Good

Is the service responsive?

Our findings

People were provided with personalised care based on their individual preferences. People's care records made clear their preferences, specific routines, likes and dislikes. Staff told us that they found these care records useful when they started working for the service and used them to learn about people. This meant they could provide people with individualised care. Discussions with care staff and the provider demonstrated they knew people as individuals.

Care records included people's life history, including their family, what schools they had attended, their favourite childhood memories and where they had been on holiday. This meant staff could talk to people about their past which may be significant to them. There were end of life care plans in place for people using the service, setting out any known preferences or wishes they may have when coming to the end of their life.

People were enabled to access meaningful activity both in the service and in the community. The activities people did on each day were set out in their care records, and people were supported to visit different day services or activities from other people using the service, respecting their individual preferences. On the day of our visit some people had attended a pottery class. We spoke with people before they left for the class and they were excited about going. When they returned they proudly showed us what they had made and appeared to have really enjoyed the activity. Another person had a job and staff supported them to carry on this employment by driving them to and from work. People told us that when they were at home they liked watching television and playing games with staff and other people using the service. One person said, "Dominoes, we play." Another person nodded their head in agreement. One other person said they liked watching television and pointed to some DVD's. Staff told us that when people were not at day service or other organised activities they offered people opportunities to go out in the community. For example, they said they took people shopping if they wished. One person nodded when staff said this and pointed to themselves. We asked them if they enjoyed going shopping and they nodded again, smiling. A relative told us, "They have a better social life than most. [Relative] is very busy. When I visit we play games, do puzzles. The staff play with us too."

People were supported to maintain contact with family members who were important to them. One person had a mobile phone and was supported to call their relatives regularly, one of whom was living in another care service some distance away and was unable to visit. The mother of two people using the service was elderly and unable to come to the service so the provider or care staff took these people to visit their mother regularly. This ensured people did not become isolated from those important to them.

People and their relatives knew how to make complaints. When we asked one person what they would do if they were unhappy with something at the service, they said, "I would tell" and pointed to a staff member. When we asked another person if they would tell the provider if they were upset about something, they nodded and said "Yes." There was an easy read copy of the complaints procedure displayed in a communal hallway which told people how they could complain. Relatives told us they were aware of how to complain and felt they would be listened to. One relative said, "I know how to complain and it would absolutely be taken seriously but I've never had need to." Another relative told us, "I know how to complain and they seem

really open and friendly so I'd have no problem bringing something up." At the time of our visit the service had not received any complaints.

Good

Is the service well-led?

Our findings

There was an open, honest and transparent culture in the service. People told us that the provider was nice to them and that they liked the provider. Relatives told us that they liked the provider and felt they were approachable. One said, "[Provider] is such a nice person. I could go to him with anything, [provider] cares a lot about [person]." Staff told us that the provider was approachable and they could talk to them about any issues or concerns.

Staff told us the provider led by example and that the provider was present in the service seven days a week. The provider told us this was to ensure the consistency of the service after the registered manager and former owner had stopped working for the service.

The provider had taken ownership of the service in 2017, which was rated requires improvement at the time. They told us that they had read the previous inspection report and noted the areas for improvement. They told us, and records confirmed, that when they first bought the service they carried out thorough quality assurance audits to identify where improvements were required. They also had an external consultant carry out audits of the service.

As a result of these initial quality assurance checks, they had identified a number of areas for improvement. These included improvements in the décor, such as replacing flooring in a poor state of repair and redecorating. They also identified that improvements were required to care planning and to implement a thorough and robust quality assurance system. By the time of our visit, all these actions had been carried out. We observed that the environment in the service had much improved, with new furnishings being provided for people's bedrooms and communal areas. People had been involved in the redecoration of the service and in choosing new furnishings and items such as pictures for the walls. One person showed us the pictures on the walls in the lounge and indicated to us they liked them by smiling and pointing. One relative said, "The home looks so much better. All the work [provider] has done has been great, it's never looked so good. So neat and tidy."

There was a robust quality assurance system now in place, with a range of audits being carried out to assess the quality of the service. These included audits of the meal time experience, infection control, maintenance of the premises, medication, care planning, food quality, health and safety and management of people's finances. We saw that where issues were identified, these actions were signed off when complete.

People, their relatives, staff and external professionals were given the opportunity to complete a survey of their views. We reviewed the contents of the surveys received and saw that these were all positive. People were also invited to attend meetings. Minutes of previous meetings demonstrated that people were given the opportunity to say if they were unhappy with anything, discuss food and drink and to talk about activities they would like to do or places they would like to visit.

The provider also held regular meetings with staff. Minutes of these meetings demonstrated they discussed people's needs, upcoming events, training opportunities and the organisation of tasks.

The provider told us they kept up to date with best practice by engaging with other organisations such as Age UK, external consultancy services and by reading information on the internet. They had a copy of the most recent CQC methodology and guidance about compliance. They showed us a letter demonstrating they had booked a place on the Suffolk Providers Forum later in the month. As they were new to the local area, they said they were looking into building relationships with other care services in the area to share ideas and best practice.