

SCC Adult Social Care Arundel 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

This inspection took place on 14 January 2019 and was unannounced. Arundel House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Arundel House provides a residential care and respite service for up to 18 adults with learning disabilities. At the time of our visit, there were 14 people using the service.

Arundel House 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 care home is divided into four units. Each unit had its own separate kitchen/dining area and a lounge for people to socialise and relax. The service was designed in a way that allowed people to do the things they want and live as independently as possible whilst also getting support where needed.

At the last inspection of 24 May 2016 and 06 June 2016, we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection. We found the service remained Good.

There was a Registered Manager at this location. 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 met their statutory responsibilities to the CQC.

There were enough experienced staff available to support people. Staff managed peoples' medicines in a safe way. Staff had received training in safeguarding adults at risk and knew of actions to take to protect people from abuse. Risks to people were assessed and managed adequately. Lessons were learnt from incidents and when things go wrong. Staff followed infection control procedures to reduce risks of infection.

People's needs were assessed and planned for following recommended guidance. People were supported with their meals and to meet their dietary needs. People were supported to access health and social care services they required to maintain their health and well-being. Staff worked closely with other services to ensure people's care and support were effectively delivered.

Staff received adequate training, support and supervision to be effective in their roles. Staff and the registered manager understood their roles and responsibilities under the Mental Capacity Act (MCA) 2005. 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 support this practice. People were supported appropriately to make decisions about their care and support. DoLS applications were made where necessary and the conditions of DoLS authorisations were followed.

The service had facilities suitable for people. People's rooms were well decorated with personal items such as photographs. Staff treated people with dignity and respect. People were involved in their day-to-day care; and staff respected their choices. Staff encouraged and supported people to maintain relationships important to them. Staff communicated with people in the way they understood.

People had support plans in place which contained details about how their individual care and support needs would be met. People's needs were regularly reviewed and support plans updated to reflect their current needs. The provider provided information to people in accessible formats. Staff understood equality and diversity issues and supported people appropriately to promote their protected characteristics such as disability, race, religion and culture. People were encouraged to follow their interests and develop daily living skills. People took part in a range of activities they enjoyed. Staff promoted people's independence in the way they supported them.

People and their relatives told us they knew how to complain if they were unsatisfied with the service. The quality of the service was regularly monitored and assessed. Improvement plans were developed to address areas requiring improvement. The provider worked in partnership with other organisations to develop the service. Staff understood their roles and responsibilities. The service was committed to providing quality care to people. Staff had the leadership guidance and support they needed to fulfil their roles.

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 remained Good.

Is the service effective?

Good ●

The service remained Good.

Is the service caring?

Good ●

The service remained Good.

Is the service responsive?

Good ●

The service remained Good.

Is the service well-led?

Good ●

The service remained Good.

Arundel House

Detailed findings

Background to this inspection

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

This inspection site visit took place on 14 January 2019 and it was unannounced. It was undertaken by one inspector. Before the inspection we reviewed the Provider Information Return (PIR) the registered manager had sent to us. This is information we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the other information such as notifications we held about the service and the provider. A notification is information about important events the provider is required to send to us by law. We also reviewed the monitoring report we received from the local authority.

During the inspection we interacted with four people, four support workers, the registered manager, quality assurance officer and the nominated individual. We looked at four people's care records and medicine administration record for eight people. We reviewed four staff member's recruitment, training and supervision records. We also checked records relating to the management of the service including quality audits and health and safety management records. We carried out general observations to assess how people were supported by staff.

After the inspection, we spoke with two relatives to obtain their feedback about the service.

Is the service safe?

Our findings

People indicated they felt safe using the service and relatives we spoke with told us their family members were safe using the service. One relative said, "Yes, [family member] is safe. The staff team are thorough and know how to maintain [family member's] safety." Another relative told us, "At this present time I believe my family member is safe, they are not at risk."

The procedures and systems in place to safeguard people from abuse continued to be effective. Staff were trained in safeguarding adults at risk and understood types of abuse, signs to recognise them and how to report any concerns. Staff told us if they had any concerns about people's safety, they would report it to the registered manager or whistleblow to higher authorities if concerns were not addressed promptly. The registered manager understood their role to safeguard people from abuse. They also had detailed knowledge of their local authority's safeguarding procedures which included making referrals to the local authority, investigating concerns and notifying the Care Quality Commission (CQC). Safeguarding records showed that the registered manager had acted in line with their procedure in responding to recent concerns.

People remained protected from the risks of harm. Staff continued to assess areas of risks to people and devised guidance to reduce risks identified. Areas of risks assessed included mental health conditions, physical health, behaviours, accessing the community and activities of daily living. We saw guidance in place in relation to the choking risk for one person. The guidance stated the texture and food consistency safe for the person; and the recommended sitting position when eating. A speech and language therapist was involved in writing the guidance. Another person wore personalised shoes made by a specialist manufacturer as recommended by an occupational therapist, to reduce risk of falls due to their mobility. Risk assessments were reviewed and updated to reflect people's current risks. Staff knew about the management plans in place for people.

The health and safety of the environment remained safe and well maintained. The risk of fire was assessed and actions identified had been addressed. Weekly fire alarms tests took place to check that the alarm system was working properly. Other equipment such as fire extinguishers, smoke detectors and emergency lights were also checked regularly to ensure they were functioning properly. Regular fire drills took place so staff could practice evacuation procedures. We saw valid certificates for legionella, gas safety and electrical management systems. Portable appliances were tested annually and these were up to date.

The service sustained adequate staffing levels. People's needs remained met safely by sufficient and experienced staff. One relative told us, "I think the staffing level is sufficient. The staff team is stable which is really important in delivering continuity of care." Staff told us they were sufficient to meet people's needs safely. One support worker said, "Yes, we are enough. If we need extra support management give us permission to book bank staff." A senior support worker told us, "We are enough on each shift to support people. We plan in advance and if we need more staff due to activities or people's needs we book additional staff." We noted that where people required one-to-one support this was available for them. Staff were visible throughout our inspection supporting and engaging people in activities and conversations. The

registered manager told us they planned staff cover based on people's needs and dependency and if needs changed, they adjusted the rota accordingly. The provider had a pool of regular 'bank' staff who covered planned and unplanned absences.

The provider continued to follow safe recruitment process to ensure people were supported by staff who were fit and safe to support them. Recruitment records included satisfactory references, right to work in the UK, employment history, and criminal records checks.

People's medicines continued to be administered and managed in a safe way. Medicines were administered to people by senior members of staff and staff trained on safe administration of medicine. Medicine Administration Records (MARs) showed people received their medicines as instructed. MARs were legibly signed by two staff members to confirm when medicines had been administered. Medicines were received into the service and stored safely in line with the provider's procedures. Staff understood the procedures to follow if there were unused medicines. Medicine audits were undertaken daily to ensure all medicines were accounted for.

The home was clean and well maintained. Staff knew measures to follow to prevent and reduce the risk of infection. Staff explained that effective hand washing, use of personal protective equipment (PPE) and proper disposal of clinical and bodily waste were crucial to controlling infection. Staff had received training in infection control and food hygiene.

Staff knew how to report incidents, accidents and near misses. Records of incidents and accidents were reviewed by the registered manager. Where an incident required further actions such as notifying other teams or raising a safeguarding alert, this was done. For example, medicine errors were reported to the local safeguarding team. The provider's central management team monitored incidents and accidents; and analysed them to identify trends and patterns. Actions were noted and lessons learnt were shared with staff. For example, the arrangements for supporting one person in the community was reviewed following an incident. The person's risk assessment was updated and more joint working arrangements were established with the other agencies involved in supporting the person.

Is the service effective?

Our findings

People's needs continued to be assessed in line with nationally recognised best practice guidance. Areas of needs assessed covered physical health, mental health, nutrition, eating and drinking, socialising, accessing community facilities, personal care and other activities of daily living. We noted that the service used relevant assessment tools such as falls assessment and the Disability Distress Assessment Tool (DisDAT) in determining people's needs and support required. DisDAT is a tool used to assess people's behaviour and signs of distress. As part of the assessment process carried out by the service, people were given the opportunity to visit and spend time with other people and staff to help them determine if the service was right for them. People were also given a copy of the service user's guide which contained information about the service. Where necessary other professionals such as social workers, speech and language therapists and community mental health teams were involved in assessing people's needs.

People remained supported by staff who were trained and effective in their roles. One relative told us, "The staff team seem knowledgeable and experienced. They are very thorough and know how to support [family member] with their needs." Staff told us and records showed staff received training relevant to their roles and which provided them the skills, abilities and experience to support people effectively. These included mental health awareness, medicine management, challenging behaviour, autism, epilepsy management, the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS), and safeguarding adults. New staff members completed a period of induction when they first started. One new member of staff told us, "I was given an induction. I felt confident enough before I started working with people." Records also showed and staff confirmed that they received regular support and supervision which were delivered in the form of one-to-one sessions, handovers and team meetings. Staff performance were appraised annually.

People continued to be supported to meet their nutritional needs. Care records stated people's dietary requirements and preferences. Staff supported people to do food shopping and to prepare their meals if they required this support. Where people required supervision to eat, they received this. People's choices and preferences were respected by staff. We observed staff offering drinks and fruits to people.

People continued to be supported to access healthcare services they needed. People had health action plans which stated their health needs and what actions were required to maintain good health. Staff supported people where required to visit healthcare services and to attend appointments. Records of people's visits to healthcare services were maintained including the reason for the visit, outcome and any follow up required. People were also supported to attend annual health checks and to take necessary vaccines if they wished.

People were supported to ensure their needs were met appropriately when they used other services. People had an 'About Me' section in their care records which contained information about their medical history, communication needs, risks, care and support needs, allergies, next of kin and GP details. People also had a communication passport which they took along when they visited hospitals or other services. A communication passport provides a practical and person-centred approach to passing on key information about people with complex communication difficulties who cannot easily speak for themselves. Staff told us

people took along their communication passport, health action plan and 'About Me' documents when they went to hospital or to use other services. They told us a staff member also accompanied people to hospital so they could give a handover to the hospital staff.

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. 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 authorisation 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.

The provider ensured all staff had received training in MCA. Staff obtained consent from people and their relatives before delivering care and support to them. Care plans documented people's capacity to make decisions and how staff were required to support people with decision making. Relatives confirmed staff involved them where necessary in decision making about their family member's care and support.

People's rights under DoLS remained protected. People had valid DoLS authorisations in place where required and staff understood and complied with the conditions attached to these. Records showed people had appointeeship and deputyship in place for their welfare and finances where required. The registered manager understood their responsibilities under MCA and DoLS.

The service had facilities suitable for people. People's rooms were well decorated with personal items such as photographs. Each bedroom had a wash basin and built-in wardrobes. Each unit had its own separate kitchen/dining area with a lounge. There were communal areas in each unit for people to socialise and relax. The bathroom and toilet facilities were adapted and suitable for their use.

Is the service caring?

Our findings

Staff remained caring in the way they supported people. People indicated that staff were caring and kind towards them. One relative commented, "They [staff] are quite nice and caring. The manager is nice too. The staff have a connection with my family member and they get on very well." People and staff interacted and related freely together in a friendly and relaxed manner. Staff took an interest in people's well-being and activities. We heard staff ask people how their day went and if they were alright.

Staff knew people's communication needs and communicated with them in the way they understood. People's support plans stated their communication needs and we observed staff using various methods such as signs, pictures and body language to communicate with people; and staff allowed people to express themselves without interruptions. Staff also showed they knew people's behaviour, how to gain their attention, what made people happy or distress. Throughout our inspection, we observed staff engaging with people appropriately, listening and providing reassurance where needed.

People continued to be given a choice and be involved in planning their day-to-day care and support. Relatives we spoke with confirmed staff kept them informed and discussed their loved one's care with them appropriately. One relative told us, "They [staff] involve us in every decision about my family member's care. They also give us regular updates. The communication with staff is great." Care records showed that people and their relatives had input into their care planning and their views were considered. People had staff members allocated to them as their keyworkers. People's keyworker supported them with their day-to-day care choices and to represent their views during meetings if they wished. The service had links with advocacy services and staff knew how to arrange for Independent Mental Capacity Advocates (IMCAs) to represent people's views when making important decisions.

Staff continued to treat people with dignity and respect. Throughout our visit we noted that staff spoke to people in a dignified manner. Staff shared information about people in private so others could not overhear. People were addressed in the way they wished. People were neatly dressed and well presented.

Staff encouraged and enabled people to maintain their independence. The service was designed in a way that allowed people to live as independently as possible while getting support where needed. People were supported to do things they could for themselves. People were supported to do their own food shopping and to prepare meals and drinks for themselves where they could.

Is the service responsive?

Our findings

People continued to receive care and support personalised to their individual needs. One relative told us, "The service meets my family member's changing needs. They have had stability and continuity in their care since they moved to the home. I just hope they continue to meet their needs as we don't want them to move." Each person had a support plan which gave details of their background, preferences, social network, personalities, likes, dislikes, routines and goals. People received support in line with their assessed needs which covered their mental health, physical health and activities of daily living. Support plans provided guidance on how to support people with their needs. One person was supported to maintain a healthy balanced diet as a way of managing their diabetes. Staff had involved an organisation supporting people with visual impairment to support a person to learn how to move around their room and unit independently and safely due to their impaired sight. Support plans were reviewed and updated as required to reflect changes in needs.

People continued to be supported to participate in activities they enjoyed within and outside the service. Each person had an activity plan in place which included leisure activities and educational programmes to develop skills and learning. People attended day centres where they engaged in various activities and enjoyed the company of their friends. Activities people took part in ranged from visits to places of interest, indoor games and puzzles. We saw people watching TV programmes together and chatting about it.

People's needs around their religion, disability, sexuality and relationships were assessed and noted in their care plan. Where people expressed religious views, staff supported them to attend places of worship.

Staff continued to support people to maintain relationships that mattered to them. Relatives told us they could visit their family member at the service. Staff also supported people to visit, maintain contact and send greeting cards to their relatives.

People were given information in formats they understood in line with the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information they can easily read or understand to support them to communicate effectively. We saw that people's support plans, activities plan, communication and hospital passports, and the service's complaints procedure were available in pictorial and easy read formats to make them more understandable to people.

People and their relatives knew how to raise their concerns or complain if they were unhappy with the service. One relative told us, "I have information on how to complain. I have never had to use it but know what to do if I need to." There was a complaints procedure in place which was also available in an easy read format. The registered manager had responded to complaints received in line with the provider's complaint procedure. These were resolved.

People's end of life and funeral wishes were documented in their support plans. There was no one receiving end of life care at the time of our visit but the registered manager had experience in delivering end of life

care. They told us staff would be trained as or when required and they would work closely with relatives and other professionals to ensure people received appropriate care and support.

Is the service well-led?

Our findings

There was a registered manager in post who had worked at the service for many years and they understood their role and responsibilities in providing effective care to people. The registered manager complied with the requirements of their Care Quality Commission (CQC) registration including submitting notifications of significant events at their service. They also displayed the last CQC rating of the service at the location and on the provider's website. The registered manager was supported by the nominated individual and both had experience in providing effective care and support to people.

The service delivered care and support centred around people's needs. Staff understood their roles and responsibilities in achieving good outcomes for people. Staff could tell us about the service's objectives and aims and how they worked to achieve these. They told us of the different units in the service, the needs of people in each unit and the goals they were designed to achieve. For example, one unit was designed to enable people to be as independent as possible so staff provided minimal support to them. Staff told us about the aim of the respite care provided to people.

The service continued to be well-run and managed. One relative commented, "The home is great! The registered manager manages the home very well and has made significant improvements." The registered manager was available to supervise staff and deal with the day-to-day operations of the service. Staff told us they had the leadership support and guidance to deliver their roles and meet people's needs effectively. The service had a management on-call duty system which meant staff had access to a member of the management team if they needed support out of hours.

The registered manager held regular meetings with the staff team. These meetings were used to discuss issues regarding people and other concerns. They were also used as training sessions and opportunities to share learning and good practice. Staff told us that they could discuss matters freely and as a team they found solutions together.

The service used surveys and review meetings to engage, involve and obtain feedback from people and their relatives about the service. The most recent survey and review result was positive as people and their relatives were satisfied with the quality of the service they received. The last survey was conducted in November 2018 and it recorded positive comments and feedback from relatives. These included comments such as, "I couldn't be more satisfied. Excellent service from everyone." "I cannot find any faults with this care home. [Family member] is well taken care of and all their needs taken care of" and "Very happy with the care and communication."

The quality of the service continued to be assessed and monitored. The service had a continuous improvement plan in place which showed how the provider aimed to improve the service in line with their objectives. The provider had a quality assurance team who conducted audits and reviews of the service's performance. Following a recent quality audit completed, staffing levels had been reviewed and adjusted. The service was also revising their care planning documentation systems as recommended by the team. The provider's management team regularly monitored and analysed incidents, accidents, staff training records,

and DoLS authorisations. They used the monitoring system to identify patterns and trends and took actions where necessary to reduce recurrence or improve staff learning. Senior members of staff at the service audited medicine management systems and health and safety systems.

The service continued to work in partnership with a wide range of organisations and services to improve and develop the service. They worked with the local authority commissioning and quality assurance teams to review the service. They worked closely with local day centres and local charity organisations to meet people's needs. For example, a charity organisation supporting blind and visually impaired people had been involved to deliver training to staff on how to support people with visual impairments.