Care Management Group Limited

South Hill

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

The inspection took place on 31 March 2016 and was announced. South Hill is a supported living service providing personal care support for up to 11 people with learning disabilities and complex needs. The service comprises 11 studio flats in a large detached house with additional communal living areas, and is located in Harrow.

The service did not have a registered manager in place at the time of this inspection. 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.

At this inspection an existing deputy manager had been assigned to temporarily manage the service, with support from the regional director.

People told us that they felt safe within the service. We saw positive, friendly and enabling interactions between staff and people. People were treated with dignity and respect.

People and where necessary those who mattered to them were involved in care planning. They assisted staff in identifying needs, and how people preferred to be supported. We saw that staff provided personalised care and support.

Staff knew what to do if people could not make decisions about their care needs. Where possible, people were involved in decisions about their care and how their needs would be met. Otherwise, arrangements were put in place for relatives or other representatives who could represent their best interests.

People were supported to eat and drink. Staff supported people to attend healthcare appointments and liaised with their GP and other healthcare professionals as required to meet those needs.

People's risks were anticipated, identified and monitored. This ensured that people had control and independence in their lives. Risks were regularly reviewed and updated promptly following any changes in need.

Medicines were administered safely and on time. Staff had completed training in medicines administration. People were supported to become independent with their medicines in a structured and safe way. People understood what their medicines were and why they had been prescribed.

There were systems to monitor important aspects of the service. This ensured the services continued to receive internal and external audit, which were used to monitor quality and to make improvements.

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. Staff were able to tell us how to recognise abuse and knew how to report it appropriately.

People were actively encouraged and supported to report concerns. There were sufficient staff to ensure people's needs were met.

Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were managed effectively. Risk assessments were shared with healthcare professionals.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Peoples healthcare needs were monitored and referrals were made when necessary to ensure their wellbeing.

People were supported to have enough to eat and drink to ensure their dietary needs were met.

Is the service caring?

Good

The service was caring.

The interactions between staff and people using the service were kind and caring. People told us staff were kind.

Staff respected people's privacy and treated them with respect and dignity.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed and care and support plans

were produced identifying how to support them with their individual needs.

Care plans were personalised to meet the needs of individuals.

People and their relatives knew how to make a complaint and these were responded to and resolved appropriately.

Is the service well-led?

Good

The service was well led.

The management encouraged a positive and open culture that encouraged best practice.

Staff felt able to have open and transparent discussions with the management through one-to one meetings and staff meetings.

There were effective systems in place to monitor and improve the quality of the service provided.

South Hill

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 31 March 2016 and was announced. The provider was given 48 hours' notice because the location provided domiciliary care services and we needed to be sure that someone would be present in the office. The inspection team consisted of one adult social care inspector and a specialist advisor.

Before the inspection we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We also read the local authority quality monitoring team report, which had identified areas for improvements, and which we saw the service had actioned.

During the inspection we spoke with the regional director, the deputy manager, a registered manager from a sister organisation who was supporting with day to day management of the home, and five staff. We also visited three people who used the service in their own flats.

We looked at records that related to people's individual care and support needs. These included support plans, risk assessments and daily monitoring records. We also looked at six staff recruitment files and records associated with the management of the service, including quality audits.

Good

Is the service safe?

Our findings

People told us that they felt safe. Their comments included, "I feel safe because l keep keys of my room and I have staff 24 hours a day to support me" and another said "Staff make sure the place is safe."

People were protected from the risk of abuse. This was because the provider followed safeguarding procedures to protect them from abuse. There were appropriate procedures in place to help ensure people were protected from all forms of abuse. Staff had received training on how to identify abuse and understood safeguarding procedures. They described the different ways that people might experience abuse and the correct steps to take if they were concerned that abuse had taken place. Safeguarding information was on display in the communal hallway, which provided staff with immediate access to information and guidance on how to report any concerns about people's safety. Each person had an easy to read safeguarding folder in their rooms.

Staff told us they were confident that any concerns reported to managers would be treated seriously and appropriately investigated. They told us they could report allegations of abuse to the local authority safeguarding team and the Care Quality Commission (CQC) if management staff had taken no action in response to relevant information. This meant that the service reported safeguarding concerns appropriately so that CQC was able to monitor safeguarding issues effectively.

The service managed risks to people in order to protect them from harm. Prior to people using the service people were assessed and care plans and risk assessments were written to make sure that their needs could be met in a safe way. Risk management plans recorded concerns and actions required to address risks whilst maintaining people's independence. The plans indicated where risks could occur and measures were put in place to minimise the likelihood of incidents occurring. For instance, one person told us, "I love to do the garden and I get paid to cut the grass"; a matter he seemed to take pride in. Risks assessments were carried out in terms of the weather conditions, weed killers, plant foods, electric and lawn mowers were identified, including action to be taken to reduce the risk. In addition, the person was supported to enrol on a 'garden safety course', which covered common garden hazards, garden equipment hazards, protective equipment and garden safety practices. Thus, risks were managed whilst still supporting the person to safely do what they wanted.

In another example, we saw staff managed the equipment in the kitchen area which could present risks for people rather than restricting people's access to the area. This meant staff had explored and provided the least restrictive option which promoted people's safety without limiting the opportunities to develop and interact with others. These assessments were reviewed and updated periodically and when people's needs changed to ensure they remained current. Staff were aware of the risk assessments and how to work in line with the guidance. They could describe the actions they would take to protect people from harm.

The recruitment practice was safe and thorough. Two professional references or three character references had been obtained and formal interviews arranged. The deputy manager told us that staff were not allowed to commence employment until a Disclosure and Barring Service (DBS) check had been obtained. This

helped to ensure people employed were of good character and had been assessed as suitable to work with people.

People were safe because staffing levels were assessed and monitored to ensure they were sufficient to meet their identified needs at all times. There was a rota system in place to ensure that enough staff were on duty. Staffing levels were flexible so that if people needed extra support due to illness or to take part in their particular interests there were staff available for this. We saw an example on one rota where staffing levels had increased beyond the usual ratio to support staff to care for a person who needed temporary extra care. There were 10 people in residence. Staffing levels were five care staff for morning and afternoon shifts; and two care staff working waking staff at night. These levels excluded the manager or deputy manager, who worked during office hours. At the time of this inspection, there were two vacancies for support workers and one a manager position. We saw evidence the service was actively recruiting for these positions.

We looked at how people were supported with their medicines. One person told us "I am very happy with the way staff help me with my medicines." This person was quite clear if he needed to know anything he would ask. A second person whose first language was not English was supported by a member of staff whose skill set also included knowledge of this person's dialect. This person could tell us about his medicines, including which medicines he took at which time of day with support of staff.
The deputy manager could evidence from training records that she had been trained and assessed as competent to support staff and sign off other senior staff to administer medicines. Five staff had completed medicines training and a further five had training dates booked for April 2016. Only trained staff administered medicines.

Medicines were stored safely in locked medicines cupboards in people's bedrooms, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. Each person had a folder with their medicine support plan which gave clear information to staff about the medicine usage and side effects. The deputy manager could evidence that prescriptions were ordered in a timely manner. We saw copies of current prescriptions. Medicines no longer required were returned to the supplying pharmacy for destruction. Medicines reviews had been completed by people's GP in the last 12 months.
There was a record of essential maintenance carried out. These included safety inspections of electrical installations. There was a fire risk assessment in place, and the deputy manager and people confirmed weekly fire evacuation drills. A member of staff was a fire marshal and Fire alarms are tested on a weekly basis.

Good

Is the service effective?

Our findings

People were supported to have their assessed needs, preferences and choices met by staff who had the right skills and competencies. One person told us, "Staff are skilled at what they do", and another said, "Staff are very competent. I did not know how to manage my time but staff taught me. Now l can go out on my own and come back home on time." Commenting on staff competency, the same person also told us, "I did not know how to do my laundry before l came here, but l can now do it on my own."

Staff felt well trained and supported. One staff member said. "We get a lot of training here. We have e-learning and face to face training. Some of us have been supported to study for a diploma in social care" and another said, "We have been supported to complete a lot of training, including safeguarding and mental capacity training." The service was receptive of staff suggestions for training and supported the individual staff member's professional development. We saw from staff meeting minutes that staff were encouraged to suggest training requirements for the team and the service.

Staff told us they received a formal induction programme when they started work. This included an introduction to relevant areas of the organisation; including, policies and procedures. The induction covered other areas such as safeguarding, privacy and dignity, health and safety and nutrition and hydration. New staff also shadowed experienced staff until they felt confident to care for people unsupervised. The induction was in line with the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working lives.

Staff told us they received regular supervision from their manager. They described the supervision as a two-way process, where they were able to discuss any issues they thought were relevant to their role. This support provided staff with an opportunity to discuss issues and agree on an approach if they were unsure. Staff described the deputy manager as supportive and approachable.

Staff had completed a range of training sessions, both provided by means of e-learning and face to face. Training completed included, safeguarding, Mental Capacity Act 2005 (MCA), moving and handling, Deprivation of Liberty Safeguards (DoLS), infection control and health and safety. The staff training records also showed upcoming training sessions booked for staff.

The deputy manager and staff knew in some instances they had to make decisions for people they supported and when to involve others if needed. When people could not make a specific decision this had been correctly assessed and decisions were made in the best interests of the person.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Any applications must be made to the Court of Protection (CPO).

We checked whether the service was working within the principles of the MCA. We observed that staff routinely asked for people's consent before giving assistance. In each instance, we observed they waited for a response. We saw that people could access all shared areas of the service when they wanted to. People freely accessed areas of the building, including the lounge, kitchen, and dining room. So, even though people had cooking and refrigeration facilities in his own rooms, they could opt to utilise the communal kitchen facilities. People could go to the local shops, college, cinema or cafés with or without support from the staff. One person told us, "I have a freedom pass. It allows me to go everywhere in London" and another said, "I go to play football every evening." This showed that people could have the independence and freedom to choose what they did with as little restriction on their liberty as possible. A local authority social worker had made four applications to the CPO for people who may have been deprived of their liberty on safety grounds; subject to continuous supervision, for example.

People were supported to have enough to eat and drink. People purchased their own food, with support from their families and staff. One person told us, "I cook my own food but at times l need staff support and this is given" and another said, "I cook and staff help. I completed a basic cooking course." Staff knew people's likes and dislikes and ensured people's nutritional needs were being met. There was a system in place to monitor people's weight by way of individual weight charts. These checks took place on a monthly basis and recorded in people's care plans so they could be monitored. For example, one person had a diabetes health action plan, which recommended a carbohydrate controlled diet. There was a diabetes care plan in place and there was a daily food diary/ menu plan documenting this person's food intake.

People had access to healthcare services, including GP, district nurses, dentists and chiropodists and were supported to maintain good health. People had received annual health checks to identify developing health problems early. Women were supported to attend preventative screening tests, and so did men. There were instances when this was not always possible to facilitate because of people' complex needs, but the service tried everything possible to ensure people accessed healthcare services. In one example, a person who refused to keep healthcare appointments due to anxiety was referred for cognitive behaviour therapy (CBT). This looked at strategies and techniques to manage this person's worries. Staff told us, and so did evidence from care records that this person had since attended a range of healthcare appointments.

Good

Is the service caring?

Our findings

People were supported by staff who were kind, respectful and caring. One person told us, "Staff are excellent. They help me to clean my carpet and with shopping" and another said, "Staff are always kind to me. They always make sure I am okay." A compliment form one person read, 'Thank you for your care and support and checking on me."

Staff told us how they made sure people's privacy and dignity was respected. They said they knocked on people's doors before entering their rooms, which we observed. Staff knocked on doors and asked permission before entering people's rooms. Staff told us they tried to maintain people's independence as much as possible by supporting them to manage as many aspects of their care that they could.

There was an inclusion policy in place. We observed staff engaged with the people in a kind and supportive manner and people seemed comfortable in making requests of staff. On the day of the inspection one person told us she was going out for shopping. Staff took time supporting her to prepare before, she could go out. As with the other people, staff were observed to be kind, supportive and enabling in their approach to the individuals they were spending time with. In another instance, we observed another person asking the deputy manager if he could cut the grass and the deputy manager suggested a time when there would be enough staff for the person to be supported. The person told us, "I love to do the garden and I get paid to cut the grass." A matter he seemed to take great pride in.

People maintained personal relationships with family and friends. Care plans reflected the importance of maintaining these relationships for people and we saw from staff meeting minutes that staff were reminded to enable this. People told us that they regularly saw family and friends.

People were supported to express their views in ways that were meaningful to them and were involved in making decisions about their care and support. People told us they were fully involved in their reviews and had also signed their care plans. People attended 'tenants meetings' every month. We read a sample of minutes from these meetings. In one, end of life care was discussed and all but one person wanted to talk about this. This person preferred to have this discussed in the key worker meeting and we saw this had been respected. This meant people were valued and treated as individuals with an opinion.

Staff knew how to manage, respect and support people's choices and wishes for their end of life care as their needs change. There was an end of life policy in place. This included an "end of life refusal form", which had been completed in relevant cases. For example, the service had discussed end of life care with one person, however the person had signed they did not wish to have a plan in place for the time being but would approach staff when they were ready to talk about it. This shows people were given the opportunity to discuss end of life care and could change their mind and have a plan introduced whenever they choose.

Good

Is the service responsive?

Our findings

People received personalised care, treatment and support. We saw from care plans that people were provided with support that met their identified needs. The care plans were reviewed regularly and where possible signed by the individual or a representative. As people's needs changed the care and support they received were changed to meet those needs and care plans were reviewed and updated. This ensured that care plans contained up to date information. People gave us consistent feedback that staff were aware of their needs and provided care for them.

The care plans of people were person centred, and included information about their likes and dislikes. The files also contained risk assessments and like care plans, they were also personalised. For example, a person centred plan of one person documented all their needs; physical, mental, health, social, spiritual and emotional. This had been translated into an easy read plan. This person liked guinea pigs, and these had been pictorially used throughout the plan to encourage the person to access their information. The plan recorded information about the person's likes and dislikes, including how to meet their nutritional requirements. Staff were knowledgeable about people they supported and could tell us about individual's backgrounds and preferences.

The service sought feedback from people who used the service by conducting surveys. In a survey that was carried out in 2015, 20% of respondents said that their relatives were not involved in their reviews. . As a result, a recommendation was made that the service needed to make improvements in involving families. The service has since received positive feedback from relatives regarding the improvements made in involving families. Care records showed that people and their relatives had been involved in the assessments and on-going reviews of people's needs. People told us and there was evidence by way of their signatures confirming they were actively involved in their care planning process. People and staff also confirmed that families were actively involved in people's care planning.

People were supported to engage in activities to stimulate and promote their overall wellbeing. They were enabled to take part in personalised activities and encouraged to maintain hobbies and interests. A monthly programme of activities was displayed in people's bedrooms. A plan of one person indicated a range of weekly activities such as yoga, swimming, bowling, cinema and college classes. People confirmed they were happy with the activities on offer and records of individual activities were maintained and available for reference. One person told us, "I go to play football in the evening." Another person said, "I go swimming." People went on short trips abroad with support from staff. One person told us, "Last week I went to X with staff, for my birthday."

The service had a policy and procedure in place for dealing with any concerns or complaints. People and those who matter to them knew who to contact if they needed to raise a concern or make a complaint. One person told us, "If someone is to abuse me, I will go to a member of staff and they will take it further." The deputy manager told us, "We take complaints very seriously." She told us that they used concerns and

complaints to improve their service and raise standards of care. No complaints had been received in the last 12 months. However, in the past we saw that where a complaint or concern had been received these were responded to within the recommended time scales. Action had been taken and the outcome had been recorded and fed back to the person concerned.

Good

Is the service well-led?

Our findings

People receiving care, those important to them and staff told us that the service had a management team that was approachable and took action when needed to address issues. They described the deputy manager as, 'a good listener'; 'supportive' and 'approachable'. A staff member told us, "CMG is an excellent organisation to work for."

There was a clear leadership structure in place and staff felt supported by management. The registered manager of the service had left the organisation at the time of this inspection. We saw evidence the service was actively recruiting to fill the vacated position. In the interim, arrangements had been put in place for an existing deputy manager to temporarily manage the service, with support from the regional director and a registered manager from a sister service. Staff were aware of this arrangement and were aware of their own roles and responsibilities.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. Registered providers are required to inform the Care Quality Commission of certain incidents and events that happen within the service. Providers are required, by law, to notify us about and report incidents to other agencies when deemed necessary so they can decide if any action is required to keep people safe and well.

The service held regular team meetings. There was an open culture within the service and staff were given opportunities to raise any issues at team meetings and felt confident in doing so, knowing they would be supported if they did. We saw that staff were kept up to date about important areas of the service such as, safeguarding, service user updates, training, and service improvements. At the end of meetings an action plan was developed. This was revisited at the next meeting to ensure that any actions identified had been completed. We saw this was actioned and discussed under 'actions from previous meeting'. If something was identified it was followed up and progress monitored. Apart from staff meetings, staff told us their views were also prompted through surveys, supervisions, and on an impromptu basis during their work.

The service regularly invited feedback by asking people to complete a questionnaire. In a survey the service carried out in 2015, the service received mostly positive responses across all areas that were assessed. One person suggested more activities to be incorporated in their daily activity schedule. We saw that the service had reviewed the activity plans for all the people and made necessary improvements. People's activities were reviewed on a monthly basis. 'Tenants meetings' and during key working sessions to ensure improvements were maintained. This showed us that the provider valued the views of people.

The service had quality assurance systems in place to monitor the service and check whether it was delivering high quality care. Regular audits designed to monitor the quality of care and identify any areas where improvements could be made had been completed. The director of the service had undertaken monthly audits of the service. Likewise, the registered manager undertook a range of audits throughout the year. These included: medication, care files; health and safety, infection control, safety and suitability of premises. The local authority had also carried out a monitoring review. Their report confirmed there had

been improvements and we saw that where actions were identified these had been implemented.