Avenues South East

1-3 Emily Jackson Close

Inspection report

Eardley Road
Sevenoaks
Kent
TN13 1XH

Tel: 01732465987
Website: www.avenuesgroup.org.uk

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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

We inspected 1-3 Emily Jackson Close on 21 and 22 September 2017. This was an unannounced inspection. 1-3 Emily Jackson Close provides accommodation with personal care and support to 18 people with learning disabilities and physical disabilities. The service is split into three bungalows that can accommodate up to six people each. People had multiple and complex needs and were unable to tell us about their experiences of using the service.

At our last inspection on 4th April 2017, the service was rated as Good. At this inspection, we found the service remained Good.

There was no registered manager in post. At the time of our inspection, an acting manager in post was going through the processes with the Care Quality Commission (CQC) to register. 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 provider had systems in place to protect people against abuse and harm. The registered provider had effective policies and procedures that gave staff guidance on how to report abuse. Staff demonstrated good knowledge of the safeguarding policy and procedures.

Risks to people's safety had been assessed and actions taken to protect people from the risk of harm. Risk assessments were personalised to people's needs and reviewed on a regular basis and when required.

Staff recruitment practices ensured that staff were safe to work with vulnerable adults. There were enough staff on duty to provide safe personalised care. Trained competent staff managed medicines safely. There were regular audits carried out by trained staff to identify any areas for improvement and to ensure there were sufficient levels of stock.

The principles of the Mental Capacity Act 2005 (MCA) were adhered to for more complex decisions. People's mental capacity was being assessed appropriately and meetings took place to make decisions on people's behalf and in their best interests, when they were unable to do so. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered as per the MCA.

People were assisted with their nutrition and hydration needs. The acting manager involved a dietician to give guidance to staff on appropriate diets and methods. People who were at risk of pressure sores had

appropriate assessments in place that identified methods to mitigate risk.

People living at the service had access to a wide range of activities that were tailored to their needs. People would go on regular outings with staff to places they enjoyed going. People told us they were very satisfied with the care staff and the support they provided. Relatives told us they were happy with the service their loved ones received. People and their relatives told us they were involved in the planning of their care. Care plans were being reviewed on a monthly basis by staff. Staff respected people's privacy and dignity at all the times. The provider had ensured that people's personal information was stored securely and access only given to those that needed it.

The acting manager was approachable and took an active role in the day to day running of the service. Staff felt confident to approach the acting manager with any concerns they may have. The acting manager encouraged relatives and staff to voice their opinions of the service through regular meetings and surveys. The acting manager used effective auditing systems to identify any areas of improvement within the service. The provider had ensured that there were effective processes in place to fully investigate any complaints. Outcomes of the investigations were communicated to relevant people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

1-3 Emily Jackson Close

Detailed findings

Background to this inspection

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

The inspection took place on 21 and 22 September 2017 and was unannounced. The inspection was carried out by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The service was last inspected on 22 September 2016 and was rated Requires Improvement in the Safe domain and Good overall. A focussed inspection in April 2017 led to a rating of Good in Safe, which meant that all domains were rated as Good.

Prior to the inspection, we gathered and reviewed information we held about the service. This included notifications from the service and information shared with us by the local authority. 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.

As many people living at 1-3 Emily Jackson close could not communicate verbally to us, we observed people's care through interactions with staff. We spoke to four relatives, five members of staff, an assistant manager and acting manager. We made observations of staff interactions and the general cleanliness and safety of the home. We looked at five care plans, four medicines records, three staff files, training records and quality assurance documentation.

Good

Is the service safe?

Our findings

People's relatives told us they felt people were safe living at the service. One relative told us, "I am sure [X] is safe I have no reason to question it." Another relative told us, "There are enough staff so that makes it safe."

People were protected against abuse by staff that had received safeguarding training and could identify the types of abuse and how to appropriately react. One member of staff told us, "I would report any concerns regarding abuse to my senior or manager." Another member of staff told us, "It is about identifying the forms of abuse and reporting them quickly and properly. If I needed to I could contact social services if required." There was a whistleblowing policy, which was displayed on the noticeboard in the office, and the safeguarding policy and procedures were available on the provider's electronic database. The acting manager told us, "We have a traffic light system and if there is a safeguarding concern this is flagged and senior management will provide additional support."

Risks to people's personal safety had been assessed and plans were in place to minimise risk. People had risk assessments that were personalised to their needs and these were reviewed on a regular basis and adjusted if a person's needs had changed. Risk assessments were personalised to people's needs and gave staff guidance on how to reduce the risk. There were risk assessments including, bathing, choking, falls, and moving and handling. Staff were also given guidance on people's specific equipment and how it should be used. Staff were clearly aware of people's care needs, risks and routines and were able to explain how to support each person. Environmental risk assessments had taken place and were being reviewed for infection control risks, health and safety, window checks, maintenance, moving and handling risks, staffing levels and lone working. The provider had ensured that the service was safe with up to date safety certificates for gas appliances, electricity and equipment.

The provider had ensured there were enough staff to provide safe support at the service. One relative told us, "There seems to be a lot of staff around." Each bungalow at the service supported up to six people and had three staff, and this was increased to provide activities and one to one support when required. All staff we spoke to told us there were enough staff to provide support. The provider had ensured that staff were safe to work with the people they supported. We looked at three staff files: these included completed application forms, two references and photo identification. Staff records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure staff were suitable to work with vulnerable adults.

People's medicines were being managed and administered safely. Medicines were stored in a locked cabinet in a locked room. Two members of staff would sign in and check out medicines when people used the service. Each person had a separate medication file that contained a photo and a medication care plan outlining any risks relating to giving medicines such as refusal to take medication/spitting out tablets. There was also a list of medicines used in the home along with possible side effects, and a policy on the use of homely medicines. The file contained records of medication reviews by GPs and PRN protocols for each person.

Good

Is the service effective?

Our findings

Relatives told us they though that the staff were well trained and knew the people they supported well. One relative told us, "They know [X] inside out." Another relative told us, "It is clear they have training and they know how to use it." One member of staff told us, "We are given the time to learn and have lots of training."

Staff received training that ensured they provided safe and effective care. New staff undertook a supervised three month induction programme to equip them with the skills and knowledge to carry out their role. The acting manager used a training matrix to ensure all staff were up-to-date in core training modules that included safeguarding, Mental Capacity Act, food hygiene, and epilepsy. Agency staff were required to undergo an induction that gave them the knowledge required to support people living at the service. This covered areas such as fire evacuation plans and how to share information on people's needs. Staff were encouraged to use the monthly supervision sessions to identify any gaps in knowledge. One staff member told us, "It doesn't matter how much you know, you always have supervision to talk about what you don't know".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the capacity to do so 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 so that they can 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 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. Staff had a good understanding of the MCA and how it affected their roles and the people they support. The acting manager had carried out appropriate assessments of each person and had applied for DoLS authorisations when required. Best interest decision meetings were held when a person was unable to make a decision about their care. The acting manager arranged for an Independent Mental Capacity Advocate (IMCA) to attend the best interest meetings when required, to support and represent the people in the decision-making process. This showed the service was supporting people in line with the MCA.

Staff, people and health professionals were involved in the development of a four week menu that was suitable to people's needs. A dietician worked in conjunction with staff, providing nutritional advice as well as how food should be served; including the consistency of the puree if required. Staff were enthusiastic about the quality and variety of food provided. One staff member told us, "They really appreciate the different food, from different cultures and countries. We've removed any added salt from the diet now and use herbs and spices instead". Staff involved people in the preparation of their meals. For example, one person was supported to choose which vegetables were to be included in a soup. How the person

communicated their likes and dislikes was recorded in their care plan, and staff used this guidance to help understand which vegetables the person wanted to be included in the soup. Each day staff ate the same meal prepared for people using the service. One staff member told us, "If we don't like it, why would we give it to the residents?"

Staff were supporting people with their routine health visits. The expected frequency and outcome of the visits were recorded in the persons care plan. These visits included the GP, dietician, physiotherapist, dentist and Speech and Language Therapist. A visiting health professional told us, "Everything I needed was there, it was all very well documented. I think they respond appropriately and always follow through with what I ask of them".

Good

Is the service caring?

Our findings

People's relatives spoke very positively about the caring nature of the staff. One relative told us, "They take such good care of [X]." Another relative told us, "They are brilliant." A third relative told us, "I have the greatest admiration for what they do there."

Staff were seen to be kind and caring towards the people they supported. One member of staff was seen to assist someone mop the communal area. The member of staff took time and encouraged the person to do as much as they wanted to do. It was clear that the member of staff had built a good rapport with the person as they took turns to use the mop with the member of staff giving guidance as they mopped. Staff were seen to use appropriate methods of communication as identified in people's care plans. Staff were speaking to people clearly and could identify if a person acknowledged them and what they were saying.

Staff demonstrated that they had good knowledge of the people they supported and fully respected their privacy and dignity. One member of staff told us, "I always ensure that we respect their dignity especially when giving personal care. I will make sure the doors are close and that the person is covered up." Another member of staff told us, "[X] loves going out for walks so we always make sure that [X] goes out for walks during the day." This was recorded in the persons care plan. We also saw that this person went out for a walk on both days of inspection with staff.

People living at the service were encouraged to be as independent as possible. Staff told us that it was important that they encourage people to be as independent as possible by providing the correct support. Some people living at the service were unable to get physically involved with day to day tasks. One member of staff told us, "We try to involve people as much as possible in their everyday lives." We observed one member of staff talking though how they were preparing a meal to a person living at the service. Where people could get involved we observed staff supporting people attend to cleaning the communal areas of the bungalows and assisting laying the tables.

There were no restrictions on when friends and family members could visit. One member of staff told us, "People's friends and family can visit when they like. However, they do tend to treat this like a home and call up the person first and let them know." One relative told us, "I could turn up any time, but I always ring out of courtesy."

People's private information was respected and kept secure at all times. People's personal information was kept in a locked cabinet that only staff had access. We observed that staff never spoke about people's private matters in communal areas and that all discussion regarding people's care was left to private hand over sessions.

Good

Is the service responsive?

Our findings

People's relatives told us that there was plenty of choice regarding activities. One relative told us, "I was surprised and impressed at the amount of activities they do." Another relative told us, "They involved them in home activities, such as cooking and loading the dishwasher, from day one." A third relative told us, "They are trying her with different clubs and activities, such as sewing and painting."

Communal and personalised activities were on offer daily at the service. Photographs displayed throughout the service showed people had recently attended an 'It's a Knockout' competition organised by a local community group, a summer fete and a summer party. Swimming classes took place weekly, and were organised by a physiotherapist. Each birthday was celebrated with a party, and the person was supported to choose their own decorations, cake and party food. Activities were reviewed monthly and changed when required. People were also encouraged and supported to take an active domestic role within the service, such as helping with the laundry.

People had their needs assessed before they moved into the home. Information was sought from the person, their relatives and professionals involved in their care. This information was used to produce care plans that were detailed and personalised to the individual. They included information about the person's family history, the support they required, how staff were to provide support, how staff gain consent for support, how the person makes their own choices about their care, and their goals.

A key worker reviewed people's care plans and goals on monthly basis. A key worker is a person who works directly with people to get to know them well and develop their care. Reviews of people's care were being carried out on a monthly basis and took into account what the person had learned, whether they had any concerns, their health and wellbeing and positive risk taking. A formal review of the care plan took place every 6 months that involved people and their relatives. One relative told us, "I was impressed that they did their best to involve [my relative] in her own care planning". These reviews were clearly structured, with family or health professions being invited when appropriate. Other reviews took place when people's needs changed. For example, whilst recording one person's weight on a monthly basis, staff were concerned about their weight loss. The dietician was contacted, and a fortified diet was prescribed. Staff continued to record weight and arranged a further review once the person's weight had reached a certain level. This showed staff were able to respond to people's needs.

People and their relatives were encouraged to make complaints or raise any concerns. The provider had a clear complaints policy and procedure that informed people of how to complain and who else they could contact to discuss any concerns. The policy was on display throughout the service, and an easy-read version was available for people using the service. There had been two complaints in the previous 12 months, both of which had been responded to in line with the policy.

Good

Is the service well-led?

Our findings

Relatives and staff spoke positively about the acting manager. One relative told us, "We speak to her quite a lot and she is always about when we visit." A member of staff told us, "She is very supportive and if we need anything she will be there." At the time of our inspection, there was no registered manager in place. An acting manager had been appointed and was going through the process with the Care Quality Commission (CQC) to become registered.

People's records were not being archived effectively. We found that many records presented information that was no longer valid for the person using the service. For example, contacts for people who were no longer contactable and care methods that were no longer required for people. However, care plans did also display the up to date methods required to provide person centred care for people and this was located after outdated records. This made care plans difficult to navigate and obtain a clear overview of needs and risks. We spoke to staff who could demonstrate knowledge of up to date care records. Any agency staff had to go through an induction of the people they would be supporting and this limited risk. We reported our concerns to the acting manager who told us, "I will start work on this immediately." On the second day of inspection care plans had started to be updated to remove information that was no longer valid and clearly identify people's needs.

The acting manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour that aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. All staff and relatives we spoke told us that they could approach the acting manager at any time. The acting manager told us, "It is important that anybody can approach me. I take responsibility, own up to any failures, and make sure they are put right. I have to be open and honest."

The registered provider had ensured that audits were taking place to make improvements across the service in line with the provider's policy. Audits carried out by the management team included monthly, weekly and daily service checks, and medicine audits. It was noted in one weekly audit that a new thermometer was required in the kitchen and this was obtained. A monthly service check identified that staff signatures required to be updated and this was completed. A recent medicine audit identified that some stock was out of date and this was safely removed. There was a monthly health and safety check inspection that covered kitchen and fire safety checks, staffing and accident and incidents. Senior management would visit the service every three months to carry out a financial and quality audit of the service. The acting manager told us, "There is a traffic light system and if we are rated green it will be three months before we are visited again. If there are concerns then they will visit us more frequently until the issues are resolved. If there are any safeguarding alerts this will mean that a quality visit will be completed straight away."

The provider ensured that people, relatives and staff voices were heard through surveys and meetings. A people and relative survey was carried out yearly along with a staff survey. The 2017 survey was being sent

out in October 2017. The previous survey gave positive feedback and noted improvements made with the service accommodating more external activities.