Care Quality Commission

Southside Partnership

Southside Partnership - Ambleside Avenue

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

Overall summary

Southside Partnership - Ambleside Avenue provides personal care and accommodation for up to six people with learning disabilities and a range of other physical and sensory needs. At the time of our visit there were six people living in the home.

At our last inspection on 18 December 2013 the service was meeting the regulations inspected.

There is registered manager at the home. 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.

Summary of findings

Staff were knowledgeable in recognising signs of potential abuse. They knew the action to take to keep people safe and the reporting procedures to follow.

Staff had the correct information to administer medicines safely and people received medicines when they were prescribed.

Recruitment procedures were safe and there were enough staff available to care for people. Staff had received appropriate training to enable them to meet people's needs. Staff liaised with healthcare professionals to obtain advice about how to support people with their healthcare needs. Staff were implementing care practices that reflected the advice received. For example people were assisted at mealtimes using the advice given by speech and language and occupational therapists.

People were assisted to eat and drink sufficient amounts to meet their individual needs and preferences. People were cared for in line with the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). 'Best interest meetings' were held as required by the MCA in situations when people could not give consent, for example, for a medical procedure.

People were treated in a caring manner and with regard for their dignity and individuality. Staff were attentive to people's non-verbal communication and provided care that took account of their individual needs and preferences. Specialist equipment was provided when appropriate. Adaptations to the building were made to meet particular needs. These included sensory aids to assist people with visual impairments to get around the home and equipment designed to help people with mobility needs.

There were systems to ensure the quality of the service provided was checked regularly and action was taken if necessary to ensure suitable standards of care. Appropriate action was taken in response to incidents with a view to preventing recurrence.

Summary of findings

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 home was safe. Staff were knowledgeable in recognising signs of potential abuse and followed reporting procedures. Recruitment processes ensured staff employed had appropriate skills, knowledge and experience.

People received medicines when they were prescribed.

There were sufficient staff to meet people's needs. Risks were assessed and managed with the aim of preventing harm to people.

Is the service effective?

Good

The home was effective. Staff were trained in a range of subjects that reflected people's specialist needs. Systems, such as training and supervision were in place to support staff to provide appropriate care.

Meals were provided which met people's needs and preferences. Staff assisted people with meals and drinks and ensured they had sufficient to meet their nutritional needs. People's healthcare needs were met and staff acted on advice from involved professionals.

Staff were aware of the Mental Capacity Act 2005 and in the Deprivation of Liberty Safeguards and acted in accordance with them.

Is the service caring?

Good

The home was caring. Staff treated people with respect and regard for their dignity and privacy.

Staff were aware of how people communicated... They were attentive to people's non-verbal communication, recognising what they were saying and responding to their wishes.

Is the service responsive?

Good

The service was responsive. Care planning took account of people's individual needs. A range of health professionals had assisted to write care guidelines and this ensured their specialist advice was reflected in people's care.

People had opportunities to take part in activities which they enjoyed including swimming, bowling, sensory activities, going to church and attending social clubs. The home had developed methods to assess what people enjoyed so they could take their views into account.

Is the service well-led?

Good

The service was well led. There was a registered manager and the focus of the home was on providing good quality care. Visits to the home were made by one of the provider's senior managers to monitor the quality of care. There were effective working relationships with other professionals involved with people at the home and this benefited people by making sure their care was co-ordinated.

Incidents were responded to appropriately and action was taken to minimise the chance of recurrence.

Southside Partnership - Ambleside Avenue

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 18 December 2014 and was unannounced. One inspector carried out the inspection. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home including records of notifications sent to us.

During the inspection we met all six people who live at the home. We undertook general observations in communal areas and during a meal time. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven staff including the registered manager, deputy manager, and five support staff. After the inspection we spoke with the service manager.

We looked at personal care and support records for three people. We looked at other records relating to the management of the service, including medicines records, communication book, staff meeting minutes and accident and incident records.

Following the inspection we asked the registered manager to send us some additional information about training records and details of people's activities and this was provided. We contacted seven professionals who were involved with people living at the home. We received a reply from one person on behalf of a multi-disciplinary team involved with people living at the home, this included speech and language therapists, occupational therapists and physiotherapists.

Good

Is the service safe?

Our findings

People were protected from harm because staff assessed risks to make sure everything was done to prevent them. Staff had completed training in person centred risk management and used this knowledge to write individual plans for people to prevent harm without limiting what they could do.

Staff knew how to report their concerns if they felt any of the people living at the service were at risk of harm. Staff were trained in safeguarding people. Several of the staff members had worked with people for a long time, and knew them well so could identify behavioural changes which may have indicated they were distressed. Staff had shared this information in the care records so they were helped to interpret people's non-verbal communication. The records contained information about other behavioural signs to help staff interpret people's communication.

Safeguarding was discussed at individual and group meetings between staff and managers. In October 2014 a team meeting was held to explore safeguarding in relation to the people who lived at the home, this helped to increase staff awareness of the particular risks they faced.

The provider had a whistleblowing procedure which staff were familiar with and had access to through the organisation's intranet records. The staff team had been trained in equality and diversity issues. This assisted staff to be aware of discrimination and the harm people could experience as a result.

People who needed assistance to move safely had equipment available and staff followed the procedures to use it safely, for example two staff were always available to assist people using a hoist. All staff had been trained in safe moving and handling methods. Risks of developing pressure ulcers had been assessed and appropriate equipment was available, including specialist cushions and beds, to reduce the risk of ulcers developing.

Staff knew how to respond to emergencies. They had received training in first aid, fire safety and dealing with medical emergencies such as choking and resuscitation. Emergency equipment was available including first aid kits, fire detection and safety systems. Regular checks made sure that the equipment was in good order.

When we visited there were three care staff on duty in addition to the deputy manager. This was to ensure sufficient staff were available to take two people to the theatre in the afternoon and to give the individual care at mealtimes that some people required. There were two vacancies in the staff team which were filled by regular staff from an agency. As the staff worked as full members of the staff team this assisted in ensuring they were familiar to people in the home and with their needs.

Staff recruitment procedures were safe. We spoke with a newly recruited member of staff who described their recruitment as "thorough and professional". They told us they had to provide information for the organisation to make checks on their suitability for the post. These included referees' details (including a previous employer) and a work history. They also provided information for a criminal records check. The recruitment process included an observation of the applicant's interaction with people with learning disabilities. Appointments to posts were not confirmed until the person had successfully completed a probation period of at least six months.

Staff gave people their medicines at the times prescribed by the GP. Records of medicines administration showed staff had appropriate information to give medicines safely. Staff had information about why each person took the medicines prescribed for them and listed potential side effects. They could take action to protect people if they showed any ill effects. Medicines given 'as needed' included instructions from the GP about when they would be necessary so people were only given them in the correct circumstances.

Good

Is the service effective?

Our findings

Staff had received training that was relevant to the needs of the people living in the home. All staff had received training the provider had identified as mandatory for their work. This included a range of health and safety courses including safe moving and handling, fire awareness, food hygiene, infection control and first aid. In addition, staff had training to meet the specialist needs of the people who lived in the home. This included supporting people with a visual impairment, autism, epilepsy, malnutrition care and assistance with eating, and communication skills including supporting non-verbal communication. Both members of the management team were undergoing training to develop their leadership skills. Three of the staff team had achieved qualifications in health and social care.

Newly appointed staff received an induction to the home and the people who lived there. One staff member told us it was useful to work alongside colleagues who were very familiar with people's needs so they could learn from their experience.

Team meetings were sometimes used to increase staff's knowledge of how to support people. For example a recent meeting had included a demonstration of a range of tools to promote communication with people with complex needs using touch and music.

All staff received regular supervision and an annual appraisal to assess their progress and identify training needs.

Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff understood that people's liberty could not be restricted without authorisation. Applications had been made in relation to DoLS for people living at the home, the manager had discussed the applications with the local authority and was waiting for the outcome. Staff identified situations when people did not have the capacity to make specific decisions independently. In these cases meetings were held to reach decisions in their best interests as required by the MCA. We saw these had been held in appropriate circumstances, for example when a person required a medical procedure and was unable to give consent.

Our observation of a meal showed staff were attentive. The meal was arranged so that people received uninterrupted support from the same member of staff. This helped to make sure the person was assisted correctly. The people who lived at the home required support at mealtimes. Specialists including dieticians, speech and language therapists, physiotherapists and occupational therapists had provided guidelines for staff to ensure that people's needs were considered and met. The guidelines were detailed and included information about the kind of food that should be served and how people were to be supported. Staff demonstrated knowledge of the guidelines and we observed them in practice during a meal we observed.

People's needs in relation to nutrition and hydration had been assessed and food and fluid charts were in place for those who required their intake to be monitored. The records were completed fully.

A document called 'keeping me safe and well' was completed to identify areas where people needed assistance with health care and these were included in care plans. Referrals were made to specialists if new needs were identified. For example people were referred for advice from community nursing staff to address their pressure care needs. Specialist equipment was provided after their assessment.

People's individual health care needs were attended to. They had regular contact with the GP and healthcare specialists as required. Their advice and recommendations were taken into account in care planning and we saw that staff implemented the plans in their work. Information about how to respond to health problems was included in records. One person was prone to eye infections and there was information about how to prevent their development, how to detect if one was occurring and the action to take in response.

Staff responded to health emergencies appropriately. We were told that when a person had an accident an ambulance was called and they were transferred to the accident and emergency department for investigations. Staff followed the hospital advice to ensure the person remained safe and well when they left hospital.

The premises had been both designed and adaptations made to take into account people's individual needs. There was level access throughout the home and garden and a lift between the two floors. Toilets and bathrooms had equipment suitable for people with mobility needs. A range of sensory features allowed people with visual impairments

Good

Is the service effective?

to find their way around the building safely. We saw a range of equipment which was suitable for the needs of people living in the home. This included sensory equipment to provide stimulation and entertainment for people and items which promoted people's independence at meals such as adapted cutlery, cups and plate guards.

Good

Is the service caring?

Our findings

People received care that was kind and compassionate. We observed staff talking with people in a warm and respectful way. While assisting people at lunchtime staff sat on the same level and responded to their non-verbal communication. For example staff noticed when the person indicated they didn't wish to eat any more. They showed awareness of people's preferences. The staff assisting people spoke calmly, told them the items making up the meal and helped in a way that was unhurried and responsive to the person.

Staff provided individualised care which reflected people's wishes. Members of the staff team had worked with the people for a long time and knew them well. They had shared their knowledge about people verbally and in individual care records. This assisted newer staff to become familiar with people's needs and methods of communication. The registered manager was aware of the foods that reflected one person's cultural background, but their experience of working with them showed that these were not the person's favourite foods. This knowledge enabled staff to ensure the person was offered a range of meals that reflected their tastes and preferences.

Staff encouraged people to dress appropriately for their activities and in a way that promoted their dignity. For example, staff supported people to change their clothes after meals if they had split some food or drink. Staff made sure that people were assisted with personal care tasks in privacy with the doors and curtains closed.

People's confidentiality was protected. People's records were kept in the office and were inaccessible to visitors. Conversations about people's needs took place in private.

Care records were personalised and focussed on each individual, for example they included a section on the person's life history so that staff were able to understand their background. They also had a section headed 'what people like and admire about me' this contributed to the records and care plans being positive about the person rather than focussing on the person's range of disabilities. For example one person's record said that people liked that the person was "helpful" and "liked a pint in the pub".

Staff contacted people's relatives, when they were known, to maintain relationships with family members. Advocacy services had been involved with people and this had assisted them to have someone independent of the home representing their interests. For example, when decisions were considered about health procedures.

People were supported to celebrate birthdays and religious festivals.

Staff showed concern for people's well-being especially as they were aging and their health needs had increased. Work was underway to develop plans for care for people at the end of their lives and plans had been completed for two people. This was being approached with sensitivity, involving relatives where possible and the team had sought the advice of social work colleagues. People had pre-paid funerals arranged and records were made of any religious or cultural needs in relation to their end of life care.

Good

Is the service responsive?

Our findings

People's individual needs were reflected in their care plans. The plans included guidelines for staff to follow to ensure they were consistent in the way they provided care. People's disabilities meant that the staff had to use their knowledge of them to assess their choices. For example each day staff completed a 'daily learning log' for each person detailing what happened that day with information about what went well and what did not go so well for them that day. This gave information about how people responded to the events and activities of the day so staff could use it to review current arrangements and, as far as possible, take their preferences into account. Care plans were reviewed and developed in response to changing needs and included input from involved professionals.

People took part in a range of activities in and out of the home and were assisted to take part in things they enjoyed. People had 'person centred active support' plans and these were used to increase their involvement in the home. For example one person was encouraged to develop independence skills by taking part in household tasks such as peeling and cutting vegetables and setting the table for meals.

On the day we visited two people went to a theatre to see a Christmas show, and we saw two other people at home using foot spas. The people looked relaxed and calm and staff said they enjoyed it. Sensory equipment was available and we saw it in use. We also saw a person enjoying a music session with a member of staff. There were good links with the community through the activities that people followed and these gave them opportunities to meet people from outside the home. The community activities included swimming, bowling, shopping, going to pubs and restaurants and going to clubs for older people. One person went to interactive story sessions run by a local voluntary organisation. People had the opportunity to go to places of worship and one person went to church each week.

Staff were aware of people's methods of communicating and were sensitive to people's moods which would assist them in detecting if people were unhappy with an aspect of their care. There had been no complaints made about the home in the last year. It would be difficult for people at the home to raise complaints independently so the contacts outside of the home, with other health and social care professionals, family members and with an advocate were important in ensuring that their views were represented. The manager took seriously concerns raised by professionals about the people living in the home and worked with them to ensure care met people's assessed needs.

Good

Is the service well-led?

Our findings

The home had a registered manager in post as required by their registration with the Care Quality Commission (CQC). They had been registered since April 2013. She was suitably qualified and experienced for her role. In addition to managing the home at Ambleside Avenue she managed another home two miles away run by the provider. Each of the homes had a deputy manager who took over management responsibility in the registered manager's absence.

A staff member described the registered manager as "a good manager, one of the best I've had" and said that she was approachable saying if they had concerns "you can go to her". We heard how staff had raised concerns with her and she had addressed these through the supervision process. They followed processes to deal with staffing concerns in the staff team. A staff member said there had been a lot of changes in the staff group over the last year but felt that they now had "a good team". We found the registered manager was committed to meeting the needs of the people who lived in the home and was striving to deliver good care for them. For example she stated her wish to "ensure that people are engaged with the best possible support."

The registered manager was familiar to and with the people who lived in the home and had developed working relationships with the range of professionals who were involved with them. There were opportunities for support through staff meetings and handover meetings between shifts. Staff told us they felt the staff team was supportive to each other, they said "we all help each other, and we work as a team."

The registered manager and staff undertook regular checks to ensure the quality of the service. Health and safety and basic finance checks were undertaken daily. Senior staff checked logs and records every week to make sure they had an overview of events in the home and people's progress. This ensured that issues could be addressed quickly when necessary. Other managers from the provider's services visited to observe care at the service and ensure staff were providing it in a way that met people's needs, and for their dignity, choice and independence to be promoted and protected. The visitors gave the registered manager feedback about their observations and this was used, in discussion with the staff team, to improve the service provided. Members of the executive board visited occasionally to ensure they were in touch with the range of services the organisation managed.

The service manager visited the home regularly and carried out audits every year, these included full financial audits, ensuring that health and safety was managed properly. Action plans for recommendations arising from these audits were drawn up and a programme of improvements developed where necessary.

The manager notified the CQC about incidents they were required to tell us about. Records of incidents included information on the action taken to prevent recurrence.

The provider had signed up to the 'Driving up Quality Code' which was established after the exposure of abuse at Winterbourne View. It aimed to ensure that people were provided with high quality support. The organisation had carried out a self-assessment based on the code to assess their progress towards meeting the identified best practice and incorporated action in their overall business plan.