Mrs Gail Fraser

Harper House - Stourbridge

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

This inspection took place on 29 January 2016, was unannounced and was carried out by one inspector. The provider is registered to provide accommodation and personal care for up to five people. People lived with a learning disability, autism and some people have additional sensory impairments. On the day of our inspection five people lived at the home.

At our last inspection in October 2013, the provider was meeting all the regulations we assessed.

There was a registered manager in post and she was present during our 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 and associated Regulations about how the service is run.

People felt safe using the service and risks to their safety had been identified. Staff knew how to support people safely and had training in how to recognise and report abuse.

Summary of findings

People were supported to take part in everyday living tasks and to do the things that they enjoyed. The risks associated with these activities were well managed so that people could undertake these safely and without any restrictions.

People had their medicines when they needed them and staff were trained to do this safely.

The staffing arrangements were flexible and ensured that people had the support they needed to meet their needs and pursue their interests.

Staff had received a full induction, appropriate training and support and were knowledgeable about the needs of people.

People were asked for their permission before staff provided care and support so that people were able to consent to their care. Where people were unable to consent to their care because they did not have the mental capacity to do this decisions were made in their best interests. Staff had worked in people's individual best interests but needed to ensure they considered potential impacts on other people.

We saw people were supported to remain healthy and well. People liked the meals and had been involved in choosing their meals and the times they preferred to eat these.

People had positive and meaningful relationships with staff who they had known for many years. We saw staff were attentive and caring towards people. Staff used people's preferred communication to ensure their individual choices were fully respected. Staff promoted and protected people's dignity and privacy while they supported people with their needs.

People's care plans described their needs and abilities and people had contributed to these. Staff supported people to follow their own daily routines and interests. Staff had supported people to express their views on the care provided and this had led to their care being tailored to meet their needs.

There was a complaints policy in place and staff were aware how they could support people to communicate if they were unhappy about something. We saw that people had named family or representatives to advocate for them.

Regular checks had been undertaken to maintain the quality of the service. The registered manager had actively looked at ways to benefit the lives of people living at the home. They had organised staffing to accommodate people's lifestyles and choices. Staff had the support and training to be able to provide a service that was based on promoting people's quality of life. This meant that people were benefiting from a service that was continually looking at how it could provide better care for people.

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?
The service was safe.

People felt safe living at the home. Staff knew how to keep people safe and had supported people with their own safety outside of the home.

Potential risks to people's well-being were well managed.

Staffing levels ensured people were safe and could enjoy their chosen lifestyle.

People received their medicines when they needed them and in a way that was safe.

Good

Is the service effective?
The service was effective.

Staff had received the training they needed to support people effectively.

People were asked for their consent in ways they understood. Staff had worked in people's individual best interests but needed to ensure they considered potential impacts on other people.

People liked their meals and had been involved in menu planning so their meals met their likes. People received support to stay healthy and well.

Good

Is the service caring?
The service was caring.

People were treated with kindness and respect by staff who knew them well and understood their likes and dislikes. Staff had positive caring relationships with people.

People's privacy and dignity was respected and their independence promoted.

People were supported to maintain relationships with people important to them.

Good

Is the service responsive?
The service was responsive.

Staff were responsive to any changes in people's needs and ensured people consistently received the support they needed.

People chose how they spent their time and were supported to follow their own recreational interests.

Staff supported people to share their concerns and people knew who to approach when they were unhappy with their support.

Good

Is the service well-led?
The service was well led.

The manager's inclusive style placed people at the centre of their focus so that the service provided revolved around people's needs.

Good

Summary of findings

The quality of the service was monitored and focused on enhancing the lives of people living in the home.

Harper House - Stourbridge

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.

This inspection took place on 29 January 2016, was unannounced and was carried out by one inspector.

We looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of serious injuries to people receiving care and any safeguarding matters.

We asked for information about the home from the local authority who is responsible for monitoring the quality and funding of placements at the home.

We met all of the people who lived at the home and spoke with three people about their experiences. Some people were unable to verbally tell us their experiences of living at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the facial expressions and gestures of two people to indicate their response to care. We spoke with the registered care manager who is also the provider, and four staff members. We looked at the care records for two people, the medicine records for five people, accident and incident records, complaints and compliments records, one staff file for training and recruitment and records related to the quality monitoring systems. In addition we observed the delivery of care to people throughout the day.

Good

Is the service safe?

Our findings

People showed us they felt safe in the company of staff. For example we saw that when staff arrived and entered the lounge two of the people began to vocalise loudly, smile and clap their hands. We saw they moved towards the staff member and touched them in greeting. People were smiling and their body language was animated. This clearly indicated that people were happy to see staff and they looked relaxed in their presence. Another person told us, “Yes they [staff] are good, look after me well”.

We saw that the views of people’s relatives and external professionals about people’s safety had been captured in people’s care records. The feedback was consistently positive and centred on the standard of care provided; the environment, and the expertise of staff. One professional described in care records that staff had the expertise to manage challenging situations in order to keep a person safe.

Staff we spoke with were knowledgeable about safeguarding and whistle blowing procedures. They had had training and were able to tell us how they would respond to allegations or concerns. They recognised that changes in people’s behaviour or mood may indicate that people were afraid, being harmed or unhappy. One staff said, “We wouldn’t hesitate to report concerns”.

We saw that risks to people’s safety were managed in a structured way. For example we saw staff were aware of people’s sensory disabilities such as epilepsy. Risk management plans within people's care records provided guidance to staff about how they should support people with epilepsy. One staff member described the precautions they took when out in the community and we saw from records that staff had acted in this way when the person had a seizure. The staff member told us, "We know the risks associated with people and before we go out we follow the precautions in their plan”. We saw that they had appropriately pulled the vehicle off the road to tend to the person and this matched the guidance staff had been given to manage situations in a safe way. We saw examples where staff practices reflected people's risk assessments. For example how they supported a person with their mobility when using the stairs. Staff described to us how they did this to ensure the person’s safety and we saw they supported the person in this way.

One person told us, “I go out by myself”. We saw this person had a detailed risk management plan which provided guidance to staff about the behaviours that might make them vulnerable within the community. This included input from health professionals and the community learning disability team so that the person benefitted from having appropriate support with their safety and welfare. We heard from staff how they supported people who could present behaviour that challenges. We saw there was a good understanding amongst the staff team about the person’s individual behaviour patterns and the strategies they should employ to reduce the risk of significantly challenging situations. We heard from staff how they put positive actions into practice when dealing with difficult situations that could potentially cause harm or compromise people’s safety. For example, recognising the signs of extreme anxiety and knowing what actions could help the person to relax. This showed there was a person centred approach to people’s individual behaviour and safety needs. We found that risks to people had been thoroughly assessed.

We saw that the registered manager had a consistent approach to the review of people’s safety. We saw this included an analysis of accident and incident reports. There had been some minor falls and trips but no pattern or trends and these had been reviewed accordingly. No incidents had taken place recently and the registered manager told us these would be reviewed in the same manner. No person required the use of aids or equipment. The manager had systems in place to check on the safety of the premises and we saw that each person had a personal evacuation plan in the event of a fire.

There was enough staff on duty to meet people’s needs and keep them safe. One person said, “There’s always two or three staff I think that’s enough”. One staff member said, “There are enough staff on duty; we can meet people’s needs as well as respond to their requests”. We saw the staffing levels were ensuring there was enough staff available to meet people’s individual needs so people could do the activities they wanted. We saw staffing levels accommodated the needs of people because we saw people were supported to go out both in the morning and afternoon. On-call arrangements were in place to support staff in an emergency or to cover staff sickness.

Recruitment processes were in place to help minimise the risks of employing unsuitable staff. We spoke with a newly

Good

Is the service safe?

recruited member of staff who confirmed that reference checks and Disclosure and Barring Service (DBS) had been undertaken before they had started work. The staff member told us, "I had to produce references and a police check before I was able to start work". We saw from staff files that the provider's recruitment processes contained the relevant checks before staff worked with people.

One person was able to tell us that they had medicine, "Yes I have some every day and some I only have when I need them". We found the systems in place for managing medicines were safe. We saw that people's medicines were stored safely and that staff had received training to administer medicines. People's medicine records had been completed to confirm that people had received their medicines as prescribed. Some people required medication on a 'when required' basis. Staff knew when people would need their 'when required' medication and written guidance on when to give this medication was available. We checked the balance of people's medicines and saw these matched their records. Daily balances of people's medicines were evident allowing staff to pick up any errors quickly. We also saw that people's communication methods had been recorded so that staff could tell from their body language or gestures if they were experiencing pain. We saw that there were systems in place to support people's right to self-medicate. One person had consented to staff managing their medicines; their records showed that they had expressed their reasons for this. Due to other people's complex needs they had been assessed as unable to manage this aspect of their care.

Good

Is the service effective?

Our findings

One person told us "I am happy with my support; staff know what I like to do." Our observations showed us that the support and assistance provided to people was effective in meeting their needs. For example, we saw staff communicated with people using a mixture of verbal communication, gestures and sign language. We saw a staff member ask a person if they would like a drink whilst they used the Makaton sign [a system of standard signs and hand signals] for a drink. The person signed back and smiled and said, “drink” which showed staff had the skills to communicate effectively with people in a way they understood.

We saw that staff recognised that some people’s non-verbal behaviour is a communication of their need. For example we saw a person present repetitive and compulsive behaviours to which staff responded consistently and positively. A staff member told us that the person’s behaviour was, “Checking we are here; they are anxious about what’s going on”. We saw staff on each occasion acknowledged the person’s presence, one staff responded to the person by saying, “We are just talking you can join us if you would like”. Another person had set routines regarding the times of their personal care. A staff member told us, “We have had training in autism and for this person they have a set routine which is their preference”. We saw that staff had established people’s choices by observing their behavioural response and that this had helped them to recognise what suited people so that they could meet their needs more effectively. We saw that people were supported to live their lives in the way that they chose. For example we saw during the day that people were supported to manage their own personal care, make choices about how they spent their time and whether they engaged in daily domestic tasks such as washing, drying or cleaning up. We saw that staff promoted people’s independence and autonomy by acknowledging their skills; “Thanks for doing that [washing a cup]”.

We spoke with one staff member who had recently started work at the home. They told us they had received an induction and had initially worked alongside other staff so they were supported to learn about people and their needs. We saw the provider had implemented the new Care Certificate to enhance their induction processes further. The Care Certificate is a set of standards designed to equip staff with the knowledge they need to provide people’s care. There was documentary evidence to show all of the staff had a development plan and training record. A senior staff member told us, “We do a full induction, observe their practice and provide regular support and supervision”. Records confirmed that these processes were established so that staff had the skills and confidence to undertake their care role.

Staff told us they were happy with the training and support they received which had included meeting the needs of people with learning disabilities, autism, schizophrenia and behaviour that challenges. They were confident they had the guidance to help them to understand people's specific needs. For example recognising the importance of providing structure for some of the people. Staff had also completed varying levels of recognised qualifications in health and social care to a level to meet people’s needs. Staff had regular supervision in which they discussed and reflected on their care practice and training needs.

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 interest 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 application procedures for this in care homes and hospitals 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.

We saw staff were seeking people’s consent by interpreting people’s gestures, expressions and actions which showed them if the person agreed to the support being offered. We observed that people made their own decisions about their care; what time they got up or went to bed, what they ate, and decisions about their personal care routines. The care records we looked at showed where people did not have the mental capacity to make decisions about aspects of their care, relevant people had been consulted to ensure decisions were made in the person's best interest.

Good

Is the service effective?

Decisions regarding some people's health had been made appropriately using this process. A staff member told us, "We had a meeting because the person did not have the capacity to make a decision about their health care".

Staff understood it was unlawful to restrict people's liberty unless authorised to do so. We saw people's movements were not restricted and some people went out independently. Staff we spoke with had received training in respect of the MCA and DoLS. The registered manager demonstrated she understood when applications for a DoLS should be considered although no one's liberty was restricted at the time of our inspection. However we noted that safeguards in place for one person's safety did impact upon other people's living arrangements. We discussed with the registered manager the need to reflect that they had considered the least restrictive options and she told us she would review this.

We saw people were supported to have sufficient to eat and drink. Menus and choices had been discussed at meetings held for the people who lived at the home. One person said, "The food's good, we choose and I have what I like". We saw staff supported people to eat when they were ready; we saw breakfast for some people was later to accommodate people's waking times and routine's. We saw that people chose to go out with staff to buy a 'fish and chip' meal. We observed they were supported to add sauces and a drink of their choice. During the day we saw people had drinks when they indicated they wanted them. We saw arrangements for online and actual shopping were taking place with people. Staff spoken with were aware of people's food likes and dislikes and risks associated with choking due to conditions such as epilepsy. We saw that staff were vigilant when supporting people at mealtimes and in the vicinity of the kitchen. People had regular opportunities to eat out. Assessments of people's nutritional risks were in place supported by weight monitoring to identify any risks.

Staff recognised changes in people's health and had taken preventative action. For example a person had seen the doctor the previous day and staff were able to tell us how they recognised that the person was not well. People's care records showed how, and when their health needs would be addressed. People were not able to tell us who they saw but we confirmed from their records that health professionals were seen regularly such as community learning disability nurses, psychiatrist, dentist, opticians and community psychiatric nurses. We saw people were supported to access specialist health practitioners for their complex needs such as the epilepsy nurse and mental health services. We saw good use was made of resources to promote people's health and well-being.

Good

Is the service caring?

Our findings

People showed us they were happy and confident to approach staff. For example we saw that before staff could greet people, people initiated their approach to staff first. We saw people smile, vocalise and touch staff to communicate their pleasure at seeing them. We saw that staff responded to people's greetings before staff greeted us which showed respect for the people they were supporting.

One person told us, "I've lived here for years with the staff".In all of our interactions with staff we found that they consistently spoke about and referred to people in a caring, positive and respectful way showing they had a high regard for people they supported. Staff members told us they felt like everyone was part of a big family. We saw that for people they had a history of living together as a group and it was evident there were strong bonds between them. The provider had known people for a number of years and she and staff considered people as part of their extended family. One person told us they had been to staff's houses and they knew staff's family members indicating a close knit bond between people and staff.

We saw staff expressed concern and compassion when describing a past emergency situation regarding a person's health. They spoke in an emotional way which showed their concern for the person's wellbeing and their response was clearly a caring one. We saw staff were caring and thoughtful because they listened to people and responded to the things that mattered to them. For example we saw one person discussing hairstyles and make-up and they received lots of compliments from staff which we saw from their smiles made them feel happy.

We saw staff assisted and supported people in a kind and caring way. We saw for example that staff always acknowledged people's attempts to communicate, verbally or non-verbally. For example when a person walked by staff spoke with them or gestured to them, "Are you alright". We saw staff listened to people and checked their own understanding by repeating back to the person to establish what they wanted. For example, "You don't want to go out now, but you want to go out later, is that right?" This showed staff were unrushed and were patient when establishing what mattered to people.

Staff described their work as a 'pleasure' and we saw they expressed pride in people's achievements. For example they were able to describe to us the personal achievements people had made. One staff member told us, "[Person's name] is brilliant; it took him some years but he has conquered those issues". We also saw correspondence from an external professional which showed staff had created a living environment in which this person was able to feel 'secure' and in which their anxieties had reduced. This showed staff had taken positive and successful action over a number of years to help relieve the person's distress.

We observed that there was a high level of engagement and interaction which was warm and inclusive and involved everyone having a say about their day. For example we heard staff speaking with people and seeing what they wanted to do and supporting them to do it, such as going out for lunch. It was evident that staff worked hard to ensure they could accommodate people's requests which we concluded showed a caring and person centred approach.

People's lifestyle choices were central to the care being delivered and we saw that the routines of the day were focused on each individual who led the way in what they wanted to do. For example people had their own specific routines and ways of doing things and we saw staff supported them to follow these so that their goals and wishes were being addressed. One person told us they enjoyed going to the library to borrow CD's which they enjoyed. We saw that staff had supported people to make choices and decisions about activities, meals and who supported them. We saw people were supported to maintain their independence and managed some aspects of their own personal care. We saw staff were attentive and respectful of people's daily routines which meant they supported them to get up or go to bed at the times they had chosen. Staff told us some people enjoyed joining in cooking, shopping and domestic tasks such as cleaning their rooms and managing aspects of their laundry, some of which we observed on the day.

We saw staff promoted people's self-esteem. For example we heard staff compliment people on their appearance. We saw people chose their preferred style of clothing and had been supported to a high standard with their appearance;

Good

Is the service caring?

dressed in individual styles that reflected their age and gender. A person told us, “I sometimes dye my hair”. This showed that staff recognised the importance of how people looked and felt about themselves.

Staff interpreted people’s body language and behaviour and knew when people were becoming anxious. We saw staff provide reassurance to reduce people’s anxiety with our presence and people responded to this.

People’s privacy was promoted and we saw that their choices had been explored and respected. For example two people shared a room; privacy screens were evident but people had stated it was their wish to share as they were accustomed to this. Arrangements were in place to support people with their personal mail, bank accounts and finances. A person told us, “I have my own money when I want it, I’m skint now though”.

One person told us they were supported to maintain relationships with people who were important to them. People were supported to have visits from and to their relative’s homes. The home’s vehicle enabled people to access places more easily.

Good

Is the service responsive?

Our findings

One person told us, “I’ve lived here for years, it’s good”. Our observations showed that people received consistent care and support that was responsive to their individual needs. For example we saw that the day was organised around people’s individual needs and that people had support in a way they needed.

People’s needs and choices had been identified with them. They had all lived together a number of years and had been involved in identifying their needs, choices and preferences by expressing these both verbally and through non-verbal communication. We saw staff knew people's needs well. A staff member said, "Everybody has their own routines and we have explored what they respond to and we support them in a consistent way”. We saw examples of this where people’s routines in the day were specific to them; the time they got up, how their personal care was carried out, and what they ate. We saw people’s care plans were personal to them, descriptive and considered their complex needs in relation to conditions such as autism, epilepsy, behavioural needs and mental health needs. Staff told us one person could put themselves or others at risk of harm if they became anxious or distressed. We saw guidance was available to staff as to how to support the person to reduce their anxiety. Staff were aware of how to respond to the person’s needs. We saw another person demonstrate some compulsive behaviour and staff responded by using strategies which distracted them so risks to their wellbeing were reduced. A structured day and set routines suited one person’s needs and we saw this had been developed around their preferences and met their needs for a degree of ‘certainty’ over their day. We found that continual assessment of people’s needs had identified their individual lifestyle preferences and people’s days evolved around these.

We saw that staff regularly reviewed people's needs with them by asking them or observing their response to the support delivered. Any concerns about people’s well-being were shared with appropriate external specialists so that a multidisciplinary approach was used to ensure that the right external professionals were involved in managing and reviewing people’s complex needs. Staff told us they handed over information at the end of shifts on a daily basis to ensure people had a consistent response to their needs.

We saw there was a high level of consideration for people’s needs which included ensuring they had a calm, spacious environment which allowed them space to choose whether to socialise or not with their peers. People were seen to direct their daily activities; choices were offered and we saw staff responded to the things people wanted to do. For example one person went out for a walk in the morning, everybody went out for lunch and another person chose to go out later in the afternoon. Some spontaneous activity also took place which had included visiting the pub, places of interest and social gatherings with people outside of the home. We saw there was flexibility in order to accommodate people’s wishes and provide care centred on the person.

Staff were aware that some people would be unable to make a complaint directly due to their communication needs and level of understanding. However people's care plans contained information about how people communicated if they were unhappy about something. We also saw that people had named family or representatives to advocate for them. We saw people’s care, their activities and general well-being were reviewed monthly. A staff member said, “By reviewing and monitoring we can see if people are communicating something that might indicate they are unhappy or sad”. The registered manager told us they had a complaints process for responding to any complaints. There had been no complaints made about the service. There were a number of compliments paid to staff and we suggested they record these as part of their feedback on people’s experiences.

We saw people were supported to maintain relationships with people who were important to them. People were supported to have visits from and to their relative’s homes. The home’s vehicle enabled people to access places more easily.

Good

Is the service well-led?

Our findings

The home was owned and managed by the registered manager who had daily contact with people and worked alongside staff on a daily basis. All of the people had lived at the home for a number of years. People showed us that this was 'their home' and this was clearly demonstrated by the style of management. For example there was a positive and inclusive culture which ensured people received person-centred care and support. People showed us that they had a positive relationship with the registered manager because we saw that they reacted in an animated way when she was present; gravitating to her, smiling and vocalising.

The registered manager had a clear set of values which we saw that staff understood and put into practice. This was evidenced by the positive interactions we observed between staff and the people they supported. We saw a high level of involvement of people in their own care; for example people directing their own routines for the day. There were no rigid routines and people had flexibility and control around when they ate or got up and what they did. A staff member told us, "Everything we do is centred on people; we take our lead from them, how they react, whether they refuse, just try and interpret what it is they want to do".

We saw people were involved in how the service was run in a way that was meaningful to them. For example staff demonstrated an understanding of equality and diversity and put this into practice by supporting people to make their own choices about their everyday opportunities and to say what they wanted or liked. These values had been used to shape the service delivery. For example staff ensured all aspects of people's care such as their dignity, independence, safety and life choices were respected this meant people were at the centre of the service and everything revolved around their needs. Flexible staffing levels ensured that people could act spontaneously and get the support they needed to enjoy their choices.

The registered manager had ensured that the views of people who lived at the homeand their families. had been regularly sought via surveys. The results of these told us that people were very happy with the care provided. We saw correspondence in people's care files where external professionals had made positive comments regarding how the home was managing people's complex needs and highlighted some examples of significant improvements for individual people. We saw that people's views about the service were also sought through regular meetings and daily conversations with staff. This showed that the registered manager had asked people what they would like and she had taken action to meet requests.

Staff were aware of the whistle blowing procedures to report concerns about the conduct of colleagues, or other professionals. Staff were confident that the registered manager would support them with any concerns. A staff member told us, "These people are like my family and all the staff feel like that; we would not see anyone mistreat them". We saw that staff were highly motivated, received the training and support they needed to meet people's needs and everyone we spoke with told us they loved working in the home.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of this requirement. The registered manager had kept themselves up to date with new developments and requirements in the care sector. Our discussions with the registered manager showed they were aware of the new Care Certificate and they had introduced this with new starters to improve the induction process.

Quality assurance and monitoring of the home was well established and carried out both on a daily basis and via regular audits. We saw that they had proactively focused on the needs of the people within the home so that any improvements were centred on the people who lived at the home. For example what meals they wanted, specific trips or entertainments. The registered manager told us they had positive links with specialist organisations that provided specific guidance that enabled them to follow best practice in the delivery of people's care.