High View Care Services Limited

High View Care Services Limited - 9 High View Road

Inspection report

9 High View Road
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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

High View Care Services Limited – 9 High View Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. High View Care Services Limited – 9 High View Road does not provide nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service supports up to five people with acquired brain injury. People also had a history of substance misuse and other mental health issues. There were four people using the service at the time of our inspection.

At our last inspection in July and August 2016 our Mental Health Inspection Team inspected the service but we did not rate independent substance misuse services at that time. However, we found areas of good practice and a few areas for improvement including ensuring safeguarding concerns were referred to the local authority and that complaints were responded to promptly. At this inspection we found the provider had taken sufficient action to improve in these areas and we rated the provider Good overall. However, we rated the provider Requires improvement in relation to the key question 'Is the service effective' as there was lack of training for staff to protect themselves from physical aggression despite this being a known risk. People were not exposed to the same risk at the time of our inspection.

There was no registered manager in post at the time of 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 2008 and associated Regulations about how the service is run. A manager had been in post since November 2017 and there had been unavoidable delays in the process of registering with us.

Risks relating to people's care were well managed and staff were trained to understand people's behaviours and how to deescalate situations where possible. Staff received training in a range of topics to help them understand people's needs, including acquired brain injury, mental health issues and substance abuse.

The provider had an in-house psychological therapies team and an occupational therapy team who provided people with individual support and worked with staff to help them understand people's needs.

People were supported by staff who the provider checked were suitable to work with them. There were sufficient numbers of staff deployed to support people safely and to spend time interacting with people in a meaningful way.

People's medicines were managed safely, and the provider had robust processes to check people received their medicines as prescribed.

Systems were in place to safeguard people from abuse as the provider trained staff to understand the signs of abuse and the action to take if they had concerns.

The premises were maintained safely with a range of health and safety checks. The premises met people's support needs as there was sufficient space for people to occupy themselves in their own company or the company of others.

The provider assessed people's needs and developed care plans to meet their needs and preferences, involving people in the process. People's care plans reflected their physical, mental, emotional and social needs, their personal history, individual preferences and interests.

The provider was meeting their responsibilities in relation to the Mental Capacity Act 2005 and people received care in line with the Act. The provider followed legal authorisation to deprive some people of their liberty as part of keeping them safe.

People received choice of food and food was provided to meet people's cultural preferences. Staff supported people with their day to day health and people had access to the healthcare professionals they needed.

Staff knew the people they supported and developed positive relationships with them. People were treated with dignity and respect. Some people were supported to build their daily living skills, so they could live independently in the future. Other people who would require a high level of care through their life were supported to maintain their independent living skills.

People were provided with activities they were interested in and the provider told us they were developing the activities provision further. People were supported to maintain and develop relationships to reduce social isolation.

A suitable complaints process was in place and complaints were responded to appropriately and clearly recorded.

Leadership was visible across the service and the provider received close support from the director of care, psychological therapies team, occupation therapy team, team leader and senior care workers. Staff understood their roles and responsibilities.

Good governance systems were in place to check the quality of the service and to gather feedback from people, staff and professionals.

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. Risks relating to people's care were suitably managed and staff were trained to understand people's behaviours and how to deescalate as far as possible.

Staff understood how to protect people from abuse and neglect.

There were enough staff to care for people and the provider checked staff were suitable to work with people.

People's medicines were managed safely with robust checks in place.

Is the service effective?

Good

The service was not always effective. Staff did not receive training to breakaway from physical attacks. Other training staff received was suitable.

Staff received supervision and appraisal.

In-house psychological therapies and occupational therapy teams supported people and helped staff understand people's needs.

People received care in line with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

People received choice of food and drink.

Is the service caring?

Good

The service was caring. Staff were caring and treated people with dignity and respect.

People were encouraged to maintain their independent living skills. Some people were supported to develop their skills, so they could move into independent living.

People were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive. People were involved in planning their own care. Care plans were kept up to date and so were reliable for staff to follow.

People were provided with activities and the provider was reviewing activities on offer to improve people's quality of life.

The provider responded to complaints appropriately.

Is the service well-led?

Good

The service was well-led. Leadership was visible, and the manager and staff understood their roles and responsibilities.

Governance systems were in place and the provider had good oversight of the service.

The provider had systems to communicate openly with people, staff and professionals and to gather their views.

High View Care Services Limited - 9 High View Road

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this, as well as other information we held about the service such as statutory notifications. Statutory notifications are used by the provider to inform us about information such as safeguarding allegations and police incidents, as required by law.

We visited the service on 17 August 2018. Our inspection was unannounced and carried out by one inspector.

During our inspection we spoke with four people using the service although most people were unable to engage well enough in conversation to answer our questions because of their conditions. We also spoke with the manager, the team leader, two support workers, the director of care and the deputy director of therapy services. We looked at care records for two people, three staff files, medicines records for three people and other records relating to the running of the service.

After our inspection we contacted three health and social care professionals to obtain their feedback on the service and we received feedback from a placements manager and social worker.

Good

Is the service safe?

Our findings

Risks relating to people's care were managed by staff and the provider encouraged positive risk taking. For example, the provider helped a person to maintain their independence in accessing the local community despite risks relating to this. The person had legal authorisation in place which required them to have staff supervision in the community. The provider helped the person build their confidence in accessing the community independently until they were able to go to the local shops alone daily while staff supervised them remotely. The director of clinical services and deputy director of therapy services told us positive risk taking was part of the ethos of the service and they always looked to support people in this way. Staff understood the risks relating to people's care and the support people required from them. Risk assessments showed the provider had suitable systems to recognise risks, assess and manage them and clear guidance was in place for staff to follow.

People were safeguarded from abuse as staff understood their responsibilities and systems were in place to learn from accidents and incidents. Staff received training on their responsibilities in safeguarding people and were confident to 'whistleblow' and raise any concerns. There had been no allegations of abuse in the past 12 months although the provider had systems in place to report any allegations to the local authority and CQC. The provider reviewed accidents and incidents to check people received the right support and that staff responded appropriately. The provider shared learning from accidents and incidents or safeguarding investigations in the organisation through discussion at team meetings.

People were supported by enough staff to meet their needs. People, management and staff told us staffing levels were sufficient. A professional told us most of their reviews were unannounced and the service was always adequately staffed. Rotas showed at least two staff were on duty at all times and additional support was provided by the in-house psychology and occupational therapy (OT) teams during the weekdays. Staff absences were covered by the staff team and staff from other services in the organisation. We also observed there were sufficient staff within the service and also to support people in the community on a group activity during the afternoon.

People were supported by staff who the provider confirmed were suitable to work with them. The provider interviewed candidates to check they had the right attributes to care for people. The provider checked the employment history and qualifications of candidates and obtained references from former employers. The provider also checked for any criminal records, identification and right to work in the UK.

People received their medicines safely and the provider had robust systems in place. Our checks of medicines records found no omissions and the medicines in stock were as expected. Staff checked medicines stocks frequently to make sure people received their medicines. People's medicines were stored securely. No one received 'as required' medicines or homely remedies at the time of our inspection although the provider's policy provided suitable guidance on managing these medicines safely should these be required. Staff received training in administering medicines and the provider assessed staff competency to administer medicines each year.

People lived in premises which were maintained safely. The provider carried out regular checks of the premises with specialist contractors and the internal staff team which included hot water temperatures, gas safety, electrical installation, electrical equipment and fire safety. We viewed the window restrictor in a person's bedroom and found these were robust and unable to be overridden. The provider told us robust window restrictors were in place across the service which reduced the risk of falls. The provider confirmed a risk assessment relating to Legionella infections had been carried out after our inspection to reduce the risk of this water borne infection.

Risks relating to infection control were managed by staff. Staff received training in infection control to help them understand their responsibilities. The provider had a cleaning schedule in place and we observed the service was clean with no malodours. Staff used personal protective equipment (PPE) when carrying out personal care and suitable food hygiene practices were followed in the kitchen.

Good

Is the service effective?

Our findings

The provider had not trained staff to protect themselves from physical aggression. Accident and incident reports showed staff had occasionally been punched and kicked although staff told us, and reports showed, people were not at risk. Staff were provided with training by the in-house psychological therapies to understand people's behaviour and how to deescalate situations to reduce the risk of incidents of aggression. However, the deputy director of therapy services told us due to people's conditions there were some situations staff may be unable to deescalate. This meant training was insufficient to reduce the risk of harm to staff. The deputy director of therapy services told the provider was considering training staff to protect themselves in a way which would not harm the person with 'breakaway' training but a decision had not been made.

People were encouraged to live healthy lives with specialist in-house support. A professional told us the service was a good example of multidisciplinary team work in action. The in-house psychological therapies and occupational therapy (OT) teams supported people individually in relation to their mental and physical health. For example, a person's fear of needles meant they had been unable to have a blood test required to change an ineffective mental health medicine. The person received a high level of support from the psychological therapies team to conquer their fear over a period of several years until they were finally able to allow their blood to be taken. The psychological therapies team and OT teams supported a person to understand their communication difficulties better and worked with them to improve in relation to this. This meant the person's anxiety reduced as did their challenging behaviours. The person told us about the time when they "couldn't speak properly" and indicated they were more content now their speech had improved. The specialist teams also supported people to understand their conditions better and why they required support from staff in certain areas.

Staff also received training to help them understood people's conditions and information was recorded in care plans for staff to refer to. The provider carried out assessments of people moving into the service and used information from people and professionals as part of this. People told us they could see a GP whenever they needed to and records showed people received regular support from a range of healthcare professionals.

People received care from staff who were well trained in other areas. The provider closely monitored staff training requirements centrally and worked with the manager to ensure staff completed the necessary training. The psychological therapies team trained staff on topics including brain injury, mental health and in managing challenging behaviour positively. New staff completed an induction which followed the Skills for Care 'care certificate'. The care certificate is a nationally recognised training programme which sets the standard for the essential skills required for staff delivering care and support. Staff received supervision from their line manager every two months during which they discussed people's changing needs, their role and training requirements. Staff also received annual appraisal where they reviewed their performance over the previous year and set goals for the coming year. Our discussion with staff showed they were confident and competent in their roles.

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

The provider assessed people's capacity to make some decisions relating to their care when they suspected they may lack capacity, in line with the MCA. The provider understood their responsibilities in relation to DoLS and had applied for DoLS authorisations for several people as part of keeping them safe. The provider ensured each person had a care plan in place to guide staff on the reasons or their DoLS authorisation and any conditions they were required to follow. An independent advocate checked the conditions of people's authorisations were followed as part of their visits. When the provider received authorisation to deprive people of their liberty they notified CQC of this as required by law. Our discussions showed staff were explain their role in relation to the MCA and DoLS and received training on this.

People received their choice of food and drink. People told us they received enough food. One person told us, "The food is okay." Staff based the menu on people's preferences and staff told us they cooked ethnic food for a person whenever they requested this. We observed a mealtime and saw people received different dishes based on their requests. Staff supported people to monitor their weights each month and reported any concerns to professionals such as the GP. A person had a care plan in place which guided staff on supporting them to maintain a healthy weight.

The premises met people's support needs. The service had sufficient space for people to spend time alone or in the company of others with a conservatory, a lounge and a dining area. We observed the provider held a BBQ during our inspection and there was ample space for several visitors. The provider had a maintenance team to carry out day to day repairs and staff told us repairs were always carried out promptly.

Good

Is the service caring?

Our findings

People's needs and wishes were understood by staff and people liked the staff who supported them. One person told us, "Staff do have a chat when you're ready." A second person told us, "I get on with all of [the staff]." A professional told us staff were very caring, professional and passionate about their work.

We observed there were enough staff and they had sufficient time to interact meaningfully with people. Staff maintained a continual presence in communal areas, so they were readily available to people.

Staff understood the best ways to communicate with people. Some people's brain injuries and mental health conditions meant communication was sometimes difficult. Staff received support in understanding people's communication needs. We observed staff were patient with people and took time to listen carefully to people to identify what they wanted to express. Staff also asked questions to clarify people's needs where necessary. Staff understood when a person shouted they were expressing their anxiety about a particular situation and staff knew the best ways to respond to this. In the annual satisfaction survey communication between staff and people was rated highly by people using the service.

People were involved in decisions relating to their care such as what clothes they wore, how they spent their time in the home and the activities they took part in outside the home. People could also choose the staff who supported them closely as their 'keyworker' in checking their care met their needs. Staff celebrated significant days for people such as birthdays and Christmas, often by arranging parties or meals out, to help people feel they mattered.

People's privacy and dignity was respected by staff. We observed staff spoke with people in a respectful manner during out inspection. Staff described how they provided people with privacy during personal care while still providing them with the right level of support. People told us they were given privacy when in their bedrooms. Staff took care to talk about confidential information in private.

People were encouraged to maintain and build their independence as far as possible. A professional told us the provider had rehabilitated a person to such an extent that they were now ready to move onto a service with less support. During the pre-assessment process the provider identified people who would be able to live more independently in the future. These people were put in the 'rehabilitation stream' and staff worked with them to build their everyday living skills supporting them to plan and cook meals, clean, do laundry, budget and go shopping. For people whose conditions meant they would always require a high level of support, the service was seen as a long-term placement. However, staff still supported them to maintain their everyday living skills. For example, a person told us they always made their own sandwiches and sometimes cooked more complex meals with staff support. The person also enjoyed going to the local shops daily to buy supplies for themselves and for the service.

Good

Is the service responsive?

Our findings

People's care plans were reliable in guiding staff as they reflected their needs and were up to date. Care plans contained information about their brain injury, mental health conditions and any history of substance abuse as well as any physical health conditions. People's emotional and social needs, personal history, individual preferences, interests and aspirations were also detailed to inform staff. Staff we spoke with understood people's needs and preferences well. The psychological therapies team were available at the scheme most days to help staff deepen their understanding of the best ways of responding to people. Staff reviewed care plans each month and this ensured any changes to people's needs and wishes were accurately reflected.

People were involved in planning their care. People were involved in care plan reviews at least annually including those led by social services and their mental health teams. At monthly meetings with their keyworker people were asked what was working for them and what could be improved to make sure their preferences were always reflected in their care plans. In monthly 'residents' meetings' people were asked their preferences in relation to the menu and group activities.

Although people were provided with activities the manager told us they were working to broaden the activities on offer. Individual activity programmes were in place based people's interests and a person told us they were usually offered the activities as per their programme which kept them busy. Group activities were provided which were often trips to local parks, shopping and meals out. During our inspection a group trip to a local park took place. One person preferred not to join group activities and told us they went to local places by themselves most days. The manager told us they were actively reviewing people's activity programmes to enhance their quality of life and this was a target in the provider's annual quality improvement plan.

People were supported to maintain and develop relationships to reduce social isolation. For example, one person was supported to visit their family members most weekends. If the person was unsettled staff would remain with the person to accompany them to particular social events with their family. Another person visited their family themselves and staff supported them remotely. The person was supported to get a mobile phone so staff could contact them at any time while they were out. The person accepted this support from staff and took responsibility to ask staff to check their phone was working each time they left the service. Personal visitors were permitted at the service and people could entertain visitors in their rooms or communal areas. The provider invited people to events at other services in the organisation such as BBQs and parties which gave people the opportunity to develop friendships.

Complaints were investigated and responded to appropriately. The provider kept detailed and accurate records of concerns and complaints. Records showed each issue was investigated and the provider took action to apologise and improve if any shortfalls were identified. The provider communicated with complainants about the action they had taken in response to the issues raised. People were provided with a service guide which had details of how to complain, and the provider's complaints leaflet guided people further.

People's preference and choices in relation to their end of life care were discussed with them and basic details noted. Care records noted people's wish regarding receiving end of life care treatment including resuscitation, as well as any preferences regarding burial or funeral services.

Good

Is the service well-led?

Our findings

The service was well-led by an experienced manager who was in the process of registering with CQC. The manager was supported by a management team which included a team leader, several senior support workers, the director of care and managers within the psychological therapies and occupational therapy team. People and staff were positive about the manager and the support they received from the management team as a whole. The management team were visible, and present at the service most days to support people. Staff understood their roles and responsibilities. The manager had qualifications in leadership and management and health and social care which helped them understand their role and responsibilities. Staff understood their roles and responsibilities and shift plans made staff clear of expectations of them each day. Staff told us they worked well as a team and developed positive relationships with colleagues.

The provider encouraged open communication and gathered feedback from people, staff and professionals. A professional told us they would not hesitate in placing more people with the organisation as the service 'ticked all the boxes'. Staff asked people for their feedback during monthly resident meetings and individual key work meetings and any suggestions were fed back to the managers and actioned. Staff meetings were held each month for staff to discuss operational issues relating to their roles. In addition, monthly 'reflective practice meetings' were held by the psychological therapies team as an opportunity for staff to discuss any particularly challenging issues they faced and find out how best to address these. Multidisciplinary managers meetings were also held for the various managers across the organisation to discuss service developments, share learning and improvements to people's care. The provider sent questionnaires to professionals to gather their feedback on the service. The provider worked closely with external professionals such as mental health teams, social workers and health care professionals to ensure people received joined-up care. In addition, the manager attended managers meetings arranged by the local authority to keep up to date with developments in the care sector.

The provider had systems in place to audit and improve the service. Audits in place included daily, weekly and monthly checks of medicines management, monthly reviews of care plans and risk assessments and a range of regular health and safety checks with annual risk assessments. The managers audited care plans and risk assessments personally to check they contained the necessary information. The provider had systems to ensure staff files contained the necessary recruitment documentation. The manager had good oversight of two-monthly staff supervision to check staff received their sessions as planned. The provider also had systems to monitor staff training needs and to ensure staff received training they needed to keep their knowledge current. However, the provider had not promptly responded to the need for staff to receive breakaway training to keep them safe from physical aggression. We found the provider's recording systems in relation to people, staff and the management of the service were robust and staff were able to easily locate and provide us with information we requested.

The provider submitted notifications to CQC as required by law such as in relation to DoLS authorisations. This allowed CQC to monitor the service and plan inspections.