Clearwater Care (Hackney) Limited

Harold Lodge

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 10 May 2017 and was unannounced. At the last inspection on 18 February 2015 the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not undertaken up to date training required for their role. During this inspection we found this issue had been addressed.

The service is registered to provide accommodation and support with personal care to a maximum of four adults with learning disabilities. At the time of inspection three people were using the service.

The previous registered manager left the service in March 2017 and a new manager had been appointed. They told us they were in the process of applying for registration with the Care Quality Commission. 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.

There were enough staff working at the service to meet people's needs and robust staff recruitment procedures were in place. Appropriate safeguarding procedures were in place. Risk assessments provided information about how to support people in a safe manner. Medicines were managed in a safe way

People were able to make choices for themselves and the service operated within the spirit of the Mental Capacity Act 2005. People told us they enjoyed the food. People were supported to access relevant health care professionals.

People told us they were treated with respect and that staff were caring. Staff had a good understanding of how to promote people's privacy, independence and dignity.

Care plans were in place which set out how to meet people's individual needs. Care plans were subject to regular review. People were supported to engage in various activities. The service had a complaints procedure in place and people knew how to make a complaint.

Staff and people spoke positively about the senior staff at the service. Systems were in place to seek the views of people on the running of the service.

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. Appropriate safeguarding procedures were in place and staff understood their responsibility for reporting any safeguarding allegations.

Risk assessments were in place which provided information about how to support people in a safe manner.

The service had enough staff to support people in a safe manner and robust staff recruitment procedures were in place.

Medicines were managed in a safe manner.

Is the service effective?

Good

The service was effective. Staff undertook regular training to support them in their role. Staff had regular one to one supervision meetings.

The service operated within the spirit of the Mental Capacity Act 2005. People were able to make choices about their care and were free to come and go from the service as they wished. This included choosing what they ate and drank.

People were supported to access relevant health care professionals if required.

Is the service caring?

Good

The service was caring. People told us they were treated with respect by staff and that staff were friendly and caring.

Staff had a good understanding of how to promote people's dignity, privacy and independence.

Is the service responsive?

Good

The service was responsive. Care plans were in place which set out how to meet people's needs in a personalised manner. Care plans were subject to regular review.

People were supported to engage in various activities in the

home.

The service had an appropriate complaints procedure in place.

Is the service well-led?

Good

The service was well-led. People and staff told us they found senior staff to be supportive and helpful.

Systems were in place for monitoring the quality of care and support at the service. Some of these included seeking the views of people using the service.

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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 the 10 May 2017 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed the information we already held about this service. This included details of its registration, previous inspection reports and any notifications they had sent us. 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.

During the inspection we observed how staff interacted with people using the service. We spoke with four members of staff. This included the acting manager, the team leader, the senior support worker and a support worker. We looked at records relating to two people including care plans and risk assessments. We viewed medicines records and quality assurance systems. We examined the staff recruitment, training and supervision records and checked various policies and procedures.

Good

Is the service safe?

Our findings

The service had a safeguarding adults procedure in place. This made clear their responsibility for reporting any allegations of abuse to the local authority and the Care Quality Commission. Staff told us and records confirmed that they undertook regular training about safeguarding adults. Staff were aware of their responsibility for reporting any allegations of abuse. One member of staff said, "If I suspect abuse the first thing I would do is make sure the service user is safe. Then I report it to my manager. If it's my manager who has abused I report it to head office. If the head office does nothing then that is when CQC come in." Another staff member replied, "Yes, we report it to the manager" when asked if they knew how to respond to abuse. The team leader told us there had been one allegation of abuse since our last inspection and records confirmed this had been dealt with appropriately in line with the provider's policy.

Where the service held money on behalf of people systems were in place to reduce the risk of financial abuse. Money was stored securely in a locked facility. Monies spent were signed for and receipts were kept. We checked financial records held and the amounts recorded tallied with the amounts at the service.

Risk assessments were in place for people which identified any risks they faced and included information about how to manage and mitigate those risks. Risk assessment covered risks associated with eating and drinking, infection and skin integrity, having seizures whilst in the community, the use of bedrails and medicines.

Risk assessments included a good level of detail. For example, the risk assessment for one person about skin integrity stated, "Staff to ensure that [person's] airflow mattress is on at all times on the lowest setting. Staff to ensure that [person] is not lying on any big folds in material in his sheets and check that his tee shirt is not pushed up the back and that there are no folds of material pressing into his skin." The assessment went on to say, "[Person] is to be rolled every two hours. He is not to lie on is back." Records confirmed that the person was rolled in line with the risk assessments. The risk assessment for another person sated, "If I have a seizure when I am stood up I want staff to lead me to a safe environment in a chair or on the floor as I can become unsteady." This showed risk assessments were personalised to each person's individual risks.

Staff told us there were enough staff working at the service to meet people's needs. One member of staff said, "At the moment the staffing levels are OK. We are not rushed." Another member of staff told us, "Yes, we have three staff for three service users. It's enough." We observed staff were able to carry out their duties in an unhurried manner and they responded to people as needed."

The service had robust staff recruitment practices in place. Staff told us that various checks were carried out on them before they commenced working at the service. One staff member said, "They went through my DBS [a criminal records check] and two references and my history of employment and they checked my right to work in the UK." Records confirmed that the service carried out relevant checks on prospective staff. This meant the service had taken steps to help ensure suitable staff was employed.

Staff had undertaken training about the safe administration of medicines and knew what action to take in

the event they made an error with a person's medicines. One staff member said, "I would call the GP to report it and complete an incident form."

Medicines were stored securely in locked and designated medicines cabinets. Records were maintained of the quantities of medicines held in stock and we found these records tallied with the actual amounts of medicines held. Medicine administration record (MAR) charts were maintained. These included the name, strength, dose and time of administration of each medicine. Staff signed these to evidence each time they administered a medicine to a person. We saw the MAR charts were completed accurately and were up to date. Where people were prescribed medicines on an 'as required' basis we saw that guidelines were in place about when this was to be administered. This meant the service had systems in place to promote the safe administration of medicines.

Good

Is the service effective?

Our findings

At the last inspection on 18 February 2015 the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not undertaken up to date training required for their role. During this inspection we found this issue had been addressed. There was a training matrix in place which showed when staff had last received any training and when they were next due to have it. Staff files also contained certificates confirming they had undertaken the training. This showed staff training was in date.

Staff told us they undertook regular training to help them develop and maintain the skills and knowledge required for their role. One staff member said, "I've just finished my E-Learning for health and safety at work, fluid and nutrition, COSHH and food hygiene." The same staff member added, "Every 12 months we have moving and handling training. They come in and show us how to use the hoist. We have a refresher course in giving medicines. That is done by [supplying pharmacist]." Another staff member said, "Every year we have training. We have moving and handling, medication, first aid training."

Records showed staff had regular one to one supervision meetings with a senior member of staff. Staff we spoke with confirmed this. One member of staff said, "We talk about how you feel at work, what improvements need to be made, what training is required and about what is going on in the service." Records evidenced supervision included discussions about staff training and personal development, timekeeping and attendance, people using the service and policies. Staff also had an annual appraisal of their performance and development needs which helped to identify what support and training was needed for the individual staff member to develop and improve their performance. This meant staff were given the support they needed to perform their roles.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found DoLS authorisation was in place for people and staff had a good understanding of what they meant for the individuals. Mental Capacity assessments had been carried out and best interest decisions had been made where people lacked the capacity to make a decision. For example, with supporting people with medicines and providing personal care.

Care plans included information about supporting people to make choices over their daily lives. For example, the care plan for one person stated, "Show [person] his clothes and say 'which one would you like to wear today'." A staff member told us how they supported people to make choices about their clothes. They said, "I open his wardrobe and he points at the clothes he wants to wear. For others I put different sets

of clothes on the bed and they pick the ones they want."

People were able to make choices about what they ate and drank. We observed staff supporting a person with their breakfast. They were shown different things to put on their toast and they were able to choose by pointing to the one they wanted. Care plans included information about people's food preferences. For example, the care plan for one person stated, "I like marmalade or jam on my toast and I like my cereal without milk." We saw that staff provided the person's breakfast in line with the care plan. The care plan for another person stated, "I like cheese and sausage sandwiches, I like liver, spicy foods and fizzy drinks." Records of food served were maintained and these showed people had access to a varied and balanced diet and to foods that reflected their cultural background.

Records showed that people had access to health care professionals as appropriate including occupational therapists, district nurses, physiotherapists, GP's, dentists and opticians. Records included details of any follow up action that was required from appointments which meant people's health care needs were being met.

Health Action Plans were in place which provided information about how to support people to maintain good health, for example through eating a balanced diet, regular exercise and access to appropriate health care professionals. Hospital Passports were in place for people which provided information to hospital staff in the event a person was admitted to hospital. This included details of the person's current medicines, medical history, communication needs and how to support the person to eat and drink.

Good

Is the service caring?

Our findings

Care plans included details of people's life history, such as where they were born were they grew up and their family. This helped staff to get a good understanding of people which aided them to build good relations with them. We observed that staff interacted with people in a caring and friendly way, for example when supporting them with meal preparation.

Care plans included information about supporting people with their communication. For example, the care plan for one person stated, "I am non-verbal but I do understand things that are said to me. Please talk to me very slowly, please don't use long complicated words to me." The care plan for the same person also included information about understanding their communication through their body language. For example, it stated, "If I stiffen myself it means I don't want you to touch me." Communication passports were in place for people which showed the service used various methods to communicate with people who had limited speech. This included the use of objects of references and interpreting body language and facial expressions. For example, the communication passport for one person stated, "Show [person] his flannel and shower gel to indicate it is time for personal care." Staff had a good understanding of how to interpret people's body language. A staff member said, "He has to give you his consent, his body language will tell you if he does not want it [personal care], his hand will push away." We observed staff using body language and picture cards to communicate with people during the course of our inspection.

Care plans including information about supporting people to be independent. For example, the care plan for one person stated, "I can wash the top half of my body but I will usually only do this when you encourage me by giving me the flannel. I can wash some of my areas below but I sometimes rush and need staff to go over these areas. I can clean my teeth myself but need staff to put toothpaste on the brush." Staff told us they sought to promote people's independence. A staff member said of supporting a person with their personal care, "We encourage him to do things for himself. He can wash with his flannel." Another member of staff said, "We try to let him do things for himself. We give him the shower head and he uses it."

Staff had a good understanding of how to promote people's privacy and dignity. One staff member said, "Before you go into someone's room you have to knock. Then you have to ask the person if they want to have a shower or a bath." The same staff member added, "To protect his dignity the bathroom door is locked. At the finish the towel is round him to take him back to his room." Another member of staff said, "You support him to the bathroom, not naked, he has to put on his robe." A third staff member said, "During personal care the door must be closed. You respect what they want to wear, how they want their hair to be combed." The service had a policy on confidentiality which made clear staff were not permitted to share confidential information about people with others unless authorised to do so. Staff had a good understanding of their responsibility with regard to confidentiality which meant people's privacy was respected. People were supported to maintain relationships with family and family were able to visit the service as they wished.

Two people showed us their bedrooms which were homely and contained their personal possessions such as family photographs. Bedrooms included an ensuite hand basin and toilet. Communal bathrooms had a

lock with an emergency override device fitted. This helped to promote people's privacy in a safe manner.

Good

Is the service responsive?

Our findings

After receiving an initial referral a senior member of staff carried out an assessment of the person's needs. This was to determine if the service was a suitable placement for the person and able to meet their assessed individual needs.

Care plans were in place for people which included personalised information based around the needs of individuals. For example, the care plan for one person on personal care stated, "I need full staff support for staff to clean my teeth twice daily. I like to wear aftershave when I am dressed in the morning for me to smell nice." The care plan for the same person about activities stated, "I like to watch Greek music videos on the telly. I like to play with my shaker while listening to music." The care plan for another person stated, "I am able to dress/undress myself with minimal support. I just need staff to remind me to put on clothes appropriate for the day in accordance to the weather and the activities I am participating in." Other areas covered by care plans included oral hygiene, using transport, managing money and hobbies and interests. Staff we spoke with had a good understanding of the content of people's care plans and were knowledgeable about how to meet the needs of individuals. People were supported to be involved in planning their care plans through care plan review meetings and monthly key worker meetings. Staff used various communication needs such as objects of reference and picture cards to help support people to communicate.

Care plans were subject to a monthly review. This meant they were able to reflect people's needs as they changed over time. Records showed people had monthly meetings with their keyworkers which enabled them to review progress made on goals within care plans. Daily records were also maintained so it was possible to monitor the care a person received on an on-going basis.

The service supported people to take part in various activities and care plans included people's preferences around this. For example, the care plan for one person stated, "I like to go to the park to feed the ducks or play football. I don't like to go to the cinema because of my concentration." On the day of inspection we observed one person went out shopping and for lunch, while another person was supported to go to the library. They looked very happy to be doing this activity as they smiled a lot when they were getting ready to go. Records showed other activities arranged by the service included trips to restaurants and bowling. The deputy manager told us that one person attended a day service where they went on trips, did baking and arts and crafts activities. The service had its own sensory room which the deputy manager told us people enjoyed.

The service had a complaints procedure in place and a copy of this was on display in the communal areas of the service. This was produced in both written and pictorial formats which helped to make it more accessible to people who used the service. The procedure included timescales for responding to complaints and details of whom people could complain to if they were not satisfied with the response from the service. The deputy manager told us there had not been any complaints received since our previous inspection.

Good

Is the service well-led?

Our findings

The service recently appointed a new manager who began working at the service in April 2017. They told us they had started the process of applying for registration with the Care Quality Commission. They were supported in the day to day running of the service by the team leader. Staff spoke positively about the senior staff at the service. One staff member said of the new manager, "So far he is doing well. He is trying to familiarise himself with things, talking to everyone." Another member of staff said of the senior staff, "They are really supportive." The service had an out of hours on-call service so that a senior member of staff was always available to provide advice. A staff member said, "There is always a weekly on-call, they always pick it [the phone] up." We observed that staff appeared relaxed and a ease when talking with senior staff at the service. This meant staff felt supported by senior managers .

Records showed the service held regular staff meetings. These enabled staff to voice their views and be involved in the running of the service. A staff member told us, "We have team meetings monthly. We talk about what's happening in the service, how things need to be done, about people's behaviour. We talk about rotas and shifts, about activities for service users." Another member of staff said, "We do team meeting every month. We talk about the feedback from the last team meeting. We pick a policy each month to talk about, last month it was medication. We talk about safeguarding and maintenance issues in the home." Minutes of the staff meeting held in April 2017 showed there were discussions about the rota, changes to care plans, medical issues, staff issues and communication.

The service held regular service user meetings. These enabled people to have input in to how the service was run and to discuss matters of importance to them. Objects of reference and picture cards were used during these meetings to help people to communicate and have meaningful participation in the meetings. Minutes of the meeting from March 2017 showed they discussed activities, appointments, food and the sensory room.

The acting manager told us the regional meaner for the provider carried out unannounced visits to the service on a quarterly basis for quality assurance and monitoring purposes. We looked at reports of these visits which showed they covered documentation within the home, observations of people using the service, medicines, health and safety, infection control, finance and training. We saw that where areas had been identified the service had dealt with this. For example with incomplete documentation.

The service carried out quarterly surveys of staff, people who used the service and relatives. This was to gain their feedback on the running of the service. Results of the surveys were analysed and we saw the service took steps to address issues raised. For example, a recent staff survey had highlighted that teamwork in the service needed to improve. In response, shift patterns were changed so that new staff worked with more experienced staff. This was to provide more balance on the shift and to provide the newer staff member the opportunity to learn and improve performance by working with an experienced staff member. Another issue raised by staff was concern over a lack of clarity about who was in charge on any given shift. In response, the rota was changed so that it made clear which member of staff was in charge of each shift. The relatives' survey carried out in February 2017 highlighted that relatives had not always seen up to date copies of

people's care plans and these were subsequently sent to all relatives. This meant the service took action to address when concerns were identified.