Inshore Support Limited

Inshore Support Limited - 10 Beeches Road

Inspection report

Beeches Road
Rowley Regis
Blackheath
West Midlands
B65 0BB

Tel: 01215594384
Website: www.inshoresupportltd.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Our inspection took place on 8 February 2017 and was unannounced.

The provider is registered to accommodate and deliver personal care to two people who have a learning disability and autism. On the day of our inspection there were two people living at the home.

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.

At our last inspection on 3 December 2015 we found that improvements were needed to show how complaints were managed. Quality assurance checks had not been recorded and events were not being reported to us consistently as required within the law.

Although some improvements had been made, this inspection identified that there were still some aspects of the service that required improvement. The systems in place to audit the quality of the service were not always effective because they did not identify where some improvements were needed. The protocol for managing prescribed creams was not followed, the CQC ratings was not displayed as is required by law and we, the Care Quality Commission (CQC) had not been notified about the outcome of DoLS applications. Although action was taken to address these issues at our inspection, these had not been identified through the day to day auditing of the service.

There was a registered manager in place. 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.

People received a safe service because the provider had clear procedures in place to support staff in recognising and reporting abuse. Risks associated with people's everyday living had been identified and plans were in place to help to reduce risks. Staff were recruited safely and staffing levels ensured that people were safe. People received their prescribed medicines by staff who had been trained to do this safely. The systems in place to ensure prescribed creams and other applications were in date were improved following the inspection.

Staff were trained to meet people's specific needs and they had regular supervision to reflect on and develop their practice. Staff understood the importance of seeking people's consent and were aware of any limitations on people's liberty. People had choices regarding what they ate and drank and were supported to access a range of health care professionals to meet their healthcare needs.

The interactions between people and staff were caring, supportive and friendly. Staff protected people's privacy and dignity and promoted their independence.

People's preferences were explored with them so that they received care that was personal to them. People were supported to pursue their hobbies and interests. Systems were in place to respond to concerns or complaints.

Staff described the management arrangements as supportive and they felt motivated. People's feedback on the service was sought.

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.

People were protected from abuse and harm by staff who understood how to keep them safe.

There were enough staff to meet people's needs safely.

People received their medication as prescribed. The registered manager took action to improve the system for monitoring short term creams to ensure safety.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the skills and knowledge to meet their complex needs.

People's capacity to consent was taken into account and any limitations on choice were understood by staff.

People had control over what they ate and drank and staff supported them to maintain a healthy diet, lifestyle and health. Health action plans were in place to support this.

Is the service caring?

Good

The service was caring.

Staff displayed warmth and a caring approach towards people.

People's individuality, independence, privacy and dignity was respected and promoted.

People made decisions about their care with support and guidance from staff and those people important to them.

Is the service responsive?

Good

The service was responsive.

People received individualised care and support, because staff involved them in planning their care and supported them to take part in activities that they enjoyed.

Arrangements were in place to ensure that concerns and complaints would be listened to and dealt with.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems were in place to monitor the quality of the service provided but were not always effective at identifying where improvements were needed.

People were cared for by staff who were supported and trained to do their job.

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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.

Our inspection took place on the 8 February 2017 and was unannounced. The inspection was conducted by one inspector.

We looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the Local Authority commissioning service who told us they had no concerns to share with us.

We met and spoke with both people and observed their day to understand how they were supported. We spoke with two relatives by telephone, three staff members and the registered manager. We looked at the care records of two people which included their medicine administration records, risk assessments and accident and incident reports. We also looked at records which supported the provider to monitor the quality and management of the service. These included health and safety, medication, care plans, complaints records, accident and incident reports and systems for obtaining people's feedback, induction processes, staffing levels, and staff training.

Good

Is the service safe?

Our findings

We asked one person if they felt safe living at the home. They told us, "I like it here; staff are good to me". Relatives that we spoke with told us that their family member was happy and that they had no concerns about their safety. One relative told us, "I have confidence in the staff; they are good to both the guys. I've never had reason to doubt they would look after (name)".

We asked a person if staff were nice to them, they responded with a 'thumbs up' sign and said, "They don't hurt me". Staff told us that they had received training in protecting people from abuse and could explain how to report any concerns they had. A staff member told us, "I've done the training and would report any concerns if I thought people were at risk of harm or abuse". The provider had procedures in place to guide staff to report concerns about people's safety to the local authority. The information we hold showed that there had been no incidents of concern.

A relative told us, "Staff are aware of safety concerns in and out of the home and keep (name) safe". We asked one person how staff helped to keep them safe. They told us, "Yesterday staff took me bowling". We asked them how staff helped them when they went out into the community. The person told us, "They help me cross roads". We observed that staff were attentive and intervened when a person needed support with self-harming behaviour. We saw another person was supervised when in the kitchen. Staff told us, "(Name) is only restricted with the kettle and hot water because (name) would be at risk of scalding themselves". We saw that both people were supported to undertake a variety of daily tasks. Risks had been assessed and individual management plans were in place to support people in each situation that they might find difficult or which could affect their safety.

The staff we spoke with were fully aware of the type of situations that upset people and could cause an escalation in anxiety or behaviour. We saw that staff followed people's behaviour management plans so that they had the support they needed to protect people from avoidable harm. This included for example, the right support and staffing levels when supporting people to undertake community activities. Staff were well informed about the risks to a person from ingesting items. A written strategy was in place and we saw staff were vigilant and followed this approach. We also heard from staff that the strategy in place had resulted in reduced behaviours in this area which in turn reduced the possibility of harm to the person.

We saw that accidents or incidents were monitored for any patterns or trends. Staff had been trained to manage incidents safely. The use of low level physical intervention strategies (such as linking a person's arm and guiding them to a quiet area) was used. Records showed that the use of this intervention in any incident was recorded on incident reports which were monitored by management. This ensured staff used the agreed and appropriate interventions as described in the person's risk assessment.

The provider had a recruitment process in place which was carried out by the provider's recruitment department. We were told checks included proof of identity, previous work history, and checks with the Disclosure and Barring service. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care. Staff we

spoke with confirmed that these checks had taken place before they commenced working in the home.

We were able to see from what people told us that there was sufficient staff in place to support people in the way they wanted and needed. We asked people if they went out. One person told us, "I go out for a cheeseburger I like that". The same person told us, "Staff take me to the cinema". We saw that staffing levels took account of risk factors so that where people needed two to one or one to one staff levels to keep them safe in the community, this was happening. Night time staffing had been arranged to ensure that people had the support they needed throughout the night. We saw staff were visible and able to respond to people's needs throughout the day. Relatives that we spoke with told us that they had no concerns about the numbers of staff available. One relative told us, "(Name) goes out quite a lot, and when I visit there's always two or more staff, I don't have any worries". Staff told us that they were confident that staffing levels enabled them to keep people safe and that 'floater' staff were planned in for events so that people had the support they needed to do the things they enjoyed, safely.

A relative told us they had no concerns about the way people's medicines were managed. People were not able to tell us about their medicines but one person gave us a 'thumbs up' when we asked if staff looked after their medicines. We saw staff explained to people what medicines they were administering and sought their consent. Staff told us that they received training in the safe handling of medicines. Medicine records showed that people received their oral medicines as prescribed. Where people had medicines on an 'as required' basis, written guidance was in place to guide staff. We found some body creams and oil for a person's ears was out of date. Staff told us they had not used these for some time. There was no system in place to record the date of opening for short term applications which could lead to these being used past their shelf life date. We saw on the providers own audit/competency checks that one of the prompts related to checking that staff were recording the date of opening of such items and this had been ticked. However this was not happening. This meant the checks were not fully effective to ensure the safety of medicines. The registered manager removed these items at the time of inspection. Following our inspection she confirmed that they had checked with their pharmacy for guidance and had dated items to ensure they were safe to use.

Good

Is the service effective?

Our findings

Relatives spoken with told us they had confidence that staff had the skills needed to support people. One relative told us, "I don't know the level of training they have had but some staff are really very good; they seem to understand people and know how to manage their behaviour". Another relative told us, "I think (name) has a new life; more independence and is happy so I have no concerns about staff ability".

Staff told us that they had received an induction when they were first employed. Several staff had commenced their induction using the Care Certificate. This is a nationally recognised induction process which provides a set of fundamental standards for the induction of adult social care workers. One staff member told us, "I had a good induction, met the people, shadowed staff and did training, I felt well prepared to do my job".

All staff had training which included managing people's behaviour. Training in the 'Prevention and Management of Violence and Aggression', (PAMOVA) had been undertaken to equip staff with the skills necessary to support people with their behaviour in a safe way. A staff member told us, "I'm confident in using the training to avert situations where behaviour may escalate". The training programme included additional training relevant to the specialist needs of people. For example staff had knowledge about understanding autism and managing epilepsy. We also saw staff were trained in the use of Makaton, a form of communication using hand signals and that they used this throughout the day to supplement their verbal communication with a person. Staff told us they were happy with the level of supervision they had in which to reflect on their practice. We saw that supervisions and appraisals were planned in advance and up to date.

Staff told us that a handover between shifts took place daily to ensure they remained up-to-date with people's care needs. They also explained that staff meetings enabled them to discuss people's support and to maintain consistency. An example was shared with us which reflected staff understood the importance of working in an agreed way to support an individual, which showed a person centred approach to the way they supported this person.

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 checked whether the home 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 that where people were being deprived of their liberty, authorisation was in place. The provider had not notified us when applications had been approved as is required and the registered manager told us they would do this retrospectively. Where

staff were waiting for approval [to deprive a person of their liberty] they worked in the 'Best interests' of a person and were able to tell us about the limitations in place on a daily basis. We saw that people's care plans addressed people's capacity and their choices as well as any limitations in place. We observed that staff understood the need to seek people's consent when delivering support. One staff member told us, "I've done training in MCA and DoLS. With one person they will give consent with signals another person requires time to process information and will give verbal consent". A relative told us, "Staff do ask (name) for consent for daily things but bigger decisions we would be involved in or maybe the consultant or GP if it was about health".

People indicated that they enjoyed their food; one person told us that their breakfast was "Nice". Another person gestured to staff and accessed the food cupboards to make their choices. We saw that people were supported to make food choices and prepare their breakfast and lunch. Staff told us they tried to promote healthy eating and take account of people's likes and preferences which were explored with them and taken into account when preparing meals. Relatives told us they were happy that people had choices about their meals and that there were no concerns about people not eating or drinking enough. We saw that people had access to the kitchen and support to make drinks and snacks as they wished.

We saw that people were supported to maintain their health and had access to their GP and other healthcare services. Each person had their own health action plan, (HAP) which had detailed information about how they took their medicines, how they expressed pain, what procedures would be tolerated and any significant issues that would need to be addressed. These documents were in picture form and staff told us would be used when people were admitted to hospital so that people's needs were known and understood. A relative told us, "If (name) was ill staff would tell me and over the time they have been there I've had no concerns that staff would recognise something was wrong and act on it".

Good

Is the service caring?

Our findings

We saw that people living in the home were comfortable in the company of staff; there was lots of friendly interaction and communication between people and staff. One person told us, "Yes" when we asked if they liked staff. Relatives described staff as friendly and approachable. One relative told us, "I'm really pleased with the care (name) gets; staff are really friendly, they keep us informed and we have a good relationship with them". Another relative told us, "(name) is happy there".

Staff were mindful that our presence could cause some anxiety and we saw they offered reassurance and support to a person who was then happy to speak with us with the support of staff. Staff were also careful to explain to us people's communication needs so that we gave people the time to process information and respond, this showed they promoted respect for people's communication needs.

People were involved in discussing and agreeing their care and support needs and this was undertaken on a regular basis. Information was presented in pictorial formats so that people could say whether they were happy or sad about the provision of such things as their meals, activities, or staff. Relatives told us they had attended reviews to discuss support and care. We saw that independent advocacy services were identified in people's care plans where they may need to access this service.

We saw that people were supported to make their own decisions. One person was pointing to outside and staff told us the person wanted to go out. We saw they reassured the person that they were going out. Staff responded to people when they indicated they wanted to make a drink or get a snack which meant people determined this for themselves. We saw throughout the day that staff listened to people's communication and were patient in their response. One person used touch and tactile gestures to communicate their needs and we saw that staff interpreted and responded to these signals in a patient manner.

People's personal appearance had been well supported; they were dressed in individual styles that reflected their age and choices. We heard staff compliment people on their appearance which showed that staff promoted people's self-esteem. A relative told us, "They take good care of (name); he is always clean and well dressed". People determined their own personal care routines and staff were able to describe these and how they supported people and protected their dignity and privacy whilst addressing any safety needs.

People were actively supported to be as independent as possible. We saw they went food shopping, prepared their own meals and undertook domestic tasks such as managing their laundry, cleaning their bedroom or tidying up after themselves in the kitchen. Staff told us that they encouraged people to do things for themselves wherever possible to promote their independence. A relative told us, "I would agree that (name) does more for himself now". We saw that no one was rushed and that staff took their time and used their training in autism awareness to ensure people's needs were met in a caring and considerate manner.

Good

Is the service responsive?

Our findings

At our last inspection in December 2015 improvements were required in relation to how the provider recorded and managed complaints. At this inspection we found improvements had been made. The registered manager told us that complaints records were now kept on site and that there was a clear process for the timeframes in which investigation and responses should be completed. We looked at the complaints records and saw no complaints had been made. We were told that letters of resolution would be kept on people's files to verify how their complaint had been managed. We saw that each person had a copy of the complaints procedure in a format suited to their communication needs. Staff were able to describe how they would recognise if someone was unhappy and that in the event people needed someone to represent their views, staff were aware of advocacy services. Relatives told us that they were confident to raise any concerns or complaints if they needed to. A relative told us, "I don't have any complaints as such but if I did I know how to and who to".

Since our last inspection in December 2015 the registered manager had ensured that people's records clearly reflected who was in attendance at a review and what was discussed. One person answered, "yes" when staff said, "We have one to one meetings to talk about you don't we?" Staff described the personal care planning (PCP) meetings that took place with each person to identify their views on their care. This ensured people's needs and preferences were taken into account when planning care. Relatives told us that they were consulted about people's care needs and had attended meetings and reviews.

We saw that staff involved people in conversations and decisions about their care on a daily basis. Individual plans were based on people's preferred wishes and their routines had been explored with them via one to one meetings. We saw this was reflected for example in the times people got up, where they ate and how they spent their day. Staff were able to tell us how each person liked things done and in what order which showed they knew people well and tried to ensure daily routines were personal to the individual and reflected their diversity. For example we saw consideration was given to the things people disliked such as crowds or busy places, as well as promoting opportunities for people to have personal space as well as a degree of structure. One staff said, "Structure and routines can be important to some people; for example we know what (name) likes to do and when they want to be left alone and we respect that".

Staff had a good understanding of people's chosen method of communication and used their skills effectively to respond to people. For example, we saw staff used repeated gestures, thumbs up and vocal praise to encourage people. Staff were seen to be attentive and responsive to people's requests.

People told us that they were supported to do the social activities that they liked to do. One person confirmed they went out regularly to places they enjoyed such as the cinema, bowling, going out for a burger and going for walks and rides in the car. People had access to their both their own transport via a Motability car and the providers transport. This enabled them to access places more easily including being able to visit their parents homes. The provider had a social training fund which staff told us enabled them to finance community activities people enjoyed, this further enhanced people's opportunities. Relatives and staff told us that people were supported to do things that they enjoyed doing. A relative told us, "(Name)

needs two staff to keep safe; he can be unpredictable". This demonstrated that staff recognised the importance of continuity so that people's planned activities went ahead and staffing levels enabled this to happen. During our visit a person indicated they wished to go out and we saw they were supported to do this. Another person confirmed they had been out the day before and nodded when asked if they had enjoyed this. A relative told us how staff ensured that time was made to accommodate the interests of their family member. They said, "Staff spend time with (name) and take him out which makes him happy". A staff member told us, "We do lots of things spontaneously but we can also plan ahead for certain activities as we have additional staff from our other home to support us".

People were supported to stay in touch with their family. One relative told us that they were very happy staff supported the person to visit them and that staff always kept them up to date with events.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2015 the registered manager's quality monitoring checks were not recorded to show what action had been taken. The registered manager acknowledged these areas needed to be improved upon and at this inspection we found some improvements had been made. We saw for example daily audits were carried out on various areas such as incidents/accidents or use of physical intervention. Health and safety checks in and around the house were undertaken and food stocks were checked to ensure they were in date and covered. People's care plans were audited to ensure they contained the correct up to date information. The registered manager informed us that lessons had been learned in relation to the security of records related to staff employed within the home. The registered manager received a monthly report from the Quality Assurance Team and an action plan was developed to ensure any shortfalls were addressed. However we noted that further improvements were needed as we found the systems and processes were not regularly followed. For example the checks on medication did not include dates of opening. Registered providers are required to notify us, the Care Quality Commission (CQC) about the outcome of DoLS applications and they had not done this. The registered manager of the residential service told us that she was not aware that she needed to do this. The registered manager told us recent computer issues had delayed some communications but we had not received this since the inspection. The provider is required by law to display their rating of the home. This was not on display at the time of inspection. Whilst the registered manager confirmed following the inspection that the rating had been wrongly placed in the display frame, this as well as the other shortfalls mentioned indicated that checks were not fully robust. It was not clear if the registered manager's divided time between the two homes was impacting upon her capacity to ensure effective governance systems were followed.

We were told that surveys were used to gather people's views about the service. A relative told us, "Yes I do get a questionnaire but I'm not sure what they do with it". The registered manager was able to describe an improvement made as a result of feedback from people. She told us the provider analysed feedback with a view to making improvements. However she was unable to find the survey until after our inspection.

There was a registered manager in place. A registered manager has legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager divided their time between two homes. Staff told us they felt supported and had access to the registered manager as well as senior staff when they needed this. Staff were happy that the management structure supported them when the registered manager was unavailable. We noted that people who lived in the home were familiar with the registered manager who knew them well and was able to demonstrate she understood their needs. This showed she did spend time in the home and that people who lived there were content in her company. We checked with relatives that in the event the registered manager was not available they could contact the provider and they confirmed that they could.

We saw that staff were well motivated and happy in their role. One staff member told us, "I love it here and I think what we provide is good quality; good opportunities for people and a safe, caring place to live". Staff told us they were aware of their roles and responsibilities with regards to whistleblowing. One staff member said, "If I thought any staff member was treating people badly I would report it".