United Response

United Response - 131 Kneller Road

Inspection report

131 Kneller 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

This was an unannounced inspection that took place on 30 August 2017.

The home provides personal care and support for up to six adults with learning disabilities and the service is managed by United Response. The home is in Whitton, Middlesex.

The home had a registered manager. 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.

In May 2015, the home met all the key questions and was rated good in each with an overall good rating.

As people had limited verbal communication relatives spoke on their behalf. We also based our findings on observation of the care provided and people's responses to it. Relatives told us the home provided a good service, its staff were friendly, hospitable and well-trained and people enjoyed living at Kneller Road. Staff supported people to choose and engage in the activities they wished. These were group and individual. The activities took place at home, in the local community and there were also trips out. The home was well maintained, had recently been redecorated and there was new furniture in the communal area. People's rooms decorated in the way they wanted them. The home provided a safe environment for people to live and work in. The home's atmosphere was warm, comfortable and inclusive.

The home had records that were comprehensive and kept up to date. These included care plans and risk assessments that contained clearly recorded, fully completed, and regularly reviewed information that enabled staff to perform their duties and people to live safely.

Staff were equipped with appropriate skills and training and provided person centred care. They supported people in a professional, friendly and caring way. The staff were very knowledgeable about the people they worked with and the field they worked in. They had access to good support and career prospects.

During our visit people were enabled and supported by staff to enjoy themselves and this was made visible by smiling faces. Staff knew when people were experiencing anxiety or discomfort and took appropriate measures to make them comfortable and calm.

Relatives said staff informed them of any changes to people's care including health needs. Staff supported people to access community based health professionals. People were protected from nutrition and hydration associated risks with balanced diets that also met their likes, dislikes and preferences. Relatives said people had good choices of meals and were encouraged to try new things.

Relatives told us the management team were approachable, responsive and encouraged feedback from

people. There were processes to consistently monitor and assess the quality of the service provided.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

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 remains Good'	**Good**
Is the service effective? 'The service remains Good'	**Good**
Is the service caring? 'The service remains Good'	**Good**
Is the service responsive? 'The service remains Good'	**Good**
Is the service well-led? 'The service remains Good'	**Good**

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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 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.

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This inspection was carried out by the inspector.

There were six people living at the home, some of whom had very limited communication skills. We spoke with three people, two relatives, three staff and the team manager. The registered manager was not present as they were on annual leave.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed care and support provided, was shown around the home and checked records, policies and procedures. These included the staff training, supervision and appraisal systems and home's maintenance and quality assurance systems.

We looked at the personal care and support plans for two people and two staff files.

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 contacted one advocate as part of the inspection process to find out their views regarding the home.

Good

Is the service safe?

Our findings

Relatives said in their opinion the service was safe. One relative told us, "I have no issues, I think the place is safe."

During our visit staff treated people equally and gave them the time and support they required to have their needs safely met. Staff were aware of the different forms of abuse and provided with training and policies and procedures to follow if they identified that it was taking place. They had also received safeguarding training and were aware of how to raise a safeguarding alert and the circumstances under which this should happen. There was no current safeguarding activity. Previous safeguarding situations were suitably reported, investigated, recorded and learnt from. Care plans also contained action plans and guidance to help prevent any previous accidents and incidents from re-occurring. Safeguarding contact information was available in the home's office.

People had individualised risk assessments that enabled them to take acceptable risks and enjoy their lives safety. These included risk assessments about their health, social activities and other aspects of daily living. The risk assessments were regularly reviewed and updated as people's needs and interests changed. There were also general risk assessments for the home and equipment used that were reviewed and updated. Equipment was regularly serviced and maintained. The risk assessments were reliant to an acceptable level, on staff observation and knowledge of people and the way they communicate as people had limited verbal communication capacity.

The team shared information regarding risks to people. This included passing on and discussing any incidents of risk during shift handovers, using communication books and at staff meetings. There were also accident and incident records kept and a whistle-blowing procedure that staff said they were comfortable using.

The staff recruitment process was thorough and records showed that it was followed. The process included scenario based interview questions to identify people's skills and knowledge of learning disabilities. References were taken up and Disclosure and Barring service (DBS) security checks carried out prior to starting in post. A DBS is a criminal record check employers undertake to make safer recruitment decisions. There was also a six month probationary period with a review. If prospective staff had gaps in their knowledge, the organisation decided if the induction training could provide this knowledge and if the person should be employed. Staff were provided with a handbook that contained the organisation's disciplinary policies and procedures.

The staff rota was flexible to meet people's needs throughout the day and night and during our visit there were sufficient numbers of staff to meet people's needs. This was reflected in the way people were enabled to do the activities they wished safely.

The home had disciplinary policies and procedures that were contained in the staff handbook and staff confirmed they had read and understood them.

The home had a de-escalation policy that staff had received training in. This included individual de-escalation guidance that was contained in people's care plans as required. Any behavioural issues were discussed during shift handovers and at staff meetings. During our visit when people displayed challenging behaviour, staff re-acted appropriately in the knowledge that the behaviour was people making an effort to communicate their thoughts, wishes and emotions. Staff also monitored the effect the behaviour had on other people and this was recorded in their care plans and used to shape their care.

During the inspection we checked that medicine was safely administered, stored, disposed of if not required and the medicine administration records (MAR) for people using the service was suitably maintained and up to date. There were regular internal audits. Staff were trained to administer medicine and this training was regularly updated.

Good

Is the service effective?

Our findings

During our visit people decided the support they needed to do the activities they wished to do. Staff very familiar with people and aware of their routines and specific needs which they met. They provided a comfortable, relaxed atmosphere that people enjoyed. One person grasped the hand of a staff member and took them to the front door. Staff were aware that this meant the person wanted to go out for a walk and they duly obliged.

Relatives said people were enabled to make their own decisions, wherever possible and that they as relatives were also involved. The type of care and support staff provided was what people needed and delivered in a friendly, enabling and appropriate way. One relative told us, "Put it like this, I answered everything to a question in the questionnaire asking what would you like to stay the same." Another relative said, "Whenever I visit the standards are very high and I've been visiting for a good few years."

Staff thought the induction and annual mandatory training they received was good and the practices we saw reflected that staff had received good quality training. One staff member said, "The training is very good and enables me to support people well." The induction was based on the 'Care Certificate Common Standards'. Training provided included safeguarding, infection control, manual handling, first aid, food hygiene, health and safety and fire awareness. When new staff were recruited they would shadow more experienced staff, during shifts to enhance their knowledge of people and the home's operational procedures. Staff also received training from the local authority that was focussed on people living at the home specifically. One person was diagnosed with dementia and in order for them to continue living at their home of many years; training input was received from physiotherapists, speech and language therapists and a psychologist.

There were monthly staff meetings that gave further opportunities to identify training needs. The records we saw demonstrated that staff had four to six weekly supervision sessions and annual appraisals. Both were partly used to identify any gaps in training that required addressing. Staff had training and development plans in place. Experiences were also shared with other homes within the organisation.

Staff used a variety of communication techniques that included familiar objects, symbols and pictures so that staff could be better understood by people. They were also aware of what certain actions meant when people wanted to communicate. The care plans and other documentation such as the complaints procedure were part pictorial to make them easier for people to understand.

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 if 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. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by the provider, all applications under the DoLS had been authorised, and the provider was complying with the conditions applied to the authorisation. Best interests meetings were arranged as required. Best interests meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. Staff received mandatory training in The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The capacity assessments were carried out by trained staff and were recorded in the care plans.Staff we spoke with understood their responsibilities regarding the Mental Capacity Act 2005 and Deprivation of liberty safeguarding. Staff continually checked that people were happy with what they were doing and activities they had chosen throughout our visit.

People's care plans contained sections for health, nutrition and diet. Full nutritional assessments were done and updated regularly. Where appropriate weight charts were kept and staff monitored how much people ate. There was also information regarding the type of support required at meal times. Staff said any concerns were raised and discussed with the person's GP. Nutritional advice and guidance was provided by staff and there were regular visits by local authority health team dieticians and other health care professionals in the community as required. If possible people were encouraged to visit the health care professionals rather than being visited. People had annual health checks. The records demonstrated that referrals were made to relevant health services as required and they were regularly liaised with. The home worked closely with the local authority and had contact with other organisations that also provided service specific guidance. Health care professionals said they had no concerns with the service provided.

The home was clean and had recently been redecorated throughout. People's bedrooms were personalised in the way they liked with their personal items. People had access to a large, secure garden at the back of the property.

Good

Is the service caring?

Our findings

Relatives said that staff treated people with dignity, respectfully and with compassion. The staff worked hard to ensure that peoples' needs were met; they were supported to pursue the interests they wanted to and experienced a good quality of life. They made efforts to ensure people led happy, rewarding lives. Staff listened to people, acknowledged and valued their opinions and acted upon them in a friendly, attentive and helpful way. The staff team were skilled, patient and aware of people's, needs and preferences. People's body language was positive and they smiled a lot indicating that they were happy in the company of staff and each other. One relative told us, "This is a super place, I couldn't do the job [staff] do." Another relative said, "Right place, right care, provided by the right people."

Staff were trained to acknowledge people's rights and treat them with respect and dignity. They demonstrated this in their approach to people during our visit. They were thoughtful, courteous, discreet and respectful even when they weren't aware that we were present. Staff consulted people about what they wanted to do and if they were happy, using slow speech and actions that people could understand. They were aware of people's individual preferences for using single words, short sentences and gestures to get their meaning across. Staff spent time engaging with people, talking in a supportive and reassuring way and projecting positive body language that people returned. One person with limited speech took us by the arm and showed us around. Staff explained this was the person's way of showing you their home.

The home had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction and on-going training and contained in the staff handbook.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of the person using the service. Relatives said they visited whenever they wished, were always made welcome and treated with courtesy. A relative said, "[staff] always ask if I would like a cup of tea and if I am staying for dinner."

Good

Is the service responsive?

Our findings

Relatives told us they were asked for their views by the home's registered manager and staff. During our visit staff asked people for their views and opinions and gave them time to decide things for themselves, explain the support they needed and encouraged people to contribute whenever possible. Due to peoples' limited verbal communication skills this was based on staff knowledge of people, their body language and re-actions to activities. Despite the limited verbal communication staff managed to meet people's needs and provide support promptly and appropriately. People's positive body language reflected the appropriateness of the support and way it was given. A relative said, "Staff have done an awful lot of work developing [relative] communication." Another relative said, "Staff know people and their routines well and this makes such a difference."

The local authority referred people to the service and provided assessment information to the home. Information from people's previous placements was also requested where available. The registered manager shared this information with staff to identify if people's needs could initially be met. The home then performed its own pre-admission needs assessments. During the course of people's visits the manager and staff would add to the assessment information.

Written information about the home and organisation was provided and there were regular reviews to check if the placement was working. If there was a problem with the placement, alternatives were discussed, considered and information provided to prospective alternative services where needs might be better met.

Where possible people, their relatives and other representatives were fully consulted and involved in the decision-making process. They were invited to visit the home as many times as they wished, before deciding if they wanted to move in, in line with the organisation's policy and procedure. Staff said it was really important to consider people's views as well as those of relatives so that the care was focussed on the individual. It was equally important to get the views of those already living at the home, whenever possible.

People's needs were regularly reviewed, re-assessed with them and their relatives and care plans re-structured to meet any needs that had changed. The care plans were individualised, person focused and developed by identified lead staff as more information became available and they became more familiar with the person and their likes, dislikes, needs and wishes.

People's care plans were part pictorial to make them easier for them to use and separated into health, lifestyle, finance and support plans. They were comprehensive, recorded people's interests, hobbies, health and life skill needs and the support they required to meet them. They were focussed on the individual and contained people's 'Social and life histories' and individual communication plans and guidance. The care plans were live documents which contained goals that were identified and agreed with people where possible. The goals were underpinned by risk assessments and reviewed monthly by keyworkers who involved people. If goals were met they were replaced with new ones. Daily notes identified if activities had taken place.

Staff encouraged people to participate in their chosen and any impromptu activities and made sure no one was left out. There was a combination of individual and group activities with a balance between those that took place at home and those within the community. People had their own weekly individual activity plans that recorded the activities they would be doing. During our visit one person went out for a walk on the spur of the moment whilst others were engaged in activities in the lounge.

The organisation had set up a hub to provide communal activities for people in the local community and at homes within the organisation such as tea and cake mornings. People had also grown a variety of vegetables and herbs in the greenhouse. The activities included drink in the local pub, shopping, aromatherapy, sensory sessions, swimming, car ride, cooking and horse riding. People were also encouraged to develop their life skills by performing tasks around the home such as making a snack, keeping their rooms tidy and putting out the rubbish. An advocate said, "[person using the service] goes on plenty of local activities and has visited Italy and Bruges."

Relatives told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly.

There was a whistle-blowing procedure that staff said they would be comfortable using.

Good

Is the service well-led?

Our findings

Relatives said the registered manager and staff were very approachable, kept them up to date and there was an open door policy that made them feel comfortable. They said they were actively encouraged to make suggestions about the service and any improvements that could be made. During our visit we found there was an open and listening culture with staff taking on board and acting upon people's views and needs. One relative told us, "The manager is well trained with lots of experience."

The organisation had a clear vision and set of values that staff understood. They said that the vision and values had been explained during induction training and regularly revisited during staff meetings. The vision and values were reflected in the management and staff practices even though the registered manager was not present.

There were clear lines of communication within the organisation and specific areas of responsibility. Staff told us the support they received from the registered manager was good. Their suggestions to improve the service were listened to and given serious consideration. A staff member said, "The manager is very supportive and there is good two way communication." Another member of staff told us, "We get good support from the organisation." A further staff member said, "We have had a stable staff team for a very long time and it's all about teamwork."

Records showed that safeguarding alerts and accidents and incidents were fully investigated, documented and procedures followed correctly. There was a clear policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in needs and support as required. Our records told us that appropriate notifications were made to the Care Quality Commission in a timely way.

There was a robust quality assurance system that contained performance indicators, identified how the home was performing, any areas that required improvement and areas where the home was performing well. The home used a range of methods to identify service quality. These included daily, weekly, monthly and quarterly provider, manager and staff audits that included, files maintenance, care plans, night reports, risk assessments, infection control, the building, equipment and medicine. There were also six monthly audits by registered managers from other homes in the organisation, on a rotational basis. Comprehensive shift handovers took place that included information about each person. This enabled required improvements to be made that meant the care provided was focussed on the individual.

A relative confirmed that they received annual questionnaires seeking their views.