United Response

United Response - 15a Vale Road

Inspection report

United Response
15a Vale Road
Aldershot
Hampshire
GU12 5HH

Tel: 01252334880
Website: www.unitedresponse.org.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?	Good

Summary of findings

Overall summary

This comprehensive inspection took place on 17 November 2016 and was unannounced.

The home provides accommodation and personal care for up to five adults who have needs arising from learning disabilities and/or autistic spectrum disorder. At the time of inspection, there were five people living at the home.

The service was previously inspected in April 2013 when the service was found compliant with all the regulations inspected.

Care was provided in a purpose-built single storey home set in grounds on the outskirts of Aldershot. The property was owned and maintained by a landlord who leased the home to United Response.

There was a registered manager running the service. 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.

The home had a happy, friendly feel with staff and people interacting with humour. There were enough staff to support people safely. People were supported by staff who knew them well. Staff showed kindness and care to people. Staff received training to ensure they had the necessary knowledge and skills to carry out their role. Staff were also supervised and appraised to support them in their role on a regular basis.

The registered manager and staff understood their responsibilities in terms of safeguarding vulnerable adults from abuse. They also understood their role in ensuring they worked within the framework of the Mental Capacity Act 2005.

Care plans described people's care and support needs. They were reviewed on a regular basis and also when changes to a person were identified. Health and social care professionals were involved to support people's care and health needs. These included people's GP, dentist, as well as specialist services such as incontinence advisors. People were supported to have a healthy diet and stay hydrated. Staff prepared meals which people enjoyed and which met their dietary needs, including food intolerances.

Staff administered, recorded and stored people's medicines safely. Individual risks had been assessed and people were supported to be as independent as possible taking these into account.

The home was well run by the registered manager and her deputy who knew people and staff well. Audits and checks were carried out to ensure the quality of the service provided. Senior managers visited the home regularly to undertake checks on the environment and people's care. Where issues were identified, actions were taken to address these. This included working with the landlord on issues relating to the

home.

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 the risks of abuse by staff who understood their responsibilities.

Medicines were stored, recorded and administered safely.

There were sufficient numbers of suitable staff to ensure people were kept safe and had their needs met.

Risks to people had been assessed and supported them to be safe.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the necessary skills and knowledge.

Staff received an induction when they first joined and refresher training from time to time.

People were supported to maintain a healthy, balanced diet.

Where people's liberty was restricted, staff ensured they worked within the principles of the Mental Capacity Act 2005.

People were supported to access health services.

Is the service caring?

Good

The service was caring

People were supported by staff who were kind and compassionate. Staff knew people well and showed concern for their well-being.

People were involved in making decisions about their care. People were treated with dignity and respect.

People's families were able to visit when they wanted.

Is the service responsive?

Good

The service was responsive.

People received care that met their needs, preferences and aspirations.

Care records reflected people's risks, needs and preferences. Care records were updated when there were changes to people.

There was a complaints policy and procedure in place.

Is the service well-led?

Good

The service was well–led by a registered manager who understood their responsibilities.

The home promoted a positive culture and involved people, their relatives and staff in developing the service.

Staff knew the registered manager and said they felt they were supported by them.

Checks and audits to ensure the quality of the service were undertaken and actions were completed to make improvements where issues were identified.

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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 17 November 2016 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed information we held on our systems. This included statutory notifications which had been submitted to us. A notification is information about important events which the service is required to tell us about by law.

We had asked the provider to complete 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. The provider had completed this in July 2015.

We spoke with two care staff working at the home on the day of the inspection, as well as the registered manager.

At the time of this inspection, five people were living at the home. We met everyone living in the home. All of the people at the home had limited or no clear verbal communication skills. Therefore we spent part of the inspection observing people as they undertook activities in the home.

We looked at a sample of records relating to the running of the home and to the care of people. We reviewed two care records, including risk assessments, care plans and three medicine administration records. We reviewed two staff records. We were also shown policies and procedures and quality

monitoring audits which related to the running of the service.

After the inspection, we contacted four health professionals and GPs at a local surgery for comments about the service. One health professional responded. We also contacted three relatives, two of whom responded.

Good

Is the service safe?

Our findings

Our observations showed people felt safe and happy living at the home. Throughout the inspection, people were moving freely around the home and interacting with staff in a relaxed, positive manner.

People were protected against the risks of potential abuse. Staff had received regular training in how to safeguard people. They were able to describe what they would do if they identified any concerns. This included reporting concerns to the registered manager and also the local authority.

The registered manager understood their role in safeguarding people from the risks of abuse. Although they had not had to report any concerns in recent years, they were able to explain the process they would follow if a concern arose.

People were protected from the risk of financial abuse. There were systems in place to record income and expenditure for each person. Where there were concerns about one person's finances which were managed by a relative, the registered manager had taken appropriate action to address this with the care manager. They also said they would report any concerns about people's finances to the safeguarding authority.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. For example, one person liked to move about the home carrying plastic cups, which they sometimes threw in doorways. Staff ensured that they had cups which would not break or cause injury to the person or others when thrown. The person had been assessed as at high risk of injury if they went in the kitchen. Actions had been taken to ensure the person was not able to enter the kitchen even when with staff. Staff talked calmly and politely to the person when they stood at the kitchen door. The person clearly understood the boundaries but did attempt to go in the kitchen on one occasion. Staff supported the person away from the kitchen using distraction methods, whilst talking kindly to them. Other people in the home were able to use the kitchen when they wanted as the door was fitted with two handles, one of which was near the top of the door. Both handles had to be opened simultaneously, which the person who was at risk in the kitchen was not able to do.

People were protected against hazards as staff followed the provider's health and safety policy and procedure. Health and safety checks had been carried out on a regular basis. These included fire equipment, water temperatures and hoist equipment safety. Where issues were identified, actions had been completed to address them.

People were kept safe from the risk of emergencies in the home. A comprehensive disaster plan had been developed to ensure staff had guidance in the event of an emergency. The plan included detailed personal emergency evacuation plans for each person. These described what people's risks, needs and support were if they needed to be evacuated.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. Both the care workers who were on duty had worked with people since the home had opened and knew all

the people very well. Staff rotas showed that there were two staff on duty at all times during the day. At night, there were also two staff on duty, one waking and one sleeping in. Staff said they really enjoyed their work and felt there were always enough staff to support people safely.

The registered manager also managed another United Response service which was close by. They said they worked with a deputy manager to ensure that one or other of them was always available to provide support and guidance to staff.

Staff were recruited safely. Safe recruitment procedures ensured that people were supported by staff with the appropriate experience and character. Detailed application forms included full work histories and interviews were held with prospective candidate. The provider's recruitment processes made sure the necessary safety checks on prospective applicants were completed prior to appointment. These included Disclosure and Barring Service (DBS) checks to confirm that employees did not have a criminal conviction that prevented them from working with vulnerable adults. The DBS is a criminal records check which helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Appropriate references were taken up and verified before candidates were offered a post.

The registered manager said they were in the process of recruiting additional staff. They said that recruitment was a challenge as the home was in an area of high wages and high employment. They said however, they very rarely had to use agency staff as permanent staff would normally fill any gaps in the rota. They also said it was important for people to have staff they were familiar with and the current staff were aware of this and would therefore take on extra duties.

There were safe medication administration systems in place and people received their medicines when required. There was an up-to-date medicine administration policy and procedure which had been reviewed in January 2016. Staff had received medicines administration training and their competency was assessed before they were allowed to carry out this duty. Medicines were stored in a locked medicines cabinet, which was neat and tidy. Most medicines were administered from a monitored dosage system (MDS) which helped to prevent errors. MDS meant that the pharmacy prepared each dose of medicine and sealed it into packs with the day and time for the medicine clearly marked. Some people had medicines which were not part of the MDS, for example creams and ointments. These were marked showing when they had been opened. Staff described how they disposed of medicines in a safe way. People had detailed guidelines for the use of any PRN (to be taken as necessary) medicines. These were kept in people's individual care plans and in the medicine cupboard.

One person had a tablet administered to them with their meal. There were clear instructions in the person's care record which detailed what staff had to do. This included advising the person about the medicine before putting it in their lunch. We observed a member of staff following the correct procedure. This included telling the person that they were putting the medicine in the lunch before helping them to swallow it with food.

People were protected from the risks of infection. The provider information return described how a hoist had shown signs of deterioration which had the potential to compromise effective infection control. This had been replaced by a different model which had not only reduced the risks for people, but also made it safer for staff to use. Staff used disposable personal protective equipment such as gloves and plastic aprons when supporting people with personal care. During lunch, they wore cloth aprons. They said this was because it felt more homely for people. However they said these aprons along with tea towels used were washed on a high temperature wash each day. The home was clean, well aired and there were no

malodorous smells. Staff said they supported some people who liked to help with chores such as loading the dishwasher.

Good

Is the service effective?

Our findings

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. The registered manager said some of the staff had worked at the home for many years and had also worked with some people at a previous home. They described how this helped people as staff understood how to communicate and work with them.

Observations during the inspection confirmed that staff knew people very well and were able to recognise people's emotions. For example, one person became slightly anxious when going into the garden. Staff reassured them that it was safe and gently led them out by holding their hand.

Staff said they had the training and skills they needed to meet people's needs. One member of staff commented "We have a good mix of e-learning and face to face training" and showed us their folder of certificates for training they had recently undertaken. Staff were provided with training which included safeguarding, fire safety and medicines administration.

Staff had also been supported to complete specialist training to meet people's individual needs, for example staff had undertaken training in epilepsy and positive behaviour support.

New staff were supported to complete an induction programme before working on their own. As part of their induction, new staff completed the standards described in the Care Certificate. The Care Certificate was developed by Skills for Care. It is a set of 15 standards that all new staff in care settings are expected to complete during their induction.

People were supported by staff who had supervisions (one to one meetings) with their line manager. Staff said supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. Staff said they felt supported by the registered manager and were able to raise any concerns or issues at any time. The registered manager kept records of supervisions undertaken. They said they also undertook appraisals with staff and were in the process of arranging dates for these with staff.

The Mental Capacity Act (MCA) 2005 provides the legal framework to assess people's capacity to make certain decisions at a certain time. When people are assessed as not having the capacity to make a decision, a best interests decision is made involving people who know the person well, such as relatives or friends, and other professionals, where relevant.

At this inspection, we found staff had an understanding of the Mental Capacity (MCA) 2005, as they were able to describe how people's capacity was assessed about specific decisions. For example one member of staff described how some people had capacity to be able to choose to lock their bedroom door. They described how each person had been assessed and where a person did not have capacity, they had recorded how to support the person in the least restrictive way. Some people did have keys for their bedrooms and were able to lock their room when they chose to.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided.

Where people are deemed to not have capacity to make a decision about a particular issue, it may be necessary to consider whether they are being deprived of their liberty in relation to the issue. If this is found to be the case, an application for a Deprivations of Liberty Safeguards (DoLS) authorisation must be made. In these circumstances the provider must do all they can to find the least restrictive ways to meet the person's needs. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

The registered manager had applied for DoLS authorisations for all five people living at the home. One of these had been authorised and the registered manager said the others were waiting to be assessed by the local authority.

People's dietary needs and preferences were also clearly recorded in their care plans. For example, one person's care plan described how they liked 'finger foods' and another person was gluten and lactose intolerant. Staff described how they ensured the person's meals that were prepared did not include ingredients which contacted either gluten or lactose. Staff said, although some people were able to eat independently, two people needed their support. They also described how some people needed their food cut up small as they ate very fast. Staff said this helped to reduce the risk of the person choking. During the lunch we observed people being helped with eating. Staff sat with people, taking their time to help them eat and chatting to them and others in the dining room.

The meal of corned beef hash had been freshly prepared and was clearly enjoyed by everyone. People were able to choose whether they had ketchup or brown sauce with their meal. A choice of cold drinks was offered and accepted by people. After lunch people were asked whether they would like a dessert of fruit or yoghurt.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and were supported to attend appointments when required. People were referred appropriately to specialists including, a continence nurse, a dietician and speech and language therapists if staff had concerns about their wellbeing. A health professional commented "We have supported four people at the home and assessed their needs." They also added "The home always contact us if they have any problems."

Some adaptations to the environment of the home had been made to meet the needs of people who lived there. For example bathrooms had been designed to support people with limited mobility and in wheelchairs more easily. One person's bedroom had been fitted with external blinds as they did not like to have curtains in their room. People helped to choose the decorations, for example one person was helping to arrange dried flowers in the dining room.

Good

Is the service caring?

Our findings

People appeared happy and contented during the inspection. They were treated with kindness and compassion in their day-to-day care by staff who spent time with them. People received care and support from staff who had got to know them well.

A relative commented "Terrific staff, wouldn't have [person] anywhere else, care is brilliant." There was laughter and banter between people and staff during the inspection. Staff spent time sitting in a lounge area with people talking about what they had done during the day. Staff knew people's individual communication skills, abilities and preferences. For example, one person's care plan described how they might communicate their happiness by clapping their hands. The care plan also described how the person may grind their teeth if they did not want to be in a particular place, such as when the environment was too busy. Another care record contained information about how a person had no verbal communication other than making a noise when excited. It also described how the person indicated they wanted a drink by waving a beaker at staff. We observed staff supporting the person with a drink on several occasions when they waved their beaker.

Staff were observed supporting people using different communication methods and helping them to respond. For example, one person in the sitting room appeared agitated at one point. Staff took time to understand the person's concern which was because staff had taken down and washed two chandeliers. Staff responded immediately and put the shades back up, which clearly pleased the person.

People's bedrooms were personalised and decorated to their taste. For example, one person had chosen the room colour and had ornaments and pictures displayed. However, staff described how another person became very agitated unless their bedroom was kept very bare. They said the person had displayed this agitation by throwing items and also taking bedding off. They described how they now ensured the person's room was kept minimal, which had lessened the person's anxiety.

Care records showed people had been supported to have independent advocacy. This included accessing independent mental capacity advocates (IMCA) where needed. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

Good

Is the service responsive?

Our findings

People or their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. Speaking with staff, they were able to explain people's preferences which reflected the information in the care plans. One relative said "They really look after [person] well and respond to his needs."

Care, treatment and support plans were personalised. Care plans contained information about the person's likes, dislikes and people important to them. The examples seen were thorough and reflected people's needs and choices. One person's care plan described 'Person does not like anything in his bedroom, he has his TV and his bed, but anything other than that he cannot cope with.'

Care plans also provided information about people's strengths and preferences throughout the record. For example a one page profile of one person had a section about 'what people like about me' which included 'my independence, happy disposition, determination.' The profile also described how the person could be supported well, which included using sensory equipment such as a bubble machine, music, films and going out for lunch. Daily notes showed that these activities took place on a regular basis.

People's needs were reviewed regularly and as required. Where necessary, health and social care professionals were involved. An example of this was when staff needed to order a specialist bed for one person, which had required the involvement of health and social professionals.

Where people required support with their personal care they were able to make choices and be as independent as possible. For example, a care plan described how one person 'will help to dress himself'. The care plan also described how the person was helped by staff to 'pick up the post.' The care plan described the positive benefits of this, for example 'opportunity to engage…gets [person] used to handing materials/interacting with staff/accepting support.' It also detailed how it was important to give the person 'lots of praise for a job well done.'

People had a range of activities they could be involved in both within the home and the local community. During the inspection, one person went out for a walk and a coffee, while other people were supported to do activities in the home. These included helping staff make a Christmas wreath for the home.

There was a complaints policy and procedure. A relative said they had never had any reason to complain but knew how to do so, if needed. The registered manager said they had not received any complaints but they would take any concerns seriously and investigate them thoroughly. They added that they would use them as an opportunity to improve the service.

Good

Is the service well-led?

Our findings

The service was well-led by an experienced manager who held appropriate care and management qualifications and had registered with the Care Quality Commission in December 2010. She also managed another home close by which was run by the provider. She described how she was supported in the management of both homes by a deputy manager.

The service promoted a positive culture. The registered manager said she had an open door policy and encouraged staff to raise concerns and issues. She described how she felt confident that people, their relatives and staff would tell her of any issues. The registered manager also regularly worked alongside staff which gave them an insight into the support people received. Staff said they felt well supported by both the registered manager and her deputy. They said they felt able to talk to them if they needed to.

The registered manager had notified CQC about significant events. We use this information to monitor the service and ensure they respond appropriately to keep people safe.

The registered manager kept up to date with current practices, legislation and national guidance. They described how they regularly met with other managers from the provider organisation to support their knowledge and skills.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. People benefitted from living in a home where the safety and quality of the service was monitored and assessed. There were regular checks and audits carried out on the building and equipment to ensure it met required standards. These included checks on water temperature and safety; fire equipment; hoist and other specialist equipment. Each quarter a senior manager would visit the home and undertake a quality assurance audit. This audit included a review of people's care records as well as checks on the home and equipment. For example an environment inspection had been carried out in September 2016. Records showed that where issues were identified, an action plan was developed to address the concerns and monitor progress.

Quality and safety were seen as the responsibility of all staff. For example, Staff completed a daily check sheet which identified tasks which needed to be carried out. These included activities such as mopping floors and other cleaning routines. Staff also completed a weekly medicines check, with the deputy manager undertaking reviews and a monthly audit of medicines administration.

The registered manager had recognised the challenges of working with the landlord of the building to ensure improvements were carried out to the building. Emails showed they had raised concerns about maintenance and improvements needed to the home. Where necessary they had escalated concerns to senior staff in the provider's organisation. The emails also showed that actions to address concerns had been completed.

People and those important to them had opportunities to feedback their views about the home and quality

of the service they received. For example, the provider had recently undertaken a survey of people's relatives. The registered manager said they expected the results from this to be available soon and described how this would help to inform improvements to the service.

People benefited from staff who understood and were confident about using the whistleblowing procedure. Staff said they had no concerns but knew how to do so if necessary.