Ordinary Life Project Association(The)

Ordinary Life Project Association - 56 Sycamore Grove

Inspection report

56 Sycamore Grove
Trowbridge
Wiltshire
BA14 0JD

Tel: 01225763056

Date of inspection visit:
25 November 2015

Date of publication:
29 February 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Ordinary Life Project Association - 56 Sycamore Grove is registered to provide accommodation and support to three people with a learning disability. The home was last inspected in April 2014 and was found to be meeting all of the standards assessed. At the time of the inspection three people were living at the home.

A registered manager was in post. 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 were enabled to make day to day decisions. They were not subject to continuous supervision in the home but needed staff supervision in the community. Deprivations of Liberty Safeguards (DoLS) applications were made to the supervisory body for some people who needed staff supervision in the community. Where there were concerns about people's ability to make specific decisions Mental Capacity Act (MCA) 2005 assessments were undertaken. MCA assessments lacked detail for people who had fluctuating capacity to make decisions. Decisions for supporting people with some behaviours were taken by the staff without consideration to the principles of the MCA (2005). This meant the MCA 2005 legal framework was not in place to make best interest decisions.

Risk management systems enabled people to take risks safely. Where risks to people's health and wellbeing were identified, action plans were developed to minimise the level of risk. However, risk assessments had been devised over a significant period of time. They were signed to say they were reviewed but not updated. This meant changes in legislation and best practice were not considered. Also risk assessments were not in place for all risk for example, audio listening devises for people who experience epilepsy seizures.

Safe systems of medicine management were in place. People said the staff administered their medicines. Members of staff signed the medication administration records (MAR) charts to show they had administered medicines as prescribed. People were taking over the counter medicines such as pain relief, vitamins and supplements over long periods of time. Protocols which gave staff guidance on when to administer over the counter remedies were in place. This meant people using homely remedies over long periods of time may have a persistent illness that requires attention from a healthcare professional.

Sufficient numbers of staff were deployed to meet people's needs. People told us there were sufficient staff on duty for them to have the attention they wanted. They said the staff were caring and their needs were met by staff who knew their likes and preferred routines. People described how staff respected their privacy and dignity.

People said they felt safe living in the home. Members of staff knew the signs of abuse and the actions they needed to take for suspected abuse. Safeguarding adults procedures were in place for staff's reference.

Recruitment procedures in place ensured that the staff working at the home were suitable to work with vulnerable adults. Records of the checks and processes followed lacked detailed. For example, the quality of the references received and the correct legislation which covered employment of staff working at the home.

People benefitted from staff that were trained and supported to meet the roles and responsibilities. The induction prepared new staff them to undertake their role at the home. They said the induction provided was detailed. Staff received training which enabled them to develop their skills to meet people's specific needs. One to one meetings with the registered manager to discuss concerns, training needs and performance were regularly held.

The dietary requirements of people living at the home were catered for. People participated in menu planning and their preferred meals were included in the menus. We saw a wide range of fresh vegetables and fruit, canned and frozen goods.

Care plans were person centred and were developed on all aspects of people's care and welfare. People said they participated in developing their care plans. The care plans described people's preferences and their routines. Members of staff told us there were handovers during shift changes which kept them informed about people's daily care needs.

Arrangements were in place for people to participate in community activities and to increase their independent living skills. People told us the staff helped them choose the most suitable community activities which met their interests and hobbies, for example, a cookery course. A rota of household chores was in place and included the tasks people had agreed to undertake which helped them develop their independent living skills.

People knew who to approach with their concerns. A system to gain people's views was in place. People had opportunities to give their feedback through house meetings and one to one sessions with specific members of staff.

Quality assurance arrangements in place ensured people's safety and well-being. Systems and processes were used to assess, monitor and improve the quality, safety and welfare of people. There were systems of auditing which ensured people received appropriate care and treatment. Annual plans were developed on the year's priorities and how they were to be delivered over the year. For example, increase staff knowledge of fundamental standards, reviewing person centred care plans and implement suggestions from people.

We made recommendations for the service to seek advice and guidance from a reputable source, about risk management.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were having homely remedies daily and over a long period of time. Guidance from healthcare professionals on long term use of homely remedies was not sought.

Risks were assessed and staff showed a good understanding of the actions needed to lower the level of risk to people. Risks were signed to indicate they were current but they were not updated for significant periods of time. This meant changes in legislation and best practice were not considered when reviewing the risk assessments.

People said they had the attention they needed from staff.

People felt safe living in the home and staff knew the procedures they must follow if there were any allegations of abuse

Is the service effective?

Good

The service was effective.

People were not under continuous supervision in the home but were supervised when they were in the community. The Chief Executive told us Deprivation of Liberty Safeguards (DoLS) were made where appropriate.

Mental Capacity Act (MCA) 2005 assessments were undertaken where there were concerns about people's ability to make specific decisions. However, some MCA assessments lacked detail for some people with fluctuating capacity to make decisions.

Members of staff benefited from one to one meetings and appraisals with their line manager. At the one to one meetings staff discussed their performance and concerns.
People dietary requirements were catered for at the home.

Is the service caring?

Good

The service was caring

People received care and treatment in their preferred manner which respected their human rights.

Members of staff were respectful and consulted people before they offered support.

People's comments indicated their care and treatment was delivered in a dignified manner.

Is the service responsive?

Good

The service was responsive

Care plans reflected people's current needs and gave the staff clear guidance on meeting people's needs.

People had opportunities to pursue their hobbies and interests. People attended clubs and participated in community activities.

People knew a complaints procedure was in place and who to approach with their complaints.

Is the service well-led?

Good

The service was well-led.

Effective systems to monitor and assess the quality of care were in place which ensured people received consistent standards of care and treatment.

Systems were in place to gather people's and staff's views. The views of people, staff and visitors to the home were gathered. People had opportunities to give feedback through group and one to one meetings with their keyworker (member of staff assigned to work with specific individuals).

Members of staff had a good understanding of the vision and values of the organisation.

Ordinary Life Project Association - 56 Sycamore Grove

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 5 November 2015 and was unannounced. The inspection was completed by one inspector.

Before the inspection we reviewed all of the information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with three people who used the service, the registered manager, the Chief Executive and two members of staff. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for two people. We also looked at records about the management of the service.

Requires Improvement

Is the service safe?

Our findings

Risk assessments were not always developed or reviewed where risks were identified. For example, risk assessments were not in place for audio monitors used for people at risk of sudden death from epilepsy. Where risk assessments were in place they had been devised over a significant period of time but they were not updated in that period. Risk assessments had been signed by the registered manager to indicate the action plans were ongoing and current.

The registered manager said people were supported to take risks safely. A member of staff said an action plan was devised where risks were identified to lower the level of risk to the person. They said some people were at risk of falls and some people needed support with weight management.

Staff said incident and accidents were assessed to identify ways of preventing a reoccurrence. The registered manager said following the staff reflected on the accidents and incidents. A refection log was completed by the staff and the section on "what other action may have helped" gave the staff an opportunity to learn from the incident and prevent a reoccurrence.

Contingency plans were in place for the safe evacuation of the property in the event of an emergency. Individual fire risk assessments were in place for hazards that may limit the person's mobility and listed the control measures to prevent the outbreak of fire. For example, fire training and equipment checks.
Safe systems of medicine management were in place. The medicine file included the person's photograph to ensure staff were able to confirm people's identity and medication administration records (MAR). MAR charts gave the directions for administration which staff signed to show administration.

People were taking over the counter medicines such as pain relief, vitamins and supplements. Protocols for these medicines gave instructions on administration and for pain relief the maximum dose to be administered was also included. Vitamins and supplements were being administered daily and over a long period of time. The regional manager said homely remedies were reviewed at annual health checks by the GP.

The three people we spoke with said they felt safe living at the home. One person said the staff made them feel safe. Members of staff knew the signs of abuse and the actions they must take when abuse was suspected. They said safeguarding of vulnerable adults training was provided annually by the organisation.

Recruitment processes were followed to ensure staff suitable to work with vulnerable adults were employed. Disclosure and Barring Service (DBS) checks were undertaken and the clearance received was included on the form. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people...

There were sufficient numbers of staff on duty on the day of the inspection. The three people we spoke with said they had the attention they needed from the staff. One person said there were two staff on duty during the day. A member of staff said that where there were activities organised additional staff were rostered to

work. They said at weekends there was lone working which had little impact on people as weekends were more relaxed. Another member of staff said staff were lone workers from 5pm onwards. They said there was an on-call system for support in the event of an emergency.

We recommend the service consider current guidance on risk management

Good

Is the service effective?

Our findings

People were supported to make decisions. One person said they made decisions about the times they got up in the morning, the clothes they wore and they participated in menu planning. A member of staff said people made decisions about moving bedrooms, menu planning and about activities. Another member of staff said people were always involved in the decision making and their consent was always gained before care was delivered.

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)

People were not subject to continuous supervision when they were at home but needed support from the staff in the community. A member of staff said people would be vulnerable in the community without their support. They said some people needed two staff to support them in the community. The chief executive said applications for Deprivation of Liberty Safeguards (Dols) were made but approval from the supervisory bodies had not been received.

Where MCA assessments were undertaken they were not completed appropriately. MCA assessments for some people had identified fluctuation capacity but the times when the person was best able to make decisions was not detailed. The Chief Executive said MCA forms were to be updated.

Risk assessments were developed for the behaviours that some other people had found difficult. We noted these risk assessment did not consider the provisions of the Mental Capacity Act (MCA) 2005. This meant the decisions made for the person were not within the MCA legal framework. For example, the person's capacity to consent to specific decisions was not assessed and decisions made by the staff to safeguard people from abuse were not made within the legal framework of the MCA
. "Communication aid" guidance was developed on how staff were to respond when people presented with particular behaviours. This guidance was not dated and lacked details on how to discourage and distract the person. Positive Behaviour Plans supplemented the communication aid guidance but we found inconsistencies between them. The Positive Behaviour Plan dated 8 February 2012 for one person was updated on 30 March 2013 and reviewed by the manager and positive behaviour specialist. This information was more detailed and described were the triggers that may cause aggressive behaviours along with the staff's response to each trigger.

One person said sometimes they got angry. They said on these occasions the staff suggested they go to their bedroom and listen to music to regain control over their behaviour or they spoke with staff.

New staff attended an induction to prepare them to work with people living at the service. A member of staff said their induction covered the organisation's procedures, specific training and shadowing of more experienced staff.

People received care and treatment from staff that were skilled and well supported. The registered manager told us one to one meetings to discuss concerns, performance and training with individual staff happened every eight weeks. A member of staff said their one to one meeting was with the registered manager. They said Health and Safety issues, concerns with people's care and with staff was discussed. This member of staff stated "helps to get things in the open". Another member of staff explained the arrangements for one to one meetings. They said one to one meetings happened every three months and at the meetings "everything is discussed".

Staff attended training that increased their skills and developed knowledge of people's needs. The registered manager said staff training was planned and delivered throughout the year. They said the training included essential training set by the provider and specialist training. For example, staff attended safeguarding adults, moving and handling and first aid training. Specialist training included epilepsy and dementia awareness. A member of staff said the training provided by the organisation was relevant to the role they were employed to perform Another member of staff said they must attend essential training set by the provider and specialist training to meet people's specific needs.

People's dietary requirements were met. Menus were based on people's preferences. Staff told us each person selected two days menu and on Sundays there was a roast dinner. We saw a wide range of frozen, tinned and fresh vegetables that met people's dietary needs. Staff told us people were supported to prepare their breakfast and lunch. They said the evening meal was prepared by the staff.

People were supported with their ongoing health care needs. Members of staff completed an easy read health action plan form on people's current health. Where people had health care needs a referral to specialist health care professionals was requested. For example, support from a continence advisor. A member of staff said appointments were organised by the staff and the outcomes of the visits were then recorded in the person's health action plan. A diary was used to record appointments and included was the nature of the visit and the specialist involved.

Good

Is the service caring?

Our findings

People had opportunities to discuss their views with their keyworker (member of staff assigned to specific people) during one to one meetings. Easy read feedback forms were completed by staff during one to one meetings. We saw recorded where people had given their views about their food preferences, places of visit and weekly activities.

We saw from the house meeting minutes that people were supported by the staff to celebrate traditional holidays and events such as Halloween.

People told us staff knew their preferences. One person said the staff knew how to meet their needs. Members of staff knew the people they were caring for. A member of staff said there was good communication between staff and people and the staff had a good understanding of people's needs. They said chatting to people gave them an understanding of people's preferences. Another member of staff said getting to know each individual created trust and having shared interest such as music helped them to build relationships with people.

Care plans were developed with people and had their preferences on how their care was to be delivered. A summary in people's care files described "what is important to people, what other people admire about them and how best to support them."

People were helped to maintain relationships with their relatives. One person told us they had recently gone on holiday with a relative. Another person said when relatives came to the home their visits were in their bedrooms for privacy.

People's rights were respected by the staff. A member of staff gave us examples on how they respected people's rights. For example, giving people choices, knocking on bedroom doors before entering and providing care and treatment in private. Another member of staff said they respected people's rights by ensuring people keys to their bedrooms were provided and by ensuring they knocked on bedroom doors and waiting for an invitation to enter.

People had access to independent advocacy services. Wiltshire People First on behalf of Health Watch Wiltshire conducted a visit to consult people on how they influenced their care. It was the conclusion of Wiltshire People First that people had opportunities to pursue their interests.

Good

Is the service responsive?

Our findings

People were aware care plans were developed to meet their needs. One person said they were involved in the development of their care plans. Staff said care plans were devised by the registered manager and the person. A member of staff said the care plans were particularly good for agency staff as they gave information on how to meet people needs. Another member of staff said the care plans provided a point of reference.

Daily routine care plans were developed on how people spent their day which included their routines for the day and daily activities. These care plans detailed the choices people made, the aspects of care they were able to manage for themselves and the support needed from the staff. Action plans were devised on areas for developing the person's skills. For example, road safety awareness,, health and communication.

Staff said that when they came on shift they received a "handover". The handover told them about people's current needs. Individual diaries were used to record people's daily activities, the care and treatment delivered and outcomes of visits.

People told us they were consulted by the staff about their interests and the staff made suggestions on activities available for them to pursue their hobbies, for example, attending cookery courses. A person told us they participated in a range of activities. For example going for coffee with the staff and pursing their religious beliefs. Another person told us they participated in community activities and joined groups, for example, gardening, shopping and attended church services. Activities planners were held in people's care records and generally people participated in community activities three times per week.

People participated in cleaning routines. Some people chose to clean their bedrooms and a rota of household tasks to be completed was in place. For example, emptying bins and dusting communal areas.

People said they approached the staff with complaints. A member of staff said attempts were made to resolve complaints when they were approached with concerns. They said where complaints were not resolved they were passed to the registered manager for investigation. Copies of complaints procedure were kept in people's care files and detailed who to approach if their concerns were not resolved to their satisfaction.

Good

Is the service well-led?

Our findings

The views of people, staff and visitors to the home were gathered. People had opportunities to give feedback through group and one to one meetings with their keyworker (member of staff assigned to work with specific individuals). The minutes of the group meeting included suggestions made by people and included were the resources needed to achieve the suggestions made. For example, leisure trips and staff to support the trips. One person said tenants meetings were organised and they attended these meetings.

The manager sought the views of agency staff and visitors using questionnaires. Nine agency and relief staff completed surveys which stated they were provided with information needed to meet people's needs.

Staff meetings were held monthly to share information and discuss all aspects of the care and treatment that people required. At the most recent staff meetings the people living at the service and the quality assurance action plan was discussed. An action plan was devised on implementing suggestions and comments, for example, updating menus. A member of staff said at team meetings the staff had opportunities to raise issues and make suggestions.

The staff had clear values about the way care should be provided and the service people should receive. The registered manager said the ethos of the service was to "facilitate people to live in a person centred way and by assisting them to make informed decisions". They said cuts in community services and seeking alternatives had been a challenge.

Members of staff had a good understanding of the vision and values of the organisation. A member of staff said the vision and values were to provide good quality of life to people and to "ensure people's needs were met". Another member of staff described the vision and values of the organisation as a "normal life that respected their rights and met their need."

The registered manager said they used consultative style of management within a framework of "what people and the organisation want". They said the role carried responsibilities for ensuring people were safe and staff were motivated. A member of staff said the registered manager was professional, worked with the team and the team worked well together. They said where there was conflict between staff these issues were discussed at one to one meetings with the registered manager. Another member of staff said the registered manager was approachable.

The registered manager told us the staff passed information of emerging risks. They said reports of accidents and incidents were passed to external manager for investigations. The area and registered manager then discussed the incidents and preventative action was then taken to minimise the potential of a repeat occurrence.

Annual plans were developed on the year's priorities and how they were to be delivered over the year. For example, increase staff knowledge of fundamental standards, reviewing person centred care plans and implement suggestions from people. A self-assessment based on achieving the year's priority sectioned into

three key areas of staffing, people and the environment was devised. Where the self-assessment identified gaps in the key areas and action plan was developed.

The standards of care and treatment were assessed by a quality assurance team which included an area manager, Human Resources (HR) and the Chief Executive. Monthly visits were conducted by the most appropriate team member to the nature of the visit. The records of the most recent visit had identified areas for improving which included repairs and redecoration. Medicine systems were checked at the previous visit and the action plan was achieved by the next visit. The registered manager told us feedback received from the quality assurance visit was added to the annual plan.