Cambian Signpost Limited

# Kimberley House

## Inspection report

Went Edge Road
Kirk Smeaton
Pontefract
West Yorkshire
WF8 3JS

Tel: 07715104919

Date of inspection visit:
16 August 2016
25 August 2016
31 August 2016

Date of publication:
28 September 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This inspection took place on 16 August 2016 was unannounced. This meant the registered provider and staff did not know we would be visiting. We spoke with staff and relatives on the telephone on 19 August 2016 and 31 August 2016. The service had not previously been inspected.

Kimberley House offers accommodation and support for up to three younger adults who are deaf or have other communication difficulties. The service is based in a converted house in the village of Kirk Smeaton. At the time of our inspection three people were using the service. The service registered with the Commission in 2013, but had been dormant for most of 2015. People started using the service again in November 2015.

The service 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 2008 and associated Regulations about how the service is run.

People told us the service kept them safe. Risks to people were assessed and plans put in place to reduce the chances of them occurring. Regular checks were made of the premises and equipment to ensure they were safe.

Accidents and incidents were investigated and monitored to see if steps could be taken to reduce the chances of them happening again. Plans were in place to support people in emergency situations.

Safeguarding policies and procedures were in place to protect from abuse. People's medicines were managed safely and they received them when needed. Staffing levels were monitored to ensure they were sufficient to provide safe support, and recruitment procedures were in place to minimise the risk of unsuitable staff being employed.

Staff received the training they needed to support people effectively, including newly recruited staff. Staff were supported through monthly supervisions, and plans were in place to conduct appraisals once staff had been in place for 12 months.

Procedures were in place to protect people's rights under the Mental Capacity Act 2005, and staff applied its principles when supporting people. People were supported to maintain a healthy diet and to access external professionals to maintain and promote their health.

People and their relatives spoke positively about the care and support they received from staff. People told us the service met their needs and they were happy living there.

People and staff clearly knew each other very well, which meant support was delivered in a professional but friendly way. Procedures were in place to arrange advocacy support where this was needed.

Care and support was based on people's assessed needs and preferences. People told us they were involved in decisions taken about their care. Plans were produced in an easy read format and contained records of discussions between staff and the people they related to ensure people understood what was in them.

People were supported to access activities that interested them and that they were able to choose what they wanted to do themselves. People and their relatives said they would know how to complaint if this was needed.

Staff spoke positively about the culture and values of the service and said they were supported by the registered manager and deputy manager. The registered manager and deputy manager carried out a range of quality assurance checks to monitor and improve standards at the service. Feedback was sought from people using the service and staff.

## 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.

Risk to people using the service were assessed and steps taken to minimise them.

People's medicines were safely managed.

Recruitment systems were in place to minimise the risks of unsuitable staff being employed.

Staff had an understanding of safeguarding issues and the action they would take to ensure people were safe.

### Is the service effective?

Good

The service was effective.

Staff received the training they needed to support people effectively and were supported through supervisions and planned appraisals.

Procedures were in place to protect people's rights under the Mental Capacity Act 2005, and staff applied its principles when supporting people.

People were supported to maintain a healthy diet and to access external professionals to maintain and promote their health.

### Is the service caring?

Good

The service was caring.

People were treated with dignity and respect by staff who knew them well.

People spoke positively about the care and support they received.

Procedures were in place to arrange advocates should they be needed.

## Is the service responsive?

Good

The service was responsive.

Care was planned and delivered in a person-centred and responsive way.

People were supported to access activities they enjoyed.

The complaints procedure was clear and promoted throughout the service.

## Is the service well-led?

Good

The service was well-led.

Staff spoke positively about the leadership of the registered manager and deputy manager.

Quality assurance checks monitored and improved standards at the service.

Feedback was sought from people and staff at regular meetings.

# Kimberley House

**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 16 August 2016 was unannounced. This meant the registered provider and staff did not know we would be visiting. We spoke with staff and relatives on the telephone on 19 August 2016 and 31 August 2016. The inspection team consisted of one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The registered 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 contacted the commissioners of the relevant local authorities who commission services at Kimberley House. We did not receive any feedback on the service.

During the inspection we spoke with three people who used the service. We spoke with one relative of a person using the service. We looked at two care plans, medicine administration records (MARs) and handover sheers. We looked at other documentation involved in running the service. We spoke with four members of staff, including the deputy manager, the area manager, and support workers. We looked at two staff files, which included recruitment records.

Good

# Is the service safe?

## Our findings

People told us the service kept them safe. One person told us, "I feel safe in the house as staff are nice and they help us. When I am stressed they help me to calm down." Another person said staff helped to reassure them when they felt anxious. Staff we spoke with understood the importance of keeping people safe and were able to give specific examples of how they did this.

Before people started using the service an assessment was completed of any risks they faced. This covered areas including health, food and fluids, medicines, communication and community access. If a risk was identified a plan was put in place to reduce the chances of harm occurring. For example, one person who enjoyed using the trampoline had a risk assessment in place to help them do this safely. Another person had risk assessments in place covering daily routines they liked to carry out. Support staff signed people's risk assessments to confirm they had read them. Risk assessments were not specifically reviewed, but the deputy manager told us staff checked to ensure they were still relevant during monthly care plan reviews and would be updated if any changes were needed. The deputy manager introduced specific risk assessment reviews following the first day of our inspection.

Regular checks were made of the premises and equipment to ensure they were safe. Records confirmed that checks were made in areas including window restrictors, fire fighting equipment and water temperatures. Fire drills were regularly carried out to ensure people and staff knew how to safely evacuate the building. Required test and maintenance certificates were in place in areas such as electrical safety, fire alarms, fire extinguishers and emergency lighting. Where issues were identified remedial action was taken. For example, a fire risk assessment completed in February 2016 made some suggestions about the alarm system used by the service. The deputy manager told us how this had been used to ensure the alarm system was suitable for people living at the service.

Accidents and incidents were investigated and monitored to see if steps could be taken to reduce the chances of them happening again. Where incidents involved behaviours that posed a risk to individuals or those around them, ABC charts were used. An ABC chart is an observational tool that allows staff to record information about a particular behaviour. The aim of using an ABC chart is to better understand what the behaviour is communicating. The deputy manager told us, "I check accidents and incidents every month to see if there are any trends."

Plans were in place to support people in emergency situations. Each person using the service had a Personal Emergency Evacuation Plan (PEEP). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. There was a business contingency plan in place to help staff provide a continuity of care to people in emergency situations that disrupted the service.

Safeguarding policies and procedures were in place to protect people from abuse. Staff had access to a safeguarding policy that provided guidance on the types of abuse that can occur in care settings and advice on how to raise any concerns they had. One member of staff we spoke with said, "If I thought abuse was

happening I would follow the procedure." Easy to read posters were displayed in communal areas offering guidance to people using the service on how to report issues. Where issues had been raised records confirmed they had been investigated. Staff also had access to a whistleblowing policy. Whistleblowing is when a person tells someone they have concerns about the service they work for.

People's medicines were managed safely. The support people needed with medicines was set out in a medicines care plan. This contained details of the medicines they used, including how they should be supported with 'as and when required' (PRN) medicines. There was confirmation on medicine care plans that their contents had been discussed with people using British Sign Language (BSL) to ensure people understood what medicines they were receiving.

Each person had a Medicine Administration Record (MAR). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. Each MAR contained an identity sheet which included a photograph of the person it related to. This helped staff ensure the right people were given the right medicines. The identify sheet also contained details of the person's GP and any known allergies they had. We reviewed two people's MARs and saw they contained no gaps in recording. Protocols were in place for people's PRN medicines to guide staff on when they might need them. Where people were using topical medicines, such as creams, detailed records were in place to advise staff their use.

No one at the service was prescribed controlled drugs but arrangements were in place to manage these appropriately if required. Controlled drugs are medicines that are liable to misuse. One person managed their own medicines, and staff told us how they were supported to do this. Records were kept of medicine stocks to ensure people were always able to assess their medicines when needed. Medicines were safely and securely stored. Storage temperatures were checked daily to ensure they were within appropriate ranges. We observed people being supported with their medicines. Support staff explained what the medicine was for and asked if the person wanted to take it. Records of administration were completed immediately to reduce the risk of mistakes occurring.

The deputy manager monitored staffing levels to ensure sufficient staff were deployed to provide safe support. A minimum of two support workers were on duty during the day, and a support worker slept over at the service during the night. No one at the service required 1:1 support. Support workers during the day worked from 8am to 11pm. The deputy manager said the registered provider was in the process of recruiting another support worker so staff could have more breaks in-between their working days.

Rotas we looked at confirmed those staffing levels. Sickness and holiday leave were covered by staff working extra shifts. One member of staff told us, "There are normally two staff and we cover if staff are not here. We're going to be alright when the new staff come in." Throughout the inspection we observed that staff were always present in communal areas of the building, and were able to assist people in a timely way whenever this was requested.

Recruitment procedures were in place to minimise the risk of unsuitable staff being employed. Applicants were required to complete an application form setting out their employment history and details of two referees. Notes of interviews confirmed applicants were asked a serious of care-based questions, such as how would they support someone with behaviours that posed a risk to themselves or those around them. Two written references and proof of identify were obtained before staff were employed, and Disclosure and Barring Service Checks carried out. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with

children and vulnerable adults.  One member of staff told us about their recruitment process, saying, "I had to do references and DBS checks."

The premises were clean and tidy. People were encouraged to assist staff in cleaning communal areas, which helped to create a homely atmosphere and promote people's life skills. People discussed the cleaning rotas at a monthly house meeting.

Good

# Is the service effective?

## Our findings

Staff received the training they needed to support people effectively. Mandatory training was provided in a number of areas, including deafness awareness, equality and diversity, health and nutrition, infection control, positive behavioural support and responding to emergencies. Mandatory training is training the registered provider thinks is necessary to support people safely. Staff also received additional training in areas that helped them to support people living at the service, such as in Managing Actual or Potential Aggression (MAPA) and, where they did not know it, British Sign Language. Training was refreshed annually to ensure it reflected current best practice. Records confirmed that most staff training was up to date, and where it was not plans were in place to arrange refresher training. Staff we spoke with spoke positively about the training, though said some of it could be better adapted to deaf staff. Staff and the deputy manager told us plans were in place to ensure all training was accessible to deaf staff. One member of staff said, "It (training) is getting better now."

Newly recruited staff were required to complete a three month induction programme before they could support people without supervision. This included learning the registered provider's policies and procedures, getting to know people and other staff at the service and delivering support while supervised by more experienced members of staff. Staff files contained completed 'starter packs' to show the training had been completed. One new member of staff told is, "I was shadowing staff during my first week. The induction is three months long."

Staff were supported through monthly supervisions, and plans were in place to conduct appraisals once staff had been in place for 12 months. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. A chart used by the deputy manager to monitor supervisions showed they were up to date. Records of supervisions showed staff were free to raise any support issues they had or general feedback about the service. One member of staff told us, "We get supervisions every month with [the deputy manager]. We talk about everything, like what we want to improve and training I want."

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 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. At the time of our inspection no one using the service was subject to a DoLS authorisation. The deputy manager was working closely with a local authority to assess the capacity of one person, and told us how this might eventually lead to a DoLS application being made. The service was also applying for DoLS authorisation in relation to another person.

Records confirmed that capacity assessments and best interest decisions were made only where there was a possibility the person lacked capacity. For example, one person could make decisions about most aspects of their support but needed help to make decisions about their food and nutrition. This was clearly documented in their care plan. This was in keeping with the principles of the Mental Capacity Act. People's consent to care was recorded in their care plans.

People were able to leave the service whenever they wanted to. The deputy manager said staff would follow some people (for whom DoLS applications had been made) if they left the service in order to ensure they were safe, but would not try to stop them from leaving. This showed that people were free to make their own decisions but that staff would act to keep them as safe as possible when doing so.

People were supported to maintain a healthy diet. Each person using the service had a 'food intake' care plan. This set out their dietary needs and preferences. Staff encouraged people to develop their food preparation knowledge and skills, and the care plan also set out what the person liked to do for them in the kitchen. For example, one person's care plan said, 'I am more confident cutting vegetables than I am peeling. I have tried both peelers that we have in the kitchen, although staff will still give me the choice of which peeler to use each day.'

Every week people and staff had a meeting to develop their own, individual menu for the following week then all went out shopping for the ingredients. The menu was displayed in the kitchen, and easy read symbols were used to assist with communication. People also had their own food, and could choose to eat something that was not on the menu if they wanted something different.

During our inspection we saw staff effectively supporting people to prepare their own lunch by encouraging them to do things for themselves but helping if needed. For example, one person made themselves a drink but added too much cordial to their glass. A support worker stepped in and explained that there was too much cordial in the glass, before explaining the correct amount to use. People and staff ate together in the dining room, which created a relaxed and homely atmosphere. Throughout the inspection we saw people helping themselves to drinks and snacks from the kitchen.

People were supported to access external professionals to maintain and promote their health. Care records we looked at contained evidence that the service worked with professionals such as GPs, dentists, opticians, audiologists, physiatrists, dieticians, physiotherapists and social workers to ensure people had access to the healthcare they needed. For example, one person's care plan contained a letter from a learning disability nurse setting out what had happened at their latest appointment and reviewing the person's support needs.

Good

# Is the service caring?

## Our findings

People and their relatives spoke positively about the care and support they received from staff. One person told us, "Staff are nice to me and they help us.  Staff help me when I am stressed and help me to calm down." Another person said, "When I first moved in I was nervous but it is completely different from the other place I lived in, but I am now gaining confidence and enjoy it here." A relative we spoke with said, "I think it's really fantastic. I could never have imagined [named person] would end up somewhere so perfect. It's so rare. Just amazing."

When we arrived to carry out the inspection we were met at the front door by people using the service, who were happy and proud to show us around their home. Throughout our visit they showed us how they had personalised the building to make it more homely by, for example, choosing how to decorate their own bedrooms. There was a very homely atmosphere at the service, with people coming and going from their bedrooms and communal areas as they pleased and sharing jokes with staff and other people at the service. Photographs of people and staff enjoying activities together displayed in communal areas also helped to personalise the service for the people living there.

People told us the service met their needs and they were happy living there. One person told us the thing that made them happiest was that staff helped them work towards their goal of living independently. The person said, "I like the staff here, it's a new modern house and my daily life is independent."

Throughout the inspection we saw numerous examples of staff treating people with respect. For example, where people were trying to explain something staff listened respectfully until the person had finished before asking if they had properly understood what the person was saying. Staff asked people if they wanted support and did not intervene without permission. One person using the service had difficulty communicating. We saw staff working with them to develop their sign language skills so they could more easily interact with staff and the other people in the house. Staff showed patience and understanding towards the person and ensured they were involved whenever possible.

People and staff clearly knew each other very well, which meant support was delivered in a professional but friendly way. Staff were able to spend time talking with people about things that were important to them. For example, we staff discussing a trip one person was planning on taking. The person was telling staff how they planned to travel and what they hoped to do on their trip, and staff said they looked forward to hearing all about it when the person got back. In another example, staff were joking with a person about the snack they were preparing for themselves and telling them a piece of fruit would taste better. The person was laughing and clearly enjoyed talking with staff as they prepared their snack.

We saw staff using appropriate touch to interact with people at the service. For example, we saw a support worker putting their hand on a person's shoulder when approaching from behind so the person wasn't startled when they then moved around to communicate with them. The person put their own hand on the support worker's hand to let them know they were aware of their presence.

At the time of our inspection no one was using an advocate. Advocates help to ensure that people's views and preferences are heard. There was an advocacy policy in place, and easy read posters in communal areas advertising advocacy services. The deputy manager explained how people would be supported to access advocacy services if these were needed.

Good

# Is the service responsive?

## Our findings

Care and support was based on people's assessed needs and preferences. People told us they were involved in decisions taken about their care. A relative we spoke with said, "[Named person] is treated like an individual."

People's support needs were assessed in a range of areas, including personal hygiene, food, health, medicines, communication, community access, behaviours that posed a risk to themselves or others, daily routines and life skills. These assessments were detailed and focused on providing support to the person by first identifying what they could and would like to do for themselves. For example, assessments were in place to see if one person had been able to remember a discussion about their care plan to see if additional support was needed with communication or decision making.

Where a support need was identified a plan was put in place to guide staff on how the person could be supported in a person-centred way. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. For example, one person's personal hygiene plan said they could sometimes appear reluctant to have a bath if they were tired and suggested that staff try to use humour to encourage them.

Plans were produced in an easy read format and contained records of discussions between staff and the people they related to ensure people understood what was in them. Throughout the inspection people were able to tell us what was in their care plans and what they wanted support with. Care plans were reviewed every month to ensure they reflected people's current support needs. A relative we spoke with said staff kept them informed about any changes in a person's care plan. They said, "I get the level of communication I want."

People using the service also had a 'journal' that was used to record their daily activities and mood, as well as any other specialist observations relevant to them. This meant staff coming onto shift were able to familiarise themselves with people's current support needs.

Staff at the service were either fluent in British Sign Language or were learning it. This helped them to provide care that responded to people's needs. Throughout the inspection we saw that people were able to tell staff what they would like and to describe any support they needed. Important information, such as on telling staff when strangers were at the door, fire safety and safeguarding, was displayed in easy to read formats in communal areas.

People were supported to access activities that interested them and that they were able to choose what they wanted to do themselves. One person we spoke with said, "I choose what activities I want to do and sometimes go out with the other residents, but only if I feel I want to." Photographs of recent activities were on display throughout the service, and these included carriage riding, choir singing, sports, deaf club and attendance at college. We also saw evidence of group trips in the local area and further afield.

Where people had requested support with a particular activity this had quickly been arranged. For example, one person liked to travel to visit someone they knew. Staff helped them do this by collecting and discussing bus and train timetables with them and creating a card for the person to carry explaining to transport staff that they were deaf and might require help. The person said, "This makes me feel safer and happier about travelling alone." Other people at the service had asked if they could go to a specific place on holiday, and staff were helping them to arrange this. People had requested a pet for the service, and two guinea pigs had been purchased that people helped look after.

There was a complaints policy in place, and this was displayed in an easy to read format in communal areas. The service had not received any complaints in the last 12 months. People and their relatives said they would know how to complaint if this was needed. One person told us, "I would complain or speak to my key worker or [the deputy manager]." A relative we spoke with told us, "If I had any concerns I would go straight to [the deputy manager]."

Good

# Is the service well-led?

## Our findings

Staff spoke positively about the culture and values of the service. One member of staff said, "People are happy here and the staff are supportive." Another told us, "It's beautiful here" and "All the staff get on really well. I love it."

The service 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 2008 and associated Regulations about how the service is run. The registered manager was also responsible for another of the registered provider's service located nearby, and split their time between that service and Kimberley House. The deputy manager was responsible for most of the day-to-day running of the service, especially when the registered manager was absent. The registered manager was on leave during our inspection.

People and their relatives spoke positively of the deputy manager and said the service was well-led. Each person using the service had the deputy manager's telephone number, and said they felt they could contact them whenever they wished. One person told us, "I text [the deputy manager] if I have any problems." A relative we spoke with said, "[The deputy manager] is very approachable, down to earth and understanding."

Staff said they felt supported by the registered manager and deputy manager, and were free to raise any support issues they had. One member of staff told us, "If I don't know something I just ask them to explain." Another told us, "I can talk to [the registered manager] privately" and "I feel supported by [the deputy manager] and [registered manager]."

The registered manager and deputy manager carried out a range of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations.
Monthly audits of medicines and health and safety were carried out, and quarterly audits of infection control. The deputy manager was arranging for a pharmacist to attend to carry out an independent audit of medicines. Where audits identified issues an action plan was put in place to monitor remedial action. For example, a health and safety audit in April 2016 identified that water temperatures were not being accurately recorded. This led to the purchase of a new thermometer to take the temperatures.

The registered provider also carried out quality assurance checks through 'quality assurance visits.' These examined a wide range of areas, including care plans, the safety of the premises and staffing levels. Reports issued to the registered manager and deputy manager contained action plans of any remedial action needed and completed of this was checked during the next quality assurance visit. However, we did note that the reports referenced CQC's old outcomes and not the regulations that have replaced them.

Feedback was sought from people using the service at weekly 'house meetings'. These discussed issues such as menus, activities and anything else people wanted to raise. Throughout the inspection we also saw staff asking people how things were going and if they were happy with the service. The deputy manager was planning on sending feedback questionnaires to people and staff once people had been living at the service for 12 months. Staff feedback was sought at regular staff meetings, and staff told us they were encouraged to speak with the registered manager and deputy manager outside of the meetings if they had issues to raise.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.