Voyage 1 Limited

# Chiltern View

## Inspection report

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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 inspection took place on 14 and 15 January 2016. It was an unannounced visit to the service.

Chiltern View is a care home for adults who have learning disabilities and or physical disabilities. Chiltern View is accessible to people of all abilities with all ground floor accommodation.
Chiltern View is registered to provide accommodation for nine people. At the time of our inspection eight people lived at Chiltern View.

We previously inspected the service on 11 June 2015. We found continued breaches of the Health and Social Care Act 2008. We found people who used the service were not protected against the risk of unsafe or inappropriate care through maintaining an accurate and complete record of the care and treatment provided. As a result we issued a warning notice for non-compliance with Regulation 17 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan to tell us what action they were taking to ensure compliance. At this inspection we found that the provider had reviewed care plans and improvements have been made in respect of recording risks and actions taken to minimise them. Staff knew about actions required and we observed this in action.

The service did not have a registered manager 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. The previous manager was deregistered with The Commission on 30 October 2015. Since then the service had support from another service manager within the same organisation. The provider had successfully recruited into the manager role and the new manager commenced in post on 04 January 2016.

People were protected from avoidable harm and or abuse. Staff had received training and were aware of what to do if concerns were raised. Contact numbers for the local safeguarding team were visible in the home.

Care and support plans included an assessment of risks to people. Appropriate plans to manage those risks were in place. Staff had read and understood the assessments and demonstrated in practice they followed the guidance.

Robust recruitment processes were in place, staff were supported to understand their role through an initial induction and on-going training.

The service sought regular feedback to check their performance. Action plans were devised to ensure any identified shortcomings were resolved.

People were supported to maintain a healthy lifestyle; changes in health were quickly reported and acted

upon.

People who lived at Chiltern View had a mixture of communication styles. Staff knew and understood these. We used observations to form a judgement about their experience. This was crossed referenced with care plans which detailed how people expressed joy or sadness.

## 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 harm because staff received training to be able to identify and report abuse. There were procedures in place for staff to follow in the event of any abuse happening.

People's likelihood of experiencing injury or harm was reduced because risk assessments had identified areas of potential risk.

### Is the service effective?

Good

The service was effective.

People received the support they needed to attend healthcare appointments and keep healthy and well.

People were cared for by staff who were aware of their roles and responsibilities.

### Is the service caring?

Good

The service was caring.

Staff were knowledgeable about the people they were supporting and aware of their personal preferences.

People were treated with respect and their privacy and dignity were upheld and promoted.

People and their families were consulted with and included in making decisions about their care and support.

### Is the service responsive?

Good

The service was responsive.

Relationships outside of the service were encouraged.

People had access to a range of activities, within the home and in the local community.

## Is the service well-led?

Good

The service was well-led.

People could be certain any serious occurrences or incidents were reported to the Care Quality Commission. This meant we could see what action the service had taken in response to these events, to protect people from the risk of harm.

People received care from staff who felt supported by the management team and were confident that any issues raised would be dealt with.

# Chiltern View

**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.

The inspection took place on the 14 and 15 January 2016 and was unannounced; this meant that the staff and provider did not know we were visiting. The inspection was carried out by one inspector.

Before the inspection we reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

Some people in the service could not communicate their experience of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
We spoke with, two relatives; the new manager and covering manager; the operational manager and quality manager and five care staff. We reviewed four staff files and five care plans and daily records. We looked at policies and procedures along with action plans and audits.

Good

# Is the service safe?

## Our findings

There were sufficient staff members to meet people's basic care needs. However staff were not always deployed in a way that kept people safe and offered opportunities for one to one time. Staff had multiple roles within the home; they were responsible for care, cooking, cleaning and health and safety checks. We observed that on day one of our inspection there were 6 people in the service and five care staff on duty. Two staff were able to facilitate a one to one activity with two people away from the service for most of the morning. This left three members of staff for two people. However when we spoke with staff they told us that they felt there was not always enough staff. One staff member told us "There is not always enough staff on duty," another staff member said "sometimes we are short, people phone in sick." We asked staff if they felt people were placed at risk due to the staffing levels. Three staff we spoke with all felt that people living at Chiltern View were well cared for and safe.

We spoke with the operational manager about staffing levels. They confirmed that a number of vacant posts had been filled, however they confirmed that staffing vacancies remained and there was on-going recruitment. The operational manager advised us that current staffing levels were based on one care staff to two people. Therefore four staff members were required for each shift. However one person required two care staff to support with transferring from wheelchair. We asked the operational manager to explain how they managed this. They told us that as two care staff were only required for a small amount of time this was manageable within the service.

Relatives told us they felt their family member was safe; one relative described the care as "very good, I have no complaints". Another said "staff know what they are doing, they have got to know X."

The service operated robust recruitment processes. Pre-employment checks were completed for staff. These included employment history, references, and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check. Where staff were awaiting a full enhanced DBS, a first response check had been undertaken. The provider had identified this as a risk and the staff did not work alone with people living in the service. This protected people from the risk of harm until all clearances were received. Records seen confirmed that staff members were entitled to work in the UK.

People were protected from abuse. The service had a safeguarding procedure in place. Staff received training on safeguarding people. Staff members were very knowledgeable on recognising abuse and how to respond to safeguarding concerns. Information about and contact details of the local safeguarding team were available for people living at the service, visitors and staff. In addition the provider had its own information leaflets on 'say what you see'. This demonstrated an open culture of reporting concerns. Staff we spoke with were aware of this, and told us they would not hesitate to contact the safeguarding team if they felt the concern was not being addressed by management.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. We saw evidence following a small car accident involving

people who lived at Chiltern view that contact was made with the emergency services. Staff observed people and recorded how people were post this event. We noted that further contact was made with the GP following observations.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Risk was an integral consideration throughout the care planning process. Where the care plan identified a high risk an additional specific risk assessment was carried out. Staff informed us they had changes in risks to people communicated to them. We saw evidence that changes to care plans were written in a communication book for staff. Risk assessments had been updated when changes were made. We did find that the risk assessment contents page did not always reflect risk assessments written. However from the records seen all high risk situations did have an additional risk assessment. We spoke with the operational manager about this and they agreed that this was on oversight and would be rectified.

The service had procedures in place to deal with emergencies. Personal emergency evacuation plans were in place for each person. These detailed the support people required in the event of an emergency. People were protected against the risk of unsafe premises. The service ensured that maintenance and safety of the building was reviewed and kept up to date. The service had support from the provider's maintenance team. The service ensured that equipment used by people was inspected routinely. Electrical and water safety certificates were in date. Some staff did comment on the delays in getting repairs completed. However on day two of our inspection we witnessed that our concerns regarding heating were responded to quickly.

Occasionally people became upset, anxious or emotional. We observed how staff dealt with these situations. Care plans and risk assessments confirmed staff had read and understood de-escalation and reassure needed to manage the situation.

There were safe medicine administration systems in place and people received their medicines when required. We observed the administration of medicine. Staff followed guidelines for safe administration. We noted that specific information was recorded for one person, on how they like their medicine given. Staff followed this care plan, and the person was talked through which medicine they were being given at the time. Staff regularly accounted for medicine stored. Only staff who had received training were asked to administer medicine. The provider undertook regular medicine audits to ensure safe handling and storage of medicine.

The environment was clean and free of offensive odour. We observed staff carried out cleaning, wet floor signs were put in place and staff ensured that they were present until the floor dried.

Good

# Is the service effective?

## Our findings

People received effective and compassionate care. Staff members were very knowledgeable about the people they were supporting. Staff were able to tell us about people's likes, dislikes and what relationships were important to them. This was also seen in observations of discussions between staff and people who lived at Chiltern View. Staff members on duty throughout our inspection were aware of what was happening in the service on each day, and were able to discuss with people what they wanted to do.

People's needs were met by staff who had access to the training they needed. This included; Mental Capacity Act and Deprivation of Liberty, Safeguarding Adults at Risk and Allergen Awareness. Staff we spoke with were able to tell us how they benefitted from the training undertaken and had a good understanding of sessions that they had attended. The provider made specialist training available when required to meet people people's needs appropriately.

New staff were supported in their role, through an induction period. This involved time to read care plans of people who lived at the service and shadowing more experienced staff. We saw that these shadow shifts were additional to usual staff levels. Staff we spoke with were supportive of new staff, and wanted them to have time to learn about Chiltern view.

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. We observed that where people required one, a mental capacity assessment was undertaken. If assessed as not having capacity to make certain decisions the service followed the guidance under the MCA. Where appropriate the service had made referrals to the local authority to authorise a DoLS. The service had a log of requests made to the local authority and when an assessment had been made. We observed that a best interest meeting had been undertaken and recorded regarding a particular decision around care and treatment.

Throughout the two days of inspection we overheard staff asking people what they would like to do and gaining verbal consent for care and treatment.

We observed a lunchtime meal. People who required support with eating their meal were supported on a one to one basis. Even when the person wished to move to another seat, the member of staff was able to

facilitate this and they continued with their meals in their new chosen seat. The staff responded well to changes in behaviour when supporting people with meals. We were informed by staff that a meeting is held on a Sunday to determine the forthcoming week's meals choices. This was then displayed in the kitchen. Staff informed us they used pictures to help people make a decision. We spoke with the operational manager about this as there was only one choice displayed. They confirmed that some improvements were needed around demonstrating choice with meals. However on day one of our inspection, one person did not eat the meal provided, so they were offered a choice of sandwiches which they ate. Staff members were present throughout the whole meal to supervise and ensure people were safe when eating. People had access to the kitchen area with a staff member present. Some people choose to tidy away their own dishes and some people who had been assessed as safe to do so were supported to make a hot drink. Fruit and cold drinks were offered through the day. Where nutritional risk was identified care plans showed that foods containing more calories should be offered.

We saw records that indicated the service worked with health and social care professionals to meet people's needs. One person had been referred to physiotherapy due to poor mobility. We found evidence of the assessment by the physiotherapist and, what advice they had provided. This was translated into a care plan and we observed staff carrying out the actions detailed in the care plan.

On day two of the inspection we noted that a medicine had been changed from being prescribed for regular use to occasional use. This was recorded in the communication book and the records had been partly amended to reflect this. However it was the responsibility of the manager or responsible person to re-write the medicine as advised by GP This had not been actioned as the managers were away from the service. However staff had stopped the regular dose as advised by the GP. We spoke with the manager about this, and they advised that due to our visit they had not had time to amend the record. This was quickly rectified when pointed out. The operational manager advised that they will look into ensuring that another person in the absence of the manager could do this.

Good

# Is the service caring?

## Our findings

We observed caring and compassionate interactions between staff and people who lived at Chiltern View. We saw people were asked about what they wanted to do during the day. Staff were knowledgeable about likes and dislikes of people they were supporting. This was confirmed by relatives of people who lived at Chiltern View. One relative told us, "Some staff have been there for a number of years, X is comfortable with them." Another relative said "I know Y is looked after well, I have not had any problems."

Staff we spoke with were passionate about providing personalised care. One staff member told us "I love working here, of course you get ups and downs, but I really enjoy working." Staff we spoke with had a good understanding of how to promote people's dignity, we observed this in action. Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. Staff supported people in way that did not draw attention to what was happening. For instance when someone showed signs that they needed to go to the bathroom, this was quickly responded to.

We observed one member of staff explaining choices of drinks to a person who had little spoken communication. The staff member was calm, patient and gave the person time to communicate their choice in their own time.

Staff knew people's individual communication skills, abilities and preferences. People's views were sought through care reviews and annual surveys. The service had introduced a keyworker system. The keyworker should spend time each month with a person using the service. The role of the keyworker was to ensure each person was given an opportunity to discuss things that were important to them. We saw that a number of meetings had taken place, but the system was not fully embedded and effective as meetings were not held regularly. We spoke with the covering manager about this. They advised that staff were committed to making the system work and felt that this would improve now the new manager was in post.

People's records included information about their personal circumstances and how they wished to be supported. For example, specific information was available to staff on positioning people while sleeping.

People's rooms were personalised. Where required additional equipment was provided to ensure people who were at risk from having a seizure did not come to harm. All potential hard surfaces were covered with cushioning.

The service recorded people's ability to make decisions; details of how people communicated were available for all staff. We saw that information was available to people in easy read formats. One person was being supported with a new mobility aid. They were being given positive feedback from staff as initially they did not like to use it. We observed and staff told us through this positive feedback the person was using the aid more often.

The operational manager advised us that when needed people are supported with advocacy. Advocates are people independent of the service who help people make decisions about their care and promote their

rights.

We saw that consideration had been given to people's wishes regarding end of life. We saw that families had been consulted on this topic.

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. It was clear when we spoke with staff that they were aware of the content of care plans. We observed staff updating records as events occurred. We saw that reviews of care were undertaken when required; care plans and risk assessments were updated with new information.

Relatives we spoke with were contacted by the service when important events took place. For instance, one relative informed us that they were always contacted when their family member was unwell and the GP had been called. One healthcare professional advised us that appropriate action was taken by staff, when advice and treatment plan were left for staff to follow.

Staff responded quickly to changes in people's needs. On day two of our inspection we observed staff contacting the GP practice when a rash was discovered on someone. Information on actions taken was handed over to the next shift, and it was recorded in care plan notes and communication book.

Relationships with people outside of the service were encouraged and supported by staff. Some people who lived at the home attended an adult education centre. The service had a regular visit from staff at the adult education centre who undertook a weekly cooking session with people. This was an interactive session. Staff told us that people enjoyed the sessions and looked forward to them.

We saw that activities were discussed with people on a weekly basis. Activities were planned so that staff were available. Activities included shopping trips and meals out. On day two we saw that one person was supported to meet their relative for a pub lunch. The service kept a separate record of activities undertaken. However we looked at one person's record and no activities had been recorded for the month of January. We spoke with the quality manager about this. They looked at the daily care records and crossed referenced it with the activities record, there was only one mention of an activity for this person. We spoke to the quality manager about the use of the recording form. It became apparent that staff were only recording activities outside of the home. They agreed that additional training and clarification would be provided for staff. We observed staff discussing with people what activities they would like to undertake.

A handover meeting was carried out from outgoing staff to incoming staff. We observed a handover meeting, and it was clear that important information was passed onto the next shift. A handover sheet was also completed. This acted as a prompt to ensure that keys and monitors were handed over.

The service had a complaints policy; relatives told us that they would not hesitate to raise any issues should they arise. One relative informed us that when they did raise an issue this was dealt with quickly and they received a satisfactory response.

Good

# Is the service well-led?

## Our findings

People were supported by a provider who was clear about their vision to provide opportunities to promote independence and deliver care in a personalised way. Staff we spoke with were aware of this vision. We spoke with a new member of staff and they told us they had benefitted from a corporate induction early on in their employment as this gave them a clear picture of how the organisation works.

Relatives we spoke with had confidence in the service, they advised us that staff were approachable and a number of staff had been in the service for a long time. However the service had undergone a number of changes at management level in recent months. A new manager was in post and staff hoped once established this would provide the service with a clear focus to provide excellent care and support.

The service was supported by the provider. Since out last inspection this has been through regular visits by the operational manager and quality manager. Staff felt this had been useful and would continue to benefit from this support.

The quality manager was responsible for carrying out audits to ensure the service was safe. We saw the results from a recent medicine audit. Action plans were developed where areas of improvement were identified. The service had an overall 'consolidated action and improvement plan'. The manager had the lead role to ensure this was regularly reviewed and updated.

The service sought feedback from people using the service, relatives, staff and professionals. This was through an annual service questionnaire. We saw that the service responded to feedback and was receptive to driving up standards of care.

Staff meetings were held, we saw that these meetings shared information with staff as well as offering them an opportunity to share their views. Staff we spoke with told us they felt they could share their views with management. They felt valued by the organisation.

The operational manager advised us the provider had recently launched a new whistleblowing service for staff. The service provided an independent confidential telephone number staff could access if they had concerns about the service.

We saw that the service had a variety of policies in place to assist with the running of the home; these included safeguarding people, health and safety and complaints.

The provider was aware of their responsibilities to report significant events to the CQC. They had notified us, for example when a decision had been made about a DoLS application and when a serious injury had occurred. We used this information to monitor the service and ensure they responded appropriately to keep people safe.