SeeAbility

SeeAbility - Fiennes House Residential Home

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

Overall summary

This inspection took place on 18 December 2014 and was unannounced.

The service provides accommodation and support for up to 12 adults with multiple disabilities. At the time of the inspection there were seven people living in the home with varying degrees of visual impairment, moderate to severe learning disabilities and mobility needs. People had very limited verbal communication skills and they required staff support with their personal care and to go into the community.

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.

Summary of findings

We were only able to have limited discussions with people living in the home because of their language difficulties. We relied mainly on our observations of care and our conversations with people's relatives and staff to understand their experiences.

People received care and support in line with their personalised care plans and appeared to be happy with the staff who were supporting them. People often responded to staff with smiles or happy noises. One person's relative told us "The staff are very caring. As far as I'm concerned the care is excellent". Relatives were happy with the general standard of care but some thought the service could do more to improve people's quality of life.

People were supported to maintain their family relationships. Relatives told us they were made welcome and were encouraged to visit the home as often as they were able to. Most people's relatives lived out of the area and staff supported people to visit them several times a year.

Personalised communication plans were in place to help staff understand the ways people expressed themselves. This included tone and noise vocalisations, facial expressions, body language, touch, and sign language or symbols for people who had sufficient sight. Staff checked with people before providing care or support and then acted on people's wishes. A member of staff said "We like to think people enjoy a good life here. Our priority is to ensure people are happy". Where people lacked the mental capacity to make certain decisions about their care and welfare the provider knew how to protect people's rights.

There were enough staff to meet people's needs and to care for them safely. Staff received tailored training in how to support each person's complex needs. Staff said they worked together as a supportive team and management were approachable and supportive. The service used local links to ensure people with disabilities were valued and involved within the local community.

People were supported to maintain good health. The provider had their own team of therapists and visual facilitators and worked closely with local health and social care professionals. Outside professionals visited the home or staff supported people to attend appointments according to people's individual needs and preferences.

The provider participated in a range of forums for exchanging ideas and best practices. This helped the service to maintain standards of care and promote further service improvements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were protected from abuse and avoidable harm.

Risks were identified and managed in ways that enabled people to lead fulfilling lives and remain safe.

There were sufficient numbers of suitably trained staff to keep people safe and meet each person's individual needs.

Good

Is the service effective?
The service was effective.

People with multiple disabilities were supported to live their lives in ways that enabled them to lead an improved quality of life.

People received effective care from staff who were trained in providing service specific care to meet people's individual needs.

The provider acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

Good

Is the service caring?
The service was caring.

People were treated with kindness, dignity and respect. People's relatives said staff were very caring and considerate.

People had complex communication needs associated with their disabilities. Staff used a range of communication methods appropriate to each person's needs to understand people's preferences.

People were supported to maintain family relationships and to avoid social isolation.

Good

Is the service responsive?
The service was responsive.

People were supported to be involved in the assessment and planning of their care to the extent they were able to do so.

Each person had a key worker with particular responsibility for ensuring the person's needs and preferences were understood and acted on. This enabled people to have a choice about their daily routines and activities.

People, relatives and staff were encouraged to express their views and the service responded appropriately to feedback.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

The provider promoted an open and caring culture centred on people's individual needs.

People were supported by a motivated team of staff.

The service had good links with the local community. Volunteers were recruited to promote increased social interaction and community involvement.

The provider's quality assurance systems were effective in identifying areas for improvement and ensuring appropriate action was implemented.

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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 18 December 2014 and was unannounced. It was carried out by one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries from and about the provider and other key information we hold about the service. At the last inspection on 4 September 2013 the service was meeting the essential standards of quality and safety and no concerns were identified.

We met six of the people living in the home but were only able to have limited communications with most of them. We spoke with four people's relatives, interviewed the registered manager and the regional service manager, and spoke with three other members of the care staff team. We observed how staff supported people, reviewed four care plans and other records relevant to the management of the service.

Good

Is the service safe?

Our findings

We were only able to have limited talks with people living in the home due to their communication and language difficulties associated with their physical and learning disabilities. We relied mostly on our observations of care and our discussions with people's relatives and the care staff to form our judgements.

Relatives of people in the home told us they had no concerns about the safety of their family members. One relative said "I have no worries, I feel completely secure" and another person's relative said "I'm confident no one would harm (their relative). If they had any problems my relative would tell me". We observed all of the people looked contented and relaxed with the staff and with each other.

The provider had systems to help protect people from the risk of abuse. All of the staff we spoke with knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff said they had never witnessed anything of concern in the home. One member of staff said "We know people really well and would recognise any changes in their behaviours that were out of character. If I had any suspicions I would speak with the manager and if necessary call the local authority safeguarding number". Training records showed all staff received refresher training in safeguarding. Safeguarding and whistle blowing policies were also available for staff to refer to. Whistle blowing is a way in which staff can report misconduct or concerns they have within their workplace.

People's risks were well managed through individual risk assessments that identified the potential risks and provided information for staff to help them avoid or reduce the risks. Risk assessments covered support for people when they went into the community, participation in social activities and leisure interests, and use of equipment to support people. For example, some people had bed rails with protective cushioning to avoid them injuring themselves. There were appropriate risk assessments in their care plans and illustration charts in their rooms showing staff how to use the bed rails safely.

Risk assessments included plans for assisting some people who needed support when they became distressed or anxious. Plans described the circumstances that may trigger the distress or anxiety and ways to avoid these triggers. For example, staff were aware that one person may sometimes hit out at staff. They knew not to stand too close to the person and to allow the person their own personal space. Staff said they did not use any physical restraint and they were trained to use distraction and calming techniques if people became distressed.

Staff received guidance on what to do in emergency situations. For example, protocols had been agreed with hospital specialists for responding to people who had seizures. Staff received training in providing people's medication and when and who to notify if people experienced prolonged seizures. Staff told us they would call the emergency ambulance service or speak with the person's GP, as appropriate, if they had concerns about a person's health. Each person had a personal evacuation plan in case they needed to vacate the home in an emergency.

Details of action taken to keep people safe and prevent future occurrences were recorded whenever an incident happened. Staff completed an incident form for every event which was then reviewed and signed off by the registered manager. For example, following a safeguarding concern, staff were reminded to clearly document people's symptoms if they became unwell and the action taken to monitor their health. This included making detailed records of all communications with external parties.

Regular health and safety checks were carried out to ensure the physical environment in the home was safe for people to live in. The registered manager carried out a set programme of weekly and monthly health and safety checks. The provider's central team also carried out an annual health and safety risk assessment at the home. A range of health and safety policies and procedures were in place to help keep people and the staff safe. Suitably qualified contractors were used to inspect and maintain the home's gas, electricity and fire safety systems.

There were enough staff to meet the needs of people and to keep them safe. We observed staff were available to support people whenever they needed assistance or wanted attention. Relatives and staff told us the home had experienced a fair amount of staff turnover but this had now settled down and they all felt the staffing numbers were fine. Staff told us they felt the number of care staff was sufficient to look after people's routine needs. They said additional staff were brought in whenever needed, for example to support people to go to college or to do other

Good

Is the service safe?

activities. Short notice absences were covered by their own bank staff where possible or by external agency staff when needed. Bank staff means a bank of people who are already employed by the service and are prepared to provide extra cover when the service is short staffed.

There were effective recruitment and selection processes to reduce the potential risks to people living in the home. Recruitment was organised through the provider's central human resources department. Appropriate checks were undertaken to identify if applicants had any criminal convictions or had been barred from working with vulnerable adults. Staff were not allowed to start work until satisfactory checks and references were obtained.

People were supported by staff to take their prescribed medicines safely. People's medicines were kept in a secure drugs cupboard within each person's room and their medicine administration records were accurate and up to date. Staff said they always checked to ensure the correct prescription and dose was given to the right person. At the end of every medicines round a second member of staff checked the administration records to ensure people's medicines had been administered correctly.

Staff received medicines training from the local pharmacy and through an in-house training programme. This was confirmed by staff and in the training records. Staff had their competency assessed by seniors and had to be authorised by the registered manager before they were allowed to support people with their medicines. These arrangements helped to ensure people received their medicines safely.

Good

Is the service effective?

Our findings

We received mixed feedback from people's relatives. One person's relative told us "As far as I'm concerned the care is excellent". Another person's relative said "We are lucky to have (their relative) here. There will always be little things we would do differently but overall we feel very happy". Other relatives were satisfied with the general standard of care but thought the service could be more creative and do more to improve people's quality of life. One relative said "I am happy with the way they deal with general health and wellbeing issues although I feel they could be more pro-active in planning activities to improve people's quality of life". Another person's relative said "(their relative) has a reasonable quality of life given the resources. They introduced some new activities but can be slow about this due to availability of staff and risk assessments".

During the inspection we observed people received care and support in line with their care plans and they appeared relaxed and happy with the staff supporting them. The support provided was to a good standard and people's needs were being met by competent staff.

Staff told us they received tailored training to ensure they knew how to effectively support and care for each person's multiple physical and learning disability needs. Most of the training was delivered by the provider's central training team but outside specialists were brought in where appropriate. One member of staff said "The training here is top notch. I received a very intensive training programme when I started". Another staff member said "I've never worked anywhere as good as this for training. For example, as part of our visual impairment training we had to carry out tasks blind folded to gain an appreciation of how life is for the sight impaired people we support".

Staff told us the provider supported them to take further qualifications such as the diploma in health and social care. The registered manager said all new staff received an intensive induction programme and were assigned a senior member of staff as a mentor. They shadowed their mentor until they achieved the required levels of competency. This ensured people received effective care from staff who had the necessary level of knowledge and skill.

Staff adapted the way they communicated with people according to each person's needs. Some people were able to communicate verbally to a limited extent but lacked understanding due to their learning disability. Other people were unable to speak but communicated through facial expressions, body language or different sounds. One person had advanced assistive technology to help them communicate and optimise their independence. This was designed and part-funded by their relative. The technology enabled them to use head movements to select pre-recorded voice messages to express their needs or choices.

Staff said everyone worked well together as a good supportive team and this helped them provide effective care and support. Care practices were discussed at monthly one to one supervision sessions and team meetings with the manager. Annual performance and development appraisal meetings took place.

The provider trained staff in the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The service followed the MCA code of practice to protect people's human rights. The MCA provides the legal framework to assess people's capacity to make certain decisions at a certain time. Deprivation of Liberty Safeguards (DoLS) provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The provider had made a number of DoLS applications to the local authority. This showed the provider was ready to follow the DoLS requirements.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. The provider's speech and language therapist visited the home most weeks to check people's dietary needs were being met. An individual menu had been prepared to meet one person's special dietary needs. Most people were able to choose from a set four weekly menu. Different textured meals were catered for, such as pureed meals for people on soft diets. Staff said alternatives were provided if people decided they did not want to have the daily menu choice.

The home had two separate kitchen and dining areas. We observed most people had their meal together in the larger dining area as this was easier to access for people with mobility needs. People had their own set positions at the dining table to accommodate different size wheelchairs and give everyone sufficient personal space to suit their individual needs. No one was rushed during their meal and staff checked if people wanted any more to eat or drink

Good

Is the service effective?

before clearing the table. Some people had adapted wheelchairs to support them at mealtimes, others had special plates and plate guards to help them eat their meal independently and others required one to one staff support to eat their meal. People received good portions and appeared to enjoy their meal.

Staff carried out monthly health checks to ensure people maintained good health and any changes in their health were detected. Gender specific health checklists were used and the same gender staff carried out the checks, unless people expressed a different preference.

The provider employed their own central team of physiotherapy, rehabilitation, speech and language therapy and visual facilitator staff. The registered manager said the local GPs and district nurses were also very supportive and visited whenever requested. Care plans contained records of hospital and other health care appointments. There were health action plans and communication passports providing important information to help external professionals understand people's needs. This included a 'vision passport' for when people visited the opticians and a 'hospital passport' for when people went into hospital.

Adaptations were made to the premises to support people's needs. There were two large communal bathrooms with assisted bathing equipment for people who could not use the ensuite facilities in their rooms. The main hallway had been specifically designed to assist people with visual disabilities. This included purpose made hand rails to guide people to the different parts of the home. People's wheelchairs had sensors installed which enabled them to follow a magnetic strip embedded along the centre of the hallway. The hallway and entrances were wide and designed to accommodate motorised wheelchairs. The provider employed an assistive technology manager to support people with sensory equipment installations and other adaptations to improve aspects of their life. For example, one person had thermostatically controlled windows installed in their room which opened and closed automatically when the temperature was outside of a comfortable range.

There was a large sensory room with equipment to stimulate people's senses using lights, sounds, music, and touch. This included a heated water bed, DVDs and materials to help people enjoy different sensory experiences. Staff said that on average two or three people were able to use the room for around an hour each per day depending on staff availability and other duties.

Good

Is the service caring?

Our findings

One person's relative said "All the staff are great. Very good and very caring". Another person's relative said "The attitude of staff is excellent. They really try to get to know people and how they like to be supported". A member of staff said "We like to think people enjoy a good life here. Our priority is to ensure people are happy". The registered manager said "The people here are lovely. To see the smiles on their face really makes my day".

We observed interactions between care staff and people were patient, supportive, kind and friendly. For example, staff involved people in baking cookies to the extent each person was able to participate. There was a lot of friendly banter and people seemed to be having fun and enjoying the sensory smells and tastes of the freshly baked treats. Staff also assisted us to communicate with people who could not express themselves verbally. People appeared to understand when staff spoke with them and often responded with smiles or happy noises.

Staff showed compassion and kindness towards people. For example, when one person was seen sucking their fingers for a while staff applied protective cream to the person's lips and fingers to prevent them from becoming sore.

Staff communicated with people in the most appropriate way and knew their personal preferences and backgrounds. Each person had a designated key worker with particular responsibility for ensuring the person's needs and preferences were known and respected by all staff. The key worker engaged with the person in whatever way was most appropriate to them. This helped ensure people's daily routines and activities matched their individual needs and preferences.

Staff treated people with dignity and respect and supported them to maintain their privacy and independence. We observed staff spoke to people in a respectful and caring manner and were sensitive to people's moods and feelings. When people needed support staff assisted them in a discrete and respectful manner, for example when people needed to use the bathroom. When personal care was provided this was done in the privacy of people's own rooms. Each person had their own individual bedroom where they could spend time in private when they wished. We observed one person spent most of the day in their room after returning from a trip out. Their relatives told us the person preferred peace and quiet and liked to be alone with their music a lot of the time.

Staff respected people's confidentiality. Staff treated personal information in confidence and did not discuss people's personal matters in front of others. Confidential information about people was kept securely in the office.

People were supported to maintain relationships with their relatives and friends. Relatives were encouraged to visit as often as they were able to and staff supported people to visit their families on a mutually agreed basis. A relative said "The staff are laid back about this. I can visit any time, there's no need to make an appointment". Another person's relative said "Staff are very considerate and flexible. They think about my needs too".

Good

Is the service responsive?

Our findings

People were supported to contribute to the assessment and planning of their care to the extent they had the mental capacity to do so. Each person had a designated key worker who understood the person's communication needs well and took particular responsibility for ensuring the person's needs and preferences were understood and met by all the staff. People had monthly care plan reviews with their key worker and care plans were updated at least every second month. Care plans were audited by the registered manager to ensure they accurately reflected people's current needs.

Each person had a personalised care plan based on their individual physical and learning disability needs. We spoke with the provider's regional service manager when they visited the home on the day of our inspection. They told us "Care plans are built around each individual. I think the organisation does personalisation really well". Care plans included clear guidance for staff on how to support people's needs. As well as detailing people's support needs, care plans identified each person's personal likes and dislikes, daily routines and activity preferences. For example, one person liked to be out in the fresh air as much as possible. This was detailed in their care plan and outside activities such as horse riding and regular walks were part of their activity plan.

Care records were up to date and accurate. Comprehensive care plan records were kept in the office but daily care and support records including a concise personal profile of each individual were kept in people's own rooms. The personal profiles provided an overview of each person's care needs and preferences and served as an accessible reference guide for new or temporary staff who were not so familiar with people's routines.

The registered manager said care staff were allocated support roles by the senior staff member on each shift. Where people showed a preference for a particular care worker they tried to accommodate the person's preferences. Staff members of the same gender were available to assist people with personal care if this was their preference.

People were supported to spend time in the community and participate in a range of social and leisure activities in line with their personal interests. This included holidays, trips out, visits to relatives, attendance at disability resource centres, main stream college courses, horse riding, and water therapy sessions. Other activities took place within the home including massage, aromatherapy and individual sessions in the sensory room. An external musician visited once a week. A relative said "(Their relative) goes out most days and has a good life there". Another person's relative said "We sometimes go into town together and people often stop and greet (their relative) which shows they are used to seeing them out and about". However, other relatives said the service could be more proactive and creative in terms of activities that would enrich people's quality of life.

Some creative ways were used to help people communicate and support their independence. For example, one person who was unable to speak used a head switch to communicate using assistive technology with pre-recorded voice phrases. They were also able to operate their motorised wheelchair, television and music equipment using the technology. They could select different colour lights on a lamp in their room to indicate their mood. Green meant they welcomed company and red meant they wished to be alone. The person's relative had designed this assistive technology with part funding from social services.

Staff said most people's relatives lived out of county but people kept in regular contact through Skype, telephone calls, emails and letters. Staff supported people to visit their relatives several times each year and relatives were encouraged to visit the home as often as they were able to. One relative said "I am always made welcome when I visit".

The registered manager said they operated an open door policy. People and their relatives were encouraged to feedback any issues or concerns to them directly or to any member of staff. At a recent staff meeting they had discussed how to recognise if someone with a communication difficulty had a complaint. People could raise issues or concerns through their key worker or their relatives or social workers. One relative said "I can email or call the manager at any time and I usually get a quick response". Another person's relative said "We receive satisfaction questionnaires two or three times each year. They encourage us to call them with any issues and they always take action to resolve matters".

The service had an appropriate complaints policy and procedure. Formal complaints were recorded and records

Good

Is the service responsive?

showed complaints were responded to appropriately and within agreed timescales. One relative said “I can’t recall having any complaints. If I raise a small issue they always listen and deal with it quickly and informally”. Another person’s relative said “They are very approachable. I wouldn’t hesitate to call the manager if I had a concern and I’m confident they would contact me if there were any problems”. However, another relative questioned the openness and responsiveness of the registered manager and senior care staff.

Good

Is the service well-led?

Our findings

The provider's stated purpose was "To enrich the lives of people with sight loss and multiple disabilities across the UK". To ensure staff understood and delivered the provider's philosophy, they received training tailored and personalised to the needs of the people living in the home. The service provided a comprehensive induction programme for new staff and there was continuing training and development for established staff. This was reinforced through monthly staff meetings and one to one staff supervision sessions with the registered manager.

Staff told us that management operated an "open door" culture and they were approachable and supportive. The registered manager and the regional service manager had both been appointed in recent months. One staff member said "The manager wants the best for people here. She's always coming up with new ideas". Another member of staff said "Both the new managers have provided a breath of fresh air and it has really brightened up the staff team. It is early days but they are introducing lots of good things and have really motivated the staff".

The managers told us they had previously worked in other service related charitable organisations and were using this experience to introduce improvements to the service. They told us the provider was open to new ideas and good practices. For example, the provider had signed up to the 'Making it Real' initiative as part of the Think Local Act Personal (TLAP) Partnership. This is a voluntary movement by councils and provider organisations to increase personalisation in adult social care services.

The provider held Regional Service User Group meetings three times a year to obtain the views of people who used the service. Agendas covered new service developments and topics people wished to discuss with the provider. Two people from the home were representatives on the regional group. People were also involved locally through care plan reviews with their key worker. The key workers were care staff with the communication skills and responsibility for ensuring each person's needs and preferences were heard and met.

People's relatives were more cautious than staff in their views about the recent changes. They told us things were now settling down after a period of management change and high staff turnover. They said the new registered manager was open and approachable but not yet as visible around the home as their predecessor. They understood it was still early days and said they were encouraged to contact management if they had any issues they wanted to discuss. Overall relatives were satisfied with the care provided although they thought further improvements could be made. A relative summed this up by saying "They do OK but there is always room for improvement".

The provider circulated annual satisfaction surveys to people's relatives and to people in the home who had sufficient mental capacity to understand the issues. One relative said "They are good at getting our input and involving us". For example, two people's relatives told us they had been involved in the selection process for the new registered manager. The results of the last survey were generally positive but some relatives had identified a need for more proactive planning and more creative ways of enriching people's lives.

The provider had a quality assurance system to check their stated purpose was being implemented and their policies and procedures were effective. The registered manager carried out a programme of weekly and monthly audits and safety checks. The provider carried out quarterly quality monitoring visits and annual health and safety checks. The quarterly visits were carried out by a regional service manager from another part of the country to ensure a fresh perspective.

Following the quarterly reviews, action plans were developed to address any identified issues and drive service improvement. For example, following the last quarterly review it was found that 'when required' medicines were not always recorded on people's medicine administration records (MAR). This meant it was not always possible to determine if the medicines had been given appropriately. Staff were reminded to always complete the reverse side of the MAR to record 'when required' medicines and to ensure they were familiar with the 'when required' medicines protocol. Quality monitoring scorecards with red, amber and green ratings were used to monitor key aspects of the service and identify trends and areas for improvement.

The regional service manager said the provider aimed to be transparent in all of its dealings with the statutory authorities. All incidents or concerns were recorded and reviewed by management and were reported to the

Good

Is the service well-led?

appropriate bodies, such as the Care Quality Commission and the local authority safeguarding team. The provider wanted staff to be equally transparent and open about any mistakes, concerns or other incidents.

Incident records were reviewed as part of the quarterly monitoring visits and any trends or learning from these incidents were identified. Where further action was needed this was noted on a visit action plan and progress was checked again at the next quarterly visit. For example, at a previous visit it was noted that some of the fire exits had been obstructed by scaffolding erected for urgent roof repairs. Staff were briefed on alternative fire exit procedures to accommodate the repair works. At the next quarterly review it was noted that the scaffolding had been removed and all staff had received fire training updates.

The provider had a strong identity as a large nationwide organisation specialising in care for people with visual impairment and other disabilities. They participated in a range of forums for exchanging information and ideas and fostering best practice in this area. They were involved with national initiatives for people with vision impairment, such as eye tests for children in special schools. They were affiliated to the Registered Care Providers Association (RCPA), they attended service related conferences and seminars and local authority provider meetings. Internal 'best practice days' were organised for staff across the country to meet and share ideas. The provider also accessed a range of online resources and training materials from service related organisations including the Care Quality Commission's website.

People were involved in the local community. Staff supported people to go into town most days of the week. There were 15 local volunteers who visited the home and provided additional social contact and support for people. The volunteers had a variety of different roles, such as: reading to people who were sight impaired, engaging people in activities, and keeping the garden and outside grounds clear and tidy for people with sight and mobility needs. The service used local links to promote people's involvement in the community, raise funds and attract volunteers to support the home. For example, many of the local shops had donated gifts for a recent raffle organised in aid of the home.

Care records showed the service worked in close partnership with local health and social care professionals to ensure people's health and wellbeing needs were met. There were records of regular individual care plan reviews with social workers and health professionals. Care plans recorded appointments with hospital specialists, GPs and other community health professionals.