

## Canterbury Oast Trust

# Ivy Cottage

### 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?	Requires Improvement ●

# Summary of findings

## Overall summary

This was a comprehensive inspection. It took place on 16th and 17th May and was unannounced. Ivy Cottage provides accommodation and personal care for five people with learning disabilities who may have complex needs.

At the time of the inspection four people were living at Ivy Cottage and there was one vacancy. The premises are purpose built on one level with good access for people with limited mobility or wheel chair users. It is set on Highlands Farm near the village of Woodchurch.

Each person had their own room with additional communal bathroom and separate wet room. There was also a lounge/diner and kitchen. There was a fenced rear garden with a paved seating area.

Ivy Cottage is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ivy Cottage accommodates people with a learning disability and some with complex needs.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

### Rating at last inspection

At our last inspection we rated the service as good. At this inspection we found the evidence continued to support the overall rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns.

However, since the last inspection the service had not remained well-led. The registered manager had been absent for several months and a deputy manager with limited management experience had taken their place.

The provider had continued to deliver good service for the people who live there but, there had been a deterioration in the day to day support for staff especially in relation to staff supervision and appraisal.

This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

### Why the service is rated Good

People were protected from abuse with sufficient numbers of trained staff to meet people's needs. Individual risk assessments provided staff with the information they needed to reduce and manage risks whilst ensuring people's individual freedom and independence was respected.

Staff rostering ensured sufficient numbers of trained staff supported people's activities, appointments and needs.

People received their medicines safely from trained staff. The service had worked with local health and social care professionals and sought guidance from the GP about the storage and administration of homely remedies as part of its regular auditing processes.

People's individual needs were met through the design of the building. The service was clean, with measures in place to protect people from cross contamination and infection. Incidents had been recorded appropriately with systems to record follow up actions.

People's needs and choices were assessed and reviewed regularly to reflect their needs and wishes. Support plans provided staff with clear guidelines about the support people needed in line with national guidelines.

Staff recruitment continued to follow safe procedures, ensuring statutory checks, induction training and shadowing of experienced staff, were all completed before new staff started work.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Their consent was sought and external advocacy used where there were limitations to verbal communication, to ensure that the provider worked in line with the principles of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS).

People were supported to eat and drink to maintain a balanced diet and stay in good health. They helped to plan their menus and assisted in meal preparation.

People attended routine and specialist health appointments with appropriate referrals made to health and social care professionals as needed.

Staff knew the people well and treated them with kindness and dignity. People were happy and relaxed with staff and, there was a clear sense of mutual respect and equality. People were supported to express their views and were encouraged to raise issues formally and informally.

The deputy manager had an open-door policy and worked hard to support staff on a day to day basis. The absence of the registered manager had weakened support and training for staff, leaving the service without sufficient day to day management experience.

We found that key management tasks and recommendations from the provider's internal audits had not been completed and have recommended that the provider support the deputy manager to address outstanding actions.

## 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 remained Good

### Is the service effective?

Good ●

The service remained Good

### Is the service caring?

Good ●

The service remained Good

### Is the service responsive?

Good ●

The service remained Good

### Is the service well-led?

Requires Improvement ●

The service was not always Well Led

We found that key management tasks had not been completed.

Actions identified by the provider's own internal audit had not been completed.

We saw that staff were committed to the provider's core vision and philosophy for the service.

The service work closely in partnership with other professionals.

# Ivy Cottage

## **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 was a comprehensive inspection. It took place on 16th and 17th May and was unannounced. Before the inspection, we reviewed information from the provider. The registered manager had completed a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the last inspection report and other information including any notifications. Notifications are information we receive when a significant event happens, like a death or serious injury.

We spoke to the quality and compliance manager, the deputy manager, three support staff and two families. Some people were unable or unwilling to give us their views of the service. We have tried to maintain the peoples 'voice' through observation and feedback from families and professionals.

We looked at a range of support documents including, care and activity plans, medicine administration records, training records, staff files, supervision and appraisal records and policies and procedures. We also asked the provider to send us a range of documents including their business continuity and development plan after the inspection, which they did.

# Is the service safe?

## Our findings

People remained safe from abuse and were supported to understand how to keep safe. Safeguarding information in an accessible format, was on display in public areas of the house. Staff were trained in safeguarding and could identify their responsibilities in reporting any concerns.

Staff were clear on how to support people with their specific behavioural needs. Support plans identified potential behavioural triggers and detailed actions that could be taken to reduce tensions and manage changes to behaviour safely. The staff also used a DisDat assessment tool (a tool designed to help them to identify signs of distress in people with limited communication).

Day to day risk was managed through daily staff handover and detailed risk assessments were effective in supporting people to keep themselves safe from situations that might harm them. One person enjoyed swimming and the service had risk assessed the local swimming pool so that the person could swim safely.

Staffing levels were safe with additional staff available for holiday and sickness cover. We observed staff reworking the daily rotas to ensure that all the people could attend local daily activities in line with their care plans and stated wishes.

Safe recruitment processes continued to be followed. For example, criminal records checks were made through the disclosure and barring service (DBS), which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. References had been obtained from the most recent employer (where possible) before staff members were appointed.

The quality and compliance manager who attended feedback as a representative of the provider told us that before a final recruitment decision was made, staff were invited for an informal visit where they could meet the people and the registered manager could assess their suitability for the role.

People were encouraged and supported in helping to keep the service clean. Monthly infection control audits were completed, regular environmental and safety checks were carried out, the results recorded, and safety systems maintained appropriately. Personal protective equipment was available and health and safety guidance was displayed to minimise the risk of cross infection and keep the service clean and odour-free.

People continued to receive their medicines safely from trained staff. Medicine administration records showed that people had received their medicines when they needed them. Medicines were accompanied by clear written guidelines so that staff understood the purpose of the medicine and the way the person liked to receive it.

There were procedures for PRN medicines (required when necessary) and medicines were stored in a lockable cabinet for security, with clear evidence of a recent pharmacy audit to monitor medicines and ensure that the service was keeping in line with best practice guidance.

Staff learned from incidents and were involved in documenting changes to support plans, updating ABC charts (used to record behavioural concerns) and debriefing through team meetings and supervision. The provider had also established procedures for escalating incidents to senior management.

Learning was then shared with other relevant professionals and multidisciplinary referrals made to other services to further support people as required. A health professional told us, "I have always found the staff present information well. They are willing to share information, they are knowledgeable and have good links with the learning disability team."

## Is the service effective?

### Our findings

People continued to be assessed using a holistic needs assessment. Staff told us the manager carried out a pre-admission assessment before a person moved to the service to ensure that care plans would reflect the persons individual support needs. The care plans were developed in line with good practice guidance such as that from the National Institute of Health and Care Excellence (NICE).

Staff confirmed that following initial assessment, the person would be invited to come to dinner for an initial visit. This would then be followed by longer visit to ensure that the person would be happy and could fit in with the other people living at the service. When the person moved in, a staff member from their previous home would accompany them for a day to help them settle in.

We saw care plans were personalised according to the individuals wishes. One person's care plan specifically noted their religious preferences not to go to a church and confirmed that staff would support them to go should they change their mind. Another person's plan contained a report showing how their use of computer technology during their weekly activities had helped them to grow in confidence and enhance their skills.

Staff told us that their induction combined 'classroom' based learning, which covered core subjects including safeguarding vulnerable adults, medication administration and health and safety with the shadowing of more experienced colleagues to learn best practice and spent time with people to understand how to support them. Training had been updated and staff were encouraged to develop their skills and learning following recent input from the Skills for Care academy. Skills for Care is an independent registered charity working with adult social care employers to set standards and qualifications for people working in social care.

Staff continued to receive supervision and appraisals and although they had been less frequent during the registered manager's absence, staff confirmed that they had received input through staff meetings where they had shared learning and reflected on best practice to maintain the most effective support for people.

People continued to have a varied diet and be involved in planning their meals, preparing snacks and assisting in making lunch. Visual instructions to assist in sandwich making were attached to the fridge and corresponded to the pictorial menu board and the menu planner for the week. Staff told us that they sat down with people and showed them picture cards and cookery books to enable everyone to be involved. At lunchtime people prepared a variety of meals and during the day people were supported to make drinks when they wanted them.

Some people had long term health conditions that affected both their ability to eat and the way they behaved. In each case, their support and health action plans clearly documented how staff had monitored the underlying health conditions with the GP and requested referrals to other professionals such as the dietitian, psychiatrist, community nurse and speech and language therapist.

Staff worked proactively with external health services. They arranged routine check-ups to monitor people's blood sugar levels, weight loss, and medication and took note of any changes, updating the care plans appropriately. People attended appointments and staff worked alongside healthcare professionals preparing hospital emergency admission bags and healthcare passports to ensure that healthcare staff could understand how the person liked to be supported.

The premises were purpose built to meet the needs of the people who live there. One person told us, "My room is amazing." There was good access for wheelchair users with wide corridors and wet rooms to enable easy access for showering. The large lounge/diner provided communal space whilst each person's room had been personalised with their choice of furniture, décor and personal items.

We spoke to a relative who was supporting a person to move to a new house. They told us that they were most impressed with recent changes to the décor and had found the staff team helpful and reassuring. The service had a large fenced garden with a summer house that provided a quiet outdoor space.

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 assisted to do so when required. When people lack mental capacity to make 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 so that they can receive care and treatment when it is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes 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 found that appropriate DoLS applications had been completed and authorisations were lawful.

People's care plans evidenced they had been asked for consent to their care. Where they could not verbalise their reply, staff confirmed that they had read the plans to the person. We observed staff asking one person for consent to allow us to contact relatives and saw that staff checked with people before they supported them.

Staff demonstrated they understood how consent applied in their everyday work when for example, a person with limited communication declined their morning shower and rather than trying to force the person, staff observed their body language and respected their wishes.

## Is the service caring?

### Our findings

Staff continued to demonstrate strong caring relationships with the people. One staff member told us, "I treat people the same way as I would like to be treated and come down to their eye level so I'm not domineering or overpowering."

Staff told us that it was important to spend time with people and staff rotas enabled social interaction during the day. When people approached staff, they responded in a friendly and natural way.

Some people had limited verbal communication but staff promoted equality using a variety of communication methods including Makaton (a combination of signs and symbols to help people communicate) photographs and 'either/or' choices to engage with people. One person used a combination of Makaton and pointing to body maps, to help staff to identify when and where they were in pain.

Visitors were encouraged and staff supported people to maintain close relationships. When one person remembered their relative's phone number, staff praised them and encouraged them to call. Another person was supported to maintain a romantic relationship, sending cards, writing letters and making phone calls.

The service continued to encourage people to express their views. Monthly resident's meetings were held and people had been consulted about their rooms, what they enjoyed doing and what they might like to do in the future. People contributed to their own six monthly annual reviews and independent advocacy support was available and had been used to support a person to move into the service.

Staff showed people dignity and respect, and provided private space for personal care. Staff told us, "We always make sure that the person has a towel or robe ready (to preserve the person's dignity) when we carry out personal care."

One person required the privacy of their room when they felt stressed and chose to listen to music to relax. We noticed that staff respected this need and remained at a discreet but close enough to be attentive should support be required.

Confidential information was stored in the staff office in locked filing cabinets. Handover was held in private and staff were careful and respectful to ensure that confidential information was kept safe.

## Is the service responsive?

### Our findings

People continued to receive individualised care that reflected their needs, choices and wishes. Daily routines were supported at a pace that suited the individuals.

When we arrived for the inspection, one person was enjoying a leisurely breakfast. Staff explained that the person took time to process information and needed a prescribed routine. We saw that they were not rushed by staff when other people left the table.

Care plans used pictures to make them more accessible, staff reviewed them monthly and noted any changes. Plans included personal details, a monthly activity profile and a range of support plans and risk assessments that provided clear instructions for staff to risk assess and support people with daily routines such as shaving, showering and personal hygiene.

The care plans were developed in a pictorial, easy-read format. Staff had worked with people to produce a holistic pen picture for each person. When people expressed themselves through their behaviour, staff had worked to identify what might cause the person to act in that way, what the behaviour was trying to communicate, how to reduce any tension and de-escalate any potential conflict.

Staff continued to promote independence and develop peoples' skills in daily living tasks including, doing the laundry, cooking, managing money and travelling safely in the community. Care plans provided staff with the information they needed to support people with these skills.

One person enjoyed shopping and to promote their independence, their support plan provided clear instructions on the best way to encourage choice by holding up several items and allowing the person to select their preference. The plan gave a clear description of what the person's body language would look like if they were enjoying themselves and how to recognise if they were not.

Staff demonstrated that they knew people well, using observation and discussion with people and their families to inform care plans. One person's plan detailed the specific gestures they used to communicate their agreement with clear guidelines that ensured consistency when supporting the person's limited verbal communication. Another plan explained clearly the effects that sweet food had on the persons mood so that they could be supported appropriately.

Staff told us, "We try to get people out into the community". Plans reflected a range of meaningful activities that were important to people including, work at a local carpentry business, art and craft sessions, attendance at a local 'speaking up' group and shopping at a local department store. The house activity rota and daily communication logs confirmed that people had been supported to attend.

Staff supported people to raise concerns. There was a current pictorial complaints policy available so that key workers could support people to make a complaint. There was evidence of concerns raised through the house and staff meetings with a staff representative meeting held once a quarter to forward concerns and

suggestions to the registered provider who responded in a timely manner.

We spoke to a relative who told us that they had received written guidance of how to complain to the registered provider although they had never felt the need to do so. Professionals we spoke to had no concerns about the service.

Staff told us that they had started to have conversations with people and their families to help people to think about how they would like to be supported at the of end of their lives. Staff told us that bereavement training was planned for later in the year. This was confirmed on the training matrix.

## Is the service well-led?

### Our findings

The service had not remained well-led. The service had a registered manager supported by a deputy 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 had been away from the service for several months and the service had been managed by the deputy manager with oversight from the quality and compliance manager who described the culture as "relaxed but muddled since not all roles are fully known".

This was supported by comments from a visiting professional who told us, "the team of carers working at Ivy Cottage are professional although recommendations which need to be approved by managers, are often slow to be implemented."

In the registered manager's absence, key management tasks had not been completed. An internal audit carried out by the registered provider in February 2018 had identified a range of actions that were still outstanding, including supervisions, mental capacity assessments and training updates.

We recommend that additional support is given to the deputy manager to complete key management tasks and to ensure that actions from key audits have been actioned.

The provider was working with Skills for Care Academy to support staff training and the service had plans to develop best practice champions from within the staff team. Staff understood and demonstrated a commitment to the core vision and philosophy of empowering people to be as independent as possible.

Staff told us that the service was moving away from task orientated care with care plans reviewed and updated to reflect the individuality and involvement of people more fully. The deputy manager demonstrated 'hands on' leadership through active involvement in delivering care and by operated an open-door policy that encouraged staff to be honest and transparent.

Staff worked well together, delivering flexible care across a range of the provider's services. This helped them to work collaboratively and understand the challenges and risks faced by people as staff worked between services within the organisation.

The service also worked in partnership with other professionals including, the community learning disability team, speech and language therapist and the community mental health team to ensure that people had received the best health outcomes.

Actions specified in the current service development plan had been carried out in part. We spoke to a relative who confirmed that she was, "most impressed with the improvements to the décor since February

2018." Another relative confirmed that external fencing had been erected in response to concerns for people's safety and that staff and people had been involved in re-designing the lounge to make it feel more homely.

The business continuity plan clearly identified the actions the service would need to take in the event of a major incident. We also looked at recommendations and learning from the last trustees visit in 2016 (trustees are people who make sure the charity is run properly) plus recent service audits carried out by senior management from the registered provider. These gave comprehensive feedback about gaps in the quality of care with clear targets for improvement during 2018.

A relative confirmed that management audits were followed up with quality questionnaires that were used by the registered provider to make improvements to the services. They told us that they 'found the service ok, the staff were supportive and they had no complaint'.