Freeways

Clevedon House

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

Clevedon House 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.

Clevedon House accommodates up to 11 people in two adjoined buildings. Some people had a learning disability and autism. Some also had physical or sensory impairment. There were 10 people using the service at the time of this inspection.

At the last inspection in September 2015 the service was rated Good.

At this inspection we found the service remained Good but we have made a recommendation that the service review their policy and practice in line with the NICE guidance and guidelines for managing medicines in care homes because medicine management was not robust.

Why the service is rated Good:

People were protected from abuse and harm because staff understood their safeguarding responsibilities and were able to assess and mitigate any individual risk to a person's safety. People said they felt safe at Clevedon House.

Staff were recruited in a safe way and available in sufficient numbers to meet people's needs.

The premises was well maintained and there were measures in place to ensure a pleasant and hygienic environment for people.

The induction and on-going training of staff ensured they were effective in their role. Staff knew how to ensure each person was supported as an individual in a way that did not discriminate against them in any way. People's legal rights were understood and upheld.

The service had 'gone back to basics' with regard to ensuring people had good food and a varied and balanced diet. This had improved some people's health. People said they liked the food.

People's health care needs were well met through staff knowledge of the person and appropriate contact with specialist health care professionals.

People were treated with kindness and respect because their views were sought and responded to and their needs were understood and met. One person said, "It's our home. The staff are just here to support us." Staff interaction with people using the service was of a high standard.

People's care and support was planned with them. Where information was important, pictorial communication was used. This included 'happy, sad' faces as a starting point for making a complaint or raising an issue. Complaints were welcomed as a way to make improvement.

People were able to follow their varied interests, with or without staff support. These included sports, gardening, voluntary work, outings and holidays. People came and went at the home as was their choice.

The service was well-led and the registered manager was praised for the improvements they had made to people's lives. People's views were sought and every opportunity taken to improve the service. Audits and checks were carried out in-house, by managers from sister homes and by the provider.

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 remains Good but we have made a recommendation to improve the robustness of the management of medicines.	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Clevedon House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 15 and 16 November 2017 and was announced. The reason it was announced was so people who would find our visit a challenge, could be informed that we would be visiting. This was to help them prepare for the visit.

The inspection team included one adult social care inspector.

Prior to the inspection we looked at previous inspection reports. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law. We used information the provider sent us in the 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 met each of the 10 people using the service and received specific feedback from four of them. During the inspection we also used different methods to give us an insight into people's experience. This included informal observation throughout the inspection. Our observation enabled us to see how staff interacted with people and see how care was provided.

We spoke with four family members and four staff members, a visiting therapist and the registered manager.

We reviewed four people's care records, two staff files and looked at quality monitoring information relating to the management of the service and safety records. We received feedback from one health and social care professional with three clients at the service and saw other feedback from questionnaires the service had received during 2017.

Good

Is the service safe?

Our findings

The service continued to be safe. However, medicines management was not fully robust although staff received training and checks on their competency. The service had reported five medicines errors in the previous 12 months. Each error had led to an investigation and changes which should address that particular error. For example, where a tablet had been found in the person's bed, it was agreed with them that they would only take their tablets when they had got up. This had removed the problem of the medicine being dropped.

There remained areas of medicine management where risk was not fully managed. For example, medicines were being stored in a room where we found the temperature was above that recommended by the manufacturer for safe storage. Neither was the temperatures being monitored. There were plans in place to move the medicines from that room and so, following our feedback, the service brought those plans forward and temperature monitoring was started. Another example was staff hand writing entries on the medicine administration record. There was no signature of the person making the record or of a second person checking it for accuracy. Staff said they had asked their pharmacy for a printed medicines administration sheet but this had not, to date, been provided. It was provided following our inspection visit. A third example was staff being disrupted when taking a medicine to a person's room. Staff bought a lockable container in which they could carry the medicine in its original packaging to the person, before the inspection ended.

We recommend that the service review their medicines policy and practice in line with the NICE guidance and guidelines for managing medicines in care homes.

There were elements of good practice in medicine management at the service. People were supported to manage their own medicines in a risk managed way. For example, the medicines were checked into the home with the person and their use discussed with them. The medicine records were colour coded for clarity and there was regular stock control to make sure the expected amount of medicines were there. Medicines were stored in a secure way and there were clear instruction for staff as to when medicines could be given if they were prescribed 'as required'.

Medicine errors were monitored by the organisation and the service had its last provider, unannounced medicine audit in December 2016. A report dated June 2017 included that managers were to have medication as a reoccurring agenda item in team meetings and individual staff supervision. This was being done.

Staffing arrangements met people's needs in a safe way. The registered manager and the team leader had 'office days' but were available to people if this was necessary. There were always two care workers in the mornings and two in the afternoon until 10.15pm. One member of staff slept on the premises at night to provide support if needed. In addition, there were 42 extra hours of staff time available which could be used flexibly, for example, toward activities or health care appointments. There were adequate staff available for people during the inspection visits and people said there were enough staff to help them.

People's individual risks were assessed and the assessments identified where action was needed to protect people. For example, relating to using the kitchen or leaving the home. Staff looked for the least restrictive way to keep people safe. Where one restriction was necessary the registered manager had consulted the local authority safeguarding adults team. This showed that people's autonomy was respected but people's safety was also a priority.

People were protected from abuse and harm because staff knew how to respond to any concerns. Throughout staffing areas information was displayed on what constituted abuse and how to respond. All staff had received safeguarding training. The registered manager had informed the safeguarding team, appropriately, when there had been a requirement to do so, such as an altercation between people using the service. Safeguarding concerns were handled correctly in line with good practice and local protocols.

There was an equalities and diversity policy in place and staff received training on equalities and diversity. Staff demonstrated that they were aware of their responsibility to help protect people from any type of discrimination and ensure people's rights were protected.

There were robust recruitment processes in place. These included pre-employment checks including references from previous employers and Disclosure and Barring Service (DBS) checks. A DBS checks helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. Staff confirmed that they did not work at the service until all checks had been completed.

The premises and vehicles were well maintained through a programme of maintenance and servicing. For example, gas, electricity and water checks were carried out in accordance with the level of risk. All staff had received health and safety training. There were arrangements in place for on-going maintenance of the building.

There were arrangements in place should an emergency occur. For example, an equipped 'emergency bag' was situated by the fire exit door and an arrangement was in place to use a sister home should people need to be evacuated. Each person had a personal evacuation plan which described their individual needs should an evacuation be necessary.

People were protected from the risk of cross infection. One person said, "The home is always nice and clean" and "It smells nice". Each person using the service was supported to look after their room, and the home, to be clean and fresh. Each person did, or helped with, their own laundry. There were two laundries each with a hot wash facility should this be needed. The service used a coloured coded system for mops and cutting boards and staff had personal protective equipment, such as gloves, to reduce any possibility of cross contamination. There was an infection control policy; infection control was audited and the staff received appropriate training in infection control and food hygiene.

Most people were involved in looking after their own finances, some with and some without staff support, based on people's choice and assessed risk. There were systems in place to ensure people's money was handled in a safe way.

Good

Is the service effective?

Our findings

The service continued to provide people with effective care and support because their needs were fully assessed, understood and met in line with relevant guidance. One person's family member said, "They are brilliant. They have got something very, very right there. They look at people as individuals". There were no people recently admitted to the service.

Some people's ability to communicate was affected by their disability but the staff were able to understand them and provide for their needs effectively. Staff knew people's care and support needs very well. For example, one person became upset when they misheard what had been said. The staff knew the best way to reassure them.

Staff received regular training in all subjects relating to providing safe and effective care. Mandatory training was organised through the provider. Training included all aspects of health and safety and subjects of relevance to people's individual conditions, such as autism. Some training had been given by relevant health care professionals or through research, for example, diabetic care.

Staff received a detailed and thorough induction, including, for staff new to care work, the nationally recognised Care Certificate. One staff member said of their induction, "The training is really good"; this was reiterated by other staff. Staff were encouraged to undertake qualifications in care.

The registered manager ensured that staff received regular one to one supervision of their work. New employees had reviews of how they were doing and to look at any areas where there was concern on either side. Yearly appraisals had been introduced so that staff performance could be kept under review.

Staff worked in accordance with the Mental Capacity Act 2005 (MCA). Each person using the service had capacity to make decisions relating to their care and support. Where consent was required for medical treatment this was understood and being arranged. The MCA provides a legal framework for making 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interest and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). No person using the service was deprived of their liberty. Each person was able to come and go as they wanted and none required constant supervision for their safety. However, some had chosen to receive staff support to go out into the community.

People were supported to maintain a healthy diet. One person said, "The food is nice here". One person's family member praised the service for improving the standard of food. This has led to the person's health improving. People took daily turns to plan the menu for the service and prepare it. Each meal had an

alternative choice available so people always had an option. For example one person did not like chicken and they said they could choose what they wanted instead. There was a wide variety of foods available for people, such as toad in the hole and bolognaise. People used the kitchen to make themselves drinks and snacks as and when they wanted to.

People's physical health was effectively promoted through contact with appropriate health care professionals, such as physiotherapy and the 'falls team' with good partnership working. This had led to people's mobility improving. Staff understand the need for mental health support. For example, one person had been referred for bereavement counselling.

Complex health conditions, such as epilepsy, were managed through contact with specialist health care professionals. People attended local practitioners, such as dentist, with staff support if this was their choice. One person required physiotherapy and had attended hydrotherapy. Staff supported the person with an exercise plan. A health care professional had described the care at Clevedon House as "Impressive". A person's family member said how quickly staff responded when the person became ill.

Each person had a health care plan and a health care passport. These provided details of their needs and how they could be met should they require health care intervention or hospitalisation, for example, how the person communicates.

People's individual needs were met through the service approach to the individual. Each person had a private room, which was very individual to the person and decorated to their taste. Some had en-suite and others shared bathing facilities. People said they were happy with the arrangements. Where one person had been unable to access a bath due to their mobility a wet room had been provided in their room. They said they liked this. Another person had agreed to move to a vacant ground floor room so they would not have to use the stairs.

The ground floor was open planned but also provided different areas of space. For example, a dining space a television/relaxation space and two quieter areas. People moved around the spaces in accordance with what they wanted to do, for example, some people chose to watch some comedy. Some people spent time in the garden area, which provided space for events such as BBQ. Adaptation helped people, examples being pictorial information, such as who was at home and who had left the building. Different height stair rails helped people of different heights use the stairs.

When there had been changes to the home environment this had been done through consultation with people and taking their individual needs and concerns into account.

Staff said that restraint was not used at the service. Each person, who might exhibit behaviours of distress, had behavioural management plans in place. Staff were observed following those plans to good effect, for example, one person was quickly calmed and reassured when they misunderstood what was happening.

Good

Is the service caring?

Our findings

The service continued to be caring because people were supported to understand that it was their home and the staff were there to support them in running their home. One person said, "I am never made to do what I don't want. It's choice isn't it? It's lovely living here" and "It's our home. The staff are just here to support us." They called the service "Our house". People got up, had breakfast and used the service as they wanted to. For example, staying in their night clothes until they were ready to change into day clothes. One person's family member felt there should be more support toward maintaining the person's hygiene. Their key worker explained how the person was being gently supported toward these, and other, changes for their dignity.

Some people took responsibility for some daily living activities which benefitted each person they lived with. For example, one person organised the menu board. Each person had a day a week when they chose the menu. This choice was then displayed, with their photo, for other people's information.

One staff member said, "We listen to resident's needs and wishes and act on them". People were consulted about every aspect of their lives and their views were taken into account and acted upon where ever this was possible. For example, regarding the menu, their finances, medicines and social activities, within and without the home. Staff ensured that people were in no way disadvantaged. This included in relation to age, disability and beliefs, each being relevant to people at this service.

Each person using the service was able to choose their own key worker. One person's family member said of the staff, "They do, genuinely, really care a lot. I am really, really impressed because staff are gentle, patient and caring". Staff had formed positive relationships with people. Many times people came up to staff to tell them something, ask for information, or just for comfort. All interactions between staff and people using the service were friendly, unrushed and done with competence.

Staff understood people's individual ways. They understood triggers which would cause the person anxiety. These included: unexpected changes in their routine or increased noise levels. Where possible staff anticipated the people's response. For example, when the flooring was changed people had this explained in advance. On the day people who wanted to avoid it went out to a place of their choosing.

Staff had the time to provide the level of care people needed. For example, during illness the flexibility of the staffing arrangements ensured the person received the required level of care they needed. Where necessary agency staff had been used to provide one to one night time support.

Family relationships were supported in accordance with people's wishes. For example, one person had lost regular contact with their family, which upset them. The registered manager therefore helped to facilitate regular contact again. People's families said how welcoming the service was.

Good

Is the service responsive?

Our findings

The service continued to be responsive.

There were examples where the service had improved people's lives. One person had, on admission, had a condition which was caused, or aggravated by, their diet. This had now been resolved through "going back to basics" with their food options. Another person's family said the person was much better than the previous year, adding, "(The person) is happy. The (registered manager) has made a big effort. (The person) is benefitting from security and companionship".

People using the service had the same opportunities available to them as people with no disability and had the support to enjoy very active lifestyles. One person told us about their working at a tuck shop, volunteering and work at a hospital. Other activities people chose included horse riding, gardening, coffee mornings, church activities, shopping, collecting for a hospice, holidays, cinema and eating out. One person attended a 'hate crime' workshop and assisted at a positive risk taking training day. One was elected chairperson on North Somerset first Advisory committee. They were very proud of this achievement.

People attended a day centre run by the provider. This included a swimming pool. People spent time in the community as and when they wanted to with staff support if this was their choice. A health care professional and people's family members said what active and interesting lives people were able to live at the service. A staff member said, "We don't do token activities".

Each person had a detailed support plan in place. This included their goals, how to meet them and how the person liked to be supported. Staff were able to be fully informed about each individual through that detail of information and staff handovers at the beginning of each shift. People using the service were fully involved in their assessment and support plan reviews; much of the information was in pictorial form to help them with this. One person said they discussed their plan with their key worker. A staff member said, "(The person) tells us what they want - their goals".

People knew how to comment or make a complaint about the service and they found the system was easy to use. A pictorial, happy or sad face, was used as a starting point to find out what was wrong and address any problem. Two people told us how they used this and how well it worked. Another said, "If you want to talk and you're not happy you can talk to the staff". There had been complaints, for example, about the home décor, and these were now addressed with new flooring throughout the communal rooms. It was policy that any issue raised would lead to the person being asked if they wanted make a complaint. The registered manager said that this system ensured people's concerns were fully responded to.

People were supported at the end of their life. People were encouraged to make decisions relating to illness and end of life care. Some had done so and some had chosen not to. The service respected and worked to meet people's wishes. This had included one person continuing to live at Clevedon House when their health had deteriorated. Staff were supported by external professionals to meet the person's needs at that time. Staff were proud that the person had continued to live an active life in their chosen home until their death.

Staff understood the impact to other residents of losing a person they lived with. To that end, some people had attended the person's funeral, the person's room had been left empty for a period of time, renamed and was to be fully redecorated before reused. Staff had also supported one person following the death of a family member.

Good

Is the service well-led?

Our findings

The service continued to remain well-led. There was a registered manager in post. They had been registered in March 2017, which was since the previous inspection. 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 vision of Freeways is to improve the quality of life for the people they support. People using the service and their family members confirmed this was achieved. The service presented as homely, friendly, open and inclusive, for example, there were easy read policies, pictorial records of resident meetings and a recent newsletter.

The registered manager was highly regarded. People, their family members, staff and a professional with three clients at the service spoke of improvements, such as increased staffing, since the new manager was in post. Comments included: "I have been especially impressed with the input from house staff over the last year, since (the registered manager) has been the manager"; "(The service) is more organised for service users – they get out a lot. We are more of a team now" and "There is a really nice ethos here."

The registered manager constantly looked at ways to improve the service through involving all stakeholders in the service. For example, team meetings included proactive or reactive strategies for people, if this was needed. Looking at other ways to improve the service had identified that hand overs, communication, rota management and team support could be improved. An action plan was put in place and positive improvements were achieved. Staff said that everybody had the opportunity to have their views heard and taken into account.

Resident meetings gave people a time to discuss what they wanted. Two people had said they wanted an activities board in the dining room and so they were going to look into this on the internet and see which would be suitable.

The staff said they felt well supported and the home was well-led. The staffing structure ensured that, at all times, support and advice was available to them. Specific staff needs had been addressed through measures which supported them in their role.

There were systems in placed to ensure the quality of the service. These included duty checklists and in-house and provider audits. For example, managers took turns to do audit checks at sister homes every two months and there was a provider level audit every two months. There was a provider monitoring visit during our inspection. Where an audit had identified action was needed this was followed up.

The service worked with health and social care professionals in line with people's specific needs, for example, towards improved mobility and eyesight. This ensured people's needs were met in line with best practice.

Feedback about the service, through anonymous survey, was sought from people, their family members, staff and health and social care professionals. The responses were mostly positive with the exception of a mention for a need to improve communication. The registered manager said ways to do this were under regular review.

The registered manager understood and met their regulatory responsibilities.