Turning Point

Weaver Court

Inspection report

Moorfield Place
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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

The inspection took place on 4 April 2016 and was unannounced.

Weaver Court is situated in the Idle area of Bradford and is registered to provide accommodation and personal care for up to 22 people who have a learning disability and autism spectrum disorders. The service was centred over two floors with communal dining and living areas, and a large enclosed garden at the back of the property. In addition, there was a separate flat for one person which was separate to the main building.

At the time of the inspection, there were 16 people living within the home and one person living in the flat.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives told us they felt safe in the home. They did not raise any safety related concerns with us. Staff we spoke with had a good understanding of how to identify and act on allegations of abuse and we saw the registered manager had followed safeguarding procedures to keep people safe.

Risks to people's health and safety were assessed by the service and risk assessments which were in place were well understood by staff.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within the legal framework of the Mental Capacity Act (MCA).

People and their relatives we spoke with told us they were generally satisfied with the service and spoke particularly positively about how kind and caring staff were. Some relatives felt general communication and interaction with management could be improved.

There were sufficient levels of staff to ensure safe care and support, although more consistent staff levels would ensure more activities would be possible within the service. Safe recruitment procedures were in place to ensure staff were of suitable character to care for vulnerable people. People and their key staff workers were matched according to who people felt most comfortable with.

Some people using the service were unable to verbally communicate with us. However, we observed care and support and looked at non-verbal communication including body language, hand and facial movements. We saw positive caring interactions between staff and people that use the service.

Staff had a good understanding of the people they were caring for. This included a high level of

understanding of people's likes, dislikes and preferences. Staff displayed motivation and desire to provide a caring and personalised approach to people

People had sufficient choice and variation of food in the home and people were supported to maintain good nutrition.

Medicines management was observed to be safe. People received their medicines as prescribed and clear records were kept.

Staff received a range of training which was generally kept up-to-date, as well as regular supervision and appraisal.

People participated in a range of activities and social activities which met their individual needs. The service owned a minibus which increased the range of opportunities available to people.

There was a system of audit and checks in place to assess and monitor the quality of the service and take appropriate action taken to improve where necessary.

Relatives and staff spoke positively about the registered manager and said they were effective in dealing with any concerns or queries.

Staff told us the management team was supportive of them and felt morale was good in the home.

Some records needed more robust and updated documentation.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received their medicines as prescribed and when they needed them.

Sufficient numbers of staff were deployed to ensure people received the required level of care and support. Safe recruitment practices were in place to help ensure staff were of suitable character to care for vulnerable persons.

People told us they felt safe in the home and robust systems were in place to identify, manage and reduce risks to people.

Is the service effective?

Good

The service was effective.

Staff received a range of relevant training at regular intervals. Staff we spoke with demonstrated a good knowledge of people and subjects we asked them about.

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards(DoLS). Where people lacked capacity, the correct best interest processes were followed.

People had access to a range of nutritious food.

People's healthcare needs were assessed and staff supported people in accessing health professionals which ensured people's needs were met.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were friendly and caring. Interactions we observed confirmed this.

We saw staff respected people's privacy, dignity and choices.

Staff had developed strong relationships with people.

Is the service responsive?

Good

The service was responsive

People received person-centred care which focussed on their needs and preferences.

People were encouraged to participate in a range of activities.

A system to manage and respond to complaints was in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

People's views on the service were sought and systems were in place to involve them in the running of the service.

A range of audits and checks were undertaken to assess and monitor the quality of the service, however some record keeping was not sufficiently robust.

Weaver Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 4 April 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Prior to the inspection, we contacted the local contracts and safeguarding team who had received no complaints or concerns about this service. Information was also reviewed about this service from notifications received from the provider and the Provider Information Return (PIR).This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we reviewed four people's care records, some in detail and others to check specific elements of care and support, as well as other information regarding the running of the service including policies, procedures, audits and staff files. We spoke with four care staff, the deputy manager and registered manager, the cook and a health care professional, as well as two people who used the service and a relative. Following the inspection we spoke to four further people's relatives over the telephone and three health care professionals.

Good

Is the service safe?

Our findings

People told us they felt safe living in the home. One person said, "I feel safe. I'm very settled." Staff told us they felt people were protected from harm and told us they had no concerns about people's safety. A health care professional also said they felt people were safe at the service. Relatives we spoke with confirmed this, saying, "[Person's name] feels safe;" and, "I think [person's name] is safe."

Safeguarding procedures were in place, which were understood by staff. Safeguarding was discussed as part of team meetings and supervisions to ensure staff were given the opportunity to raise concerns. Senior managers also periodically visited the service and held meetings with staff to discuss any concerns. A whistleblowing hotline was in place where staff could confidentially raise concerns. Where safeguarding incidents had occurred we saw appropriate referrals had been made to the local authority and action had been taken to investigate and help keep people safe.

A system was in place to record and investigate incidents which occurred in the service, for example medication errors, falls and behavioural incidents. We saw appropriate actions were put in place following these incidents demonstrating action was taken to keep people safe. For example, individualised risk assessments were in place to assess and manage risks to people's health and safety, which covered topics such as epilepsy management, eating and drinking and behaviour.

Staff files demonstrated safe recruitment procedures were in place. Candidates completed an application form detailing their previous employment and qualifications. Any gaps in employment were queried by the service. A robust selection process included candidates being invited to face to face interviews. These included a 'meet and greet', where candidates met people who used the service to determine whether they interacted appropriately with them. We saw that checks on people's backgrounds took place including a Disclosure and Barring Service (DBS) check and references. Where any previous cautions or convictions were identified, risk assessments were carried out to determine whether candidates were safe to work with vulnerable people. Staff we spoke with confirmed that when they were recruited the required checks had been undertaken.

Overall, we concluded there were sufficient staff to keep people safe. The registered manager told us they aimed to have seven support workers on duty during the day, but on some recent days they had only managed six. They told us whilst this number was sufficient to keep people safe, seven staff would ensure people had access to a greater range of activities. Staff we spoke to also confirmed this was an accurate reflection of the situation. We saw there were four support worker vacancies currently advertised which when recruited to would allow more consistent staffing levels to be maintained. We observed care and support and saw staff were visible and able to quickly intervene when people became distressed or needed support. We observed staff had time to engage in conversation with people and offer an appropriate level of care and support. Some people had one to one support and we saw arrangements were in place to ensure staff consistently provided this. Agency staff were sometimes used to cover sickness and absences where permanent staff were not available.

We found the premises to be safely managed. Window restrictors were in place to reduce the risk of falls from windows. Appropriate checks were done on systems such as fire, electric, water and gas. Daily and monthly checks of the premises were undertaken to help ensure it was kept in a safe condition. There were a number of communal areas available where people could spend time, including the choice of a large lounge or quieter seated areas. There was also a large enclosed garden area. The home was split into three different units to help provide a more personalised service to people. There was also a separate flat occupied by a person who wanted to be more independent. We identified a number of areas of the building were tired and dated and required updating. However, we saw a programme of refurbishment and replacement of furniture was underway to help modernise the environment.

Assistive technology was being used by the service to help keep people safe. For example sensor mats and door alarms were in place in some people's rooms to alert staff to their movements to help keep them safe. One person had been assessed for bed sensors due to their medical condition. We saw that a 'best interest' meeting had been held to discuss this prior to the referral being made. The service had recently signed up to the 'Telemedicines' system run by a local NHS Trust. This gave immediate access to video consultation from a qualified nurse when needed. Staff we spoke with said they had already made use of the system and felt this enhanced the wellbeing and safety of people in the service.

We found medicines to be safely managed. Medicines were given to people by trained support workers whose competency had been assessed to ensure they had the correct skills and knowledge to administer medicines safely. Systems were in place to order and dispose of medicines. Most people's medicines were supplied in dossette boxes, which are boxes that contain medicines organised into compartments by date and time, to simplify their administration. We saw a system was in place to ensure these medicines were checked by staff before administering.

We looked at medicine administration records (MAR) and saw these were well completed and showed people received their medicines as prescribed. People received their medicines at the times that they needed them. Where people refused medicines this was appropriately documented.

Stocks of medicines were monitored to identify any discrepancies. We counted a random selection of medicines and found on the most part the number of medicines present matched with the stock levels recorded. However, we also checked a random selection of seven 'as required' (PRN) medications and noted two discrepancies that we brought to the attention of the deputy manager for investigation.

Some people received PRN medicines and we saw protocols were in place which detailed when people should receive these types of medicines. This ensured staff offered these in a consistent way. However, we noted that one person's PRN medication had no protocol for administration and the deputy manager agreed that PRN systems needed updating to reflect people's needs.

We saw that some people received their medicines in liquid form and the service was writing the date of opening on the side of the bottle. This meant staff could identify should medicines would pass their safe use by date.

The completion of MAR's for topical medicine records was good, including body maps to ensure staff applied creams in a consistent manner. However, staff were not always writing the date of opening on these which meant there was a risk staff might not able to identify if these had passed their safe use by date. The topical medicines we checked were not out of date; however the deputy manager agreed systems needed to be in place to ensure this was done in future.

We saw that one person was given their medicine 'covertly', in their food. We saw that there was a protocol in place, a 'best interest' meeting had been held to assess the need, and a risk assessment had been completed.

Where medicine errors had occurred we saw these had been recorded and investigated to help prevent a re-occurrence. Periodic medicine audits took place to check the safety of the medicines management system.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of their liberty. The registered manager had submitted DoLS applications for 16 out of the 17 people living in the service. One person living in the home was deemed to have capacity, and an application had not been made for them, showing good understanding of the process. Our scrutiny of people's care records demonstrated that all relevant documentation had been completed. No DoLS authorisations were currently in place with all applications awaiting assessment by the local authority. One person had previously had a DoLS in place, but it had now expired. The service had applied for a renewal within appropriate timescales but this had not been assessed by the local authority in a timely manner. The registered manager demonstrated a good understanding of the safe application of DoLS which gave us assurance that the correct processes would continue to be followed.

Where people lacked capacity to make decisions we saw their capacity had been assessed and the best interest process followed, demonstrating the service was working with the legal framework of the MCA. We saw examples of this around many elements of people's care and support, and when decisions needed to be made, such as around medical treatment. Where people did not have representatives, they had been supported to access advocacy services. Details of these services were also on display around the premises.

Staff we spoke with told us they felt well supported by management in their role. A staff member said, "I get a lot of job satisfaction." Comprehensive face to face induction training was provided. This covered core mandatory subjects including manual handling and safeguarding. New staff without previous care experience were supported to complete the Care Certificate. The Care Certificate provides a standardised level of induction training for staff new to care work. New staff were also required to shadow experienced staff and received a local induction to service policies and procedures.

We looked at the provider's training records. These showed people received regular training updates in subjects such person centred care, positive behaviours, and medication. Mandatory training was generally up-to-date in the required subjects; however a number of staff had not received training in the Mental Capacity Act. The registered manager assured us there was a plan in place to address this.

A programme of role based competency assessments had recently been introduced by the provider to ensure staff competency in a range of key subjects was completed over the course of 2016. This had begun

to be implemented with a number of staff receiving competency assessments in support planning, Mental Capacity Act and DoLS. Where any gaps in staff knowledge were identified, plans to address these were in place.

Staff received periodic supervisions and appraisals as part of a system to review staff performance, their objectives and developmental needs. Some of these were overdue. However we saw a plan was in place to address this by the management team.

Staff received training in positive behaviour support which assisted them to manage people's anxieties. We spoke with staff about how they reduced distress experienced by specific individuals. Their answers demonstrated a good understanding of how to reduce anxiety and distress as part of a positive behavioural support strategy. We saw the training results reflected in observed interactions.

Overall, communication was good between staff, people, visitors and other healthcare professionals. A healthcare professional told us, "Staff are approachable." They said staff communicated well, for instance telling them if a person's dressing had been redone by staff, or telling them about any concerns about people. However, some relatives told us day to day communication could be improved, since messages didn't always get through, including information about medical appointments. We saw that people had access to a wide range of health care services including dentist, GPs, district nurses and Occupational Therapists. Medical information was updated in a separate medical file for each person.

We observed people enjoying the food that was provided at lunchtime and choice was offered with a varied menu, using fresh ingredients where possible. One person said, "Food is delicious." A variety of drinks and snacks were offered at mealtimes and other times during the day. People were encouraged to eat without assistance wherever possible and staff sat down to eat with people to support and encourage them with their meals. We spoke to the cook who had a good understanding of people's dietary needs and was able to say which people were on specific diets and why. This provided us with assurance that people were provided with a diet that met their individual needs.

We saw the menu was displayed in the dining room and the cook told us this was on a three week cycle, with people's preferences sought when menu planning. This showed people were being supported to have sufficient to eat, drink and maintain a balanced diet. However, one person's relative we spoke with felt they would like to see a greater emphasis on a healthier option being encouraged, since they expressed concern about the person's weight gain. Staff told us that the Speech and Language Therapy (SALT) team were involved with the service for those who had difficulty in swallowing. Some staff had received SALT training in order to become 'champions' within the home.

Good

Is the service caring?

Our findings

The atmosphere in the service was friendly and relaxed. One person told us, "Staff treat me well. They're always smiling and happy." A relative commented, "Fantastic. We think we're very lucky to have Weaver Court. There's such a nice atmosphere there. The staff are so caring and enthusiastic." Another relative commented, "[Person's name] doesn't get upset when we take [person] back. [Person's name] is quite happy." One relative we spoke with told us staff treated people well. However, they said whilst there was a core group of staff who knew their relative well, there were quite a few new staff members who were not as familiar with them.

People and staff appeared to have good relationships and staff were aware of people's needs and how to respond to these needs. For instance, we observed one person's distressed behaviour. Staff told us that they understood the best way to calm the person's anxieties at that time was to give them some space. This was also documented in the care plan. We saw the person become calmer after a period of time, which showed us that staff understood individual needs and issues and altered their approach accordingly.

We observed care and support and saw people were treated with a high level of dignity and respect from staff. We saw staff alleviate people's anxieties well and provide them with a high level of interaction and companionship. We saw staff using non-verbal communication techniques to interact positively with people. We saw staff reading to people and supporting people to listen to music which met their individual preferences. We observed that staff were particularly supportive and sensitive to people who were receiving 'end of life' care.

Dignity and respect shown to people by staff was monitored through observational audits and also discussed at supervisions and appraisals. This showed the service understood the need to treat people that use the service with a high level of dignity and respect.

Staff demonstrated a high level of understanding of the people they were caring for including likes, dislikes and personal preferences. For example, one staff member was able to tell us in detail how a person liked their breakfast preparing including how they liked their toast. Care files contained a high level of personalised information about people and their histories, which demonstrated staff at the service had taken the time to understand the person.

Birthdays were made a special event for people. The service planned bespoke events in conjunction with people and their relative's dependant on their individual preferences. We saw pictures of one recent event which showed the person enjoying celebrations with relatives, staff and other people that used the service.

The provider ran a 'People's Parliament' which aimed to assist people to express their views and increase independence. This was through attendance at monthly meetings, where they were involved in making decisions about care and support and campaigning for better rights for people with learning disabilities. The Registered Manager told us one person from Weaver Court had recently expressed an interest in this and they had been supported to attend their first meeting the previous month.

Communication needs were assessed through care planning and detailed plans of care put in place. These detailed the aids people used to help communicate effectively. Some people used sign language such as Makaton to communicate. We spoke with one relative who told us they thought staff could improve the way they used non-verbal communication to communicate with their relative. We saw some staff had received training in Makaton but others had not. The registered manager told us they were planning additional training for these staff and one staff member was enrolled on a British Sign Language Course.

Care and support plans focused on increasing people's independence and this was also achieved through the setting of goals. A person's relative told us that staff had worked hard to support them gradually make a move from downstairs to greater independence upstairs. Several small kitchenettes had been installed in the service to help increase people's involvement in preparing drinks and meals. Further work was planned, for example the installation of a cooker upstairs. A relative told us they felt the service was making positive improvements to encourage independence. They told us, "[Name of person] can shop for cakes mixes and bake in the upstairs kitchen."

The registered manager told us the provider had set up an 'assistive technology' group to look at how this could be used to improve people's lives and increase their independence. A staff member from the service attended this group. The registered manager told us this would allow this staff member to become 'a champion' for the promotion of this technology to help improve people's independence.

We saw evidence staff listened to people, for example consulting them over what they wanted to watch on the television and changing to a channel the person was happier with. They then carefully watched the person's reaction to determine whether it met their preferences. Staff told us people were encouraged to choose if and where they wanted to go on holiday and some people had already chosen their holiday destinations, which was confirmed by one person we spoke with.

Good

Is the service responsive?

Our findings

Care plans contained highly personalised information, for example how many pieces people wanted their sandwiches cut into. Staff we spoke with were familiar with people's needs and understood their plans of care.

We saw that people's needs were well assessed and staff understood these, although in a number of cases we saw assessments and care plans needed updating. A staff member we spoke with was aware of the need to update and had a plan in place to ensure this was completed.

The registered manager was able to give us examples of how people had developed as individuals, for example increasing their confidence and becoming more independent.

Monthly reviews of wellbeing took place, focussing on people's care and support, evaluating the different areas and what went well. These helped provide changes to people's care and support options as part of a plan of responsive care. We did note that some annual reviews with families were overdue and some relatives told us they didn't feel as included as they would like. The registered manager had identified this and had a plan in place to address this.

We saw some very positive examples of how the service had involved people in how the service was managed. For example the provider had recently changed furniture and curtains within the main lounge area. Each person had been supported to express their preferences with regards to the colour of the curtains and sofas. This had included using large picture boards to aid in the decision making process.

Some documentation such as service user meeting minutes, the complaints and safeguarding procedure and advocacy contact details had been translated into easy read format to promote involvement and understanding with people that used the service.

An involvement charter was in place setting out a strategy for involving people in the service. This included promoting decision making, communication, dreams and aspirations. All staff within the service had signed up to this. However the manager told us further work was required on this as they were unable to demonstrate how this tool had been used in practical terms to further enhance people's involvement in the service.

Activity records were present within care records and were individualised. We looked at these which demonstrated people had access to a range of activities, for example bowling, games and trips out. These showed links were maintained with the community, with people being supported to access local shops, restaurants and attend day centres. We saw that the service had a minibus which was used throughout the day to facilitate people's activities. However a relative we spoke to commented "We would like them to try to get [service user name] to do more."

Staff told us the service held regular themed activities, such as a 'Bollywood' themed evening, with Indian

cuisine, music and room decoration, and an Easter coffee morning, to which people and their relatives and friends had been invited.

A process was in place to bring the complaints system to the attention of people, through easy read signage throughout the premises and details within the service user guide. We spoke with one relative who had put in a recent complaint. They said they had confidence the manager would follow up and manage the complaint appropriately. Other relatives told us that they felt able to discuss any complaints or concerns with the manager. Complaints records showed a low number of complaints. We saw two had been recently received and were both currently being investigated. A number of compliments were recorded, from both external health professionals and family members, demonstrating the areas where the service exceeded expectations.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place. Statutory notifications had been reported to the Commission, for example allegations of abuse. This allowed us to monitor events occurring within the service.

We identified some issues with documentation, although we did not identify any impact on people. For example one person's file showed they had not been weighed since July 2015 despite records showing it should be monthly. We identified although they had been weighed in the community, records of this had not been placed within the care file. Service user meetings minutes also required to be documented more robustly. We saw people had goals in place within their care files which were well understood by staff. However documentation evidencing these goals was often poorly completed which made it difficult to track whether people were achieving their goals over time. We saw a number of people's assessments and care plans needed updating, and topical medicines and PRN systems needed to be more robust.

We observed a pleasant atmosphere within the home with all levels of staff engaging with people who used the service. Relatives we spoke with praised management and said they felt they could raise issues with them, although some said they would like to more contact with them. Staff we spoke with said the home was well run and they felt they could go to the registered manager with any issues. One staff member told us they felt well supported and said, "I think the management are brilliant. Everyone is listened to."

Systems were in place to assess and monitor the quality of the service. For example premises audits were undertaken each day of the week, each with a slightly different focus, and periodic infection control audits were undertaken. Audits of medication stock levels and the medicines management system were also undertaken to help ensure medicines were managed in a safe way. A full staff file audit was completed in December 2015. The registered manager also undertook spot audits during the evening and overnight to ensure people were being treated well and engaged in a range of appropriate activities by staff. We saw the provider carried out a safety audit in October 2015 when the service was rated as compliant, and carried out other quality audits periodically. We saw, following the audits, appropriate actions were in place to ensure continuous improvement of the service.

An overarching annual audit was also undertaken by the registered manager which looked at the five CQC domains. This was submitted to the provider's head office. Following the 2015 audit we saw evidence improvements had been actioned. An audit of the safety of the building was also undertaken by the registered manager.

A programme of staff observation was in place, for example observing the mealtimes support provided to ensure it was carried out in line with the risk assessments. Where issues were identified these were addressed with the staff concerned.

These audits and observations provided us with assurance that any future deficiencies in the service would be identified and rectified promptly by the provider.

Staff told us periodic staff meetings were held. We looked at records and found evidence of some staff meeting minutes from August 2015 and before. There were no recent minutes available at the time of inspection. However, following the inspection, the provider sent us further meeting minutes up to March 2016 which showed evidence regular meetings were held and quality issues discussed.

Appropriate measures were in place to involve people in the running of the service. For example there was a strong focus on involving people in choosing the menu and the decoration of the home. Service user meetings were held which were an opportunity to discuss activities, staffing and any upcoming events. One relative we spoke with told us periodic parent /carer meetings were also held and the service kept them involved in anything which occurred within the service. However, other relatives told us day to day communication could be improved and they weren't always kept informed about things such as medical appointments. Relatives we spoke to were concerned about the future of the service and felt they would like to be kept more informed about developments. The service had recently sent out annual quality surveys to people who used the service, providing another example of how the service was seeking people's views. However a poor response had been received, with only a few questionnaires returned.