Emas Limited

Sapling

Inspection report

372 Chessington Road
Epsom
Surrey
KT19 9EG

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13 September 2016

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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

Sapling provides a care home service without nursing to up to four older people with physical and learning disabilities; some are also living with the experience of dementia. The service is situated on the outskirts of Epsom, Surrey. At the time of our inspection three people lived here.

The house has one floor, with easy wheelchair access to the private garden with a patio at the rear of the property. People's bedrooms are single occupancy. Communal space consists of a lounge area and a conservatory.

The home was well decorated and adapted to meet people's needs. Flooring was smooth and uncluttered to aid people's mobility needs. The home had a homely feel and reflected the interests and lives of the people who lived there. There was positive feedback about the home and caring nature of staff from people who live here, and their relatives.

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

The inspection took place on 13 September 2016 and was unannounced.

People were safe at Sapling. There were sufficient staff deployed to meet the needs and preferences of the people that lived there. Staffing levels changed to reflect the support needs of people, such as when they had to receive one to one support to attend appointments.

Risks of harm to people had been identified and clear plans and guidelines were in place to minimise these risks, without restricting people's freedom. Staff understood their duty should they suspect abuse was taking place, including the agencies that needed to be notified, such as the local authority safeguarding team or the police.

The provider had carried out appropriate recruitment checks to ensure staff were suitable to support people in the home. Staff received an induction and ongoing training, tailored to the needs of the people they supported.

People received their medicines when they needed them. Staff managed the medicines in a safe way and were trained in the safe administration of medicines.

In the event of an emergency people would be protected because there were clear procedures in place to evacuate the building. Staff understood the support that each person would need to get safely out of the building in an emergency. An alternative location for people to stay was also identified in case the home

could not be used for a time.

People's rights under the Mental Capacity Act (2005) (MCA) were met. Where people could not make decisions for themselves best interest decisions were made on their behalf. Assessments of people's ability to make specific decisions had been completed before these decisions had been made. Staff asked people for their permission before they provided care.

The staff had an understanding of the requirements of the Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted applications in accordance with the MCA, due to the fact that some people were under constant supervision, and could not leave the home if they wanted to.

People had enough to eat and drink, and received support from staff where a need had been identified. Staff had a good understanding of specialist diets that people were on to ensure people could eat and drink safely, and still enjoy their meals.

People were supported to maintain good health as they had access to relevant healthcare professionals when they needed them. When people's health deteriorated staff responded quickly to help people and made sure they received appropriate treatment. People's health had improved due to the care and support staff gave, such as a decrease in epileptic seizures.

The staff were kind and caring and treated people with dignity and respect. Good interactions were seen throughout the day of our inspection. Staff took time to talk with people and encourage them to take part in activities. People looked relaxed and happy with the staff. People could have visitors from family and friends whenever they wanted.

Care plans were based around the individual preferences of people as well as their medical needs. They gave a good level of detail for staff to reference if they needed to know what support was required. Care plans had clear pictures and text to enable to staff to understand and know the people they cared for. People received the care and support as detailed in their care plans. Details such as favourite foods in the care plans matched with what we saw on the day of our inspection, and with what people told us.

People had access to activities that met their needs. Activities were based on people's interests, but also their medical needs or abilities. People who lived with dementia had activities to meet their needs, such as gentle exercise to maintain mobility, while other people took part in games or went for trips out shopping or to day centres. The staff knew the people they cared for as individuals, and had supported them for many years.

People knew how to make a complaint. The policy was in an easy to read format to help people and relatives know how to make a complaint if they wished. No complaints had been received since our last inspection. Staff knew how to respond to a complaint should one be received.

Quality assurance records were kept up to date to show that the provider had checked on important aspects of the management of the home. Records for checks on health and safety, infection control, and internal medicines audits were all up to date. This was a small family owned business so the provider (who was also the registered manager) was regularly working at the home to give people and staff an opportunity to talk to them, and to ensure a good standard of care was being provided to people.

People had the opportunity to be involved in how the home was managed. Surveys were completed and the feedback was reviewed, and used to improve the home.

People lived in a caring and well-managed and happy home. A relative said, "I think this is the best place for meeting my family member's needs. I don't think he could get any better care than he receives here."

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 felt safe living at the home. Appropriate checks were completed to ensure staff were safe to work at the home. There were enough staff to meet the needs of the people.

Staff understood their responsibilities around protecting people from harm.

The provider had identified risks to people's health and safety with them, and put guidelines for staff in place to minimise the risk.

People's medicines were managed in a safe way, and they had their medicines when they needed them.

Is the service effective?

Good

The service was effective

The requirements of the Mental Capacity Act were met. Assessments of people's capacity to understand decisions had been recorded in line with the Act. Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were met.

Staff said they felt supported by the manager, and had access to training to enable them to support the people that lived there.

People had enough to eat and drink and had specialist diets where a need had been identified.

People had good access to health care professionals for routine check-ups, or if they felt unwell. People's health had improved as a result of the care and support they received.

Is the service caring?

Good

The service was caring.

Staff were caring and friendly. We saw good interactions by staff

that showed respect and care.

Staff knew the people they cared for as individuals. Communication was good as staff were able to understand the people they supported.

People could have visits from friends and family, or go and visit them, whenever they wanted.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and gave detail about the support needs of people.

People had access to a range of activities that matched their interests. People had good access to the local community.

There was a clear complaints procedure in place. Staff understood their responsibilities should a complaint be received.

Is the service well-led?

Good

The service was well- led.

The registered manager had a clear set of values of the home, and staff provided care and support in a manner that met those values.

People and staff were involved in improving the service. Feedback was sought from people via an annual survey.

Staff felt supported and able to discuss any issues with the manager. The provider (who was also the registered manager) regularly spoke to people and staff to make sure they were happy.

The manager understood their responsibilities with regards to the regulations, such as when to send in notifications.

Quality assurance records were up to date and used to improve the service.

Sapling

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 13 September 2016 and was unannounced.

Due to the small size of this home the inspection team consisted of one inspector who was experienced in care and support for people with learning disabilities.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The provider had completed a 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. This information was reviewed to see if we would need to focus on any particular areas at the home.

We spoke with two people who lived at the home, two relatives and three staff which included the registered manager (who was also the provider). We also contacted the GP and commissioners of the service for their feedback. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. After the inspection we contacted two relatives and an advocate by telephone to ask for their feedback about the home. We observed how staff cared for people. We also reviewed care and other records within the home. These included four care plans and associated records, four medicine administration records, two staff recruitment files, and the records of quality assurance checks carried out by the staff.

At our previous inspection in October 2013 we had not identified any concerns at the home.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Sapling. One person said, "I'm happy here. Staff are good to me." A Relative said, "I think it is safe at Sapling, the staff are very good with the security of the home."

People were protected from the risk of abuse. Staff had a clear understanding of their responsibilities in relation to safeguarding people. Guidance on how to react if abuse was suspected was clearly displayed in the lounge area so could be viewed by people, staff and visitors. Staff were able to describe the signs that abuse may be taking place, such as bruising or a change in a person's behaviour. Staff understood that a referral to an agency, such as the local Adult Services Safeguarding Team or police should be made. Staff knew about whistleblowing and felt confident they would be supported by the provider if they felt the need to raise any concerns.

There were sufficient staffing levels deployed to keep people safe and support the health and welfare needs of people living at the home. A relative said, "There are enough staff to support our family member with their needs and interests." Staff said that they felt there were enough staff for them to support people and meet people's needs. However if another person came to stay they felt more staff would be needed. The registered manager confirmed this, and explained how the number of staff that were required were based on the support needs of the people that currently lived here. Staffing rotas for the last four weeks demonstrated that the number of staff on duty matched with the numbers specified by the registered manager. Our observations on the day showed that staff had the time to spend with people, both to meet their support needs, but to also engage in activities with them. People did not have to wait to receive care and support.

Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that they were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Accidents and incidents were reviewed to minimise the risk of them happening again. A record of accidents and incidents was kept and the information reviewed by the registered manager to look for patterns that may suggest a person's support needs had changed. Records of accidents reviewed during the inspection did not highlight any issues with regards to people's safe care and support.

Risks to people had been assessed. Assessments had been carried out in areas such as mobility, choking, falls and behaviour management. People were involved in managing the risks to themselves and others where ever possible. One person displayed a behaviour involving paper. The risk assessment had been signed by them, as had the reviews, and records of the incidents where it had happened.

Measures had been put in place to reduce these risks, such as clear guidelines for staff on reducing risks of choking, injury from falls, and self-harming behaviour. Risk assessments had been regularly reviewed to ensure that they continued to reflect people's needs. Support given by staff was seen to match the

guidelines given, such as reminding people to eat slowly when they ate, or using protective attire when they walked around the home.

People were cared for in a clean and safe environment. A relative said, "The home is always so clean and tidy." The home was well maintained. The risk of trips and falls was reduced as flooring was in good condition. Assessments had been completed to identify and manage any risks of harm to people around the home. Areas covered included infection control, and fire safety. Staff understood their responsibilities around keeping a safe environment for people. Fire safety equipment and alarms were regularly checked to ensure they would activate and be effective in the event of a fire.

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, were clearly displayed around the home. People's individual support needs in the event of an emergency had been identified and were known by staff. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely. There was also a continuity plan in place to ensure people would be cared for if the home could not be used after an emergency.

People's medicines were managed and given safely. Staff that administered medicines to people received appropriate training, which was regularly updated. Staff who supported people with medicines were able to describe what the medicine was for to ensure people were safe when taking it. For 'as required' medicine, such as paracetamol, and 'homely remedies (medicines that you can buy from a chemist without a prescription) there are guidelines in place from the GP which told staff when and how to administer the medicine in a safe way. These guidelines had been reviewed regularly with the GP to ensure they were still relevant and safe to the people who live here.

The ordering, storage, recording and disposal of medicines were safe and well managed. There were no gaps in the medicine administration records (MARs) so it was clear when people had been given their medicines. Medicines were stored in locked cabinets to keep them safe when not in use. Medicines were labelled with directions for use and contained both the expiry date and the date of opening, so that staff would know they were safe to use.

Good

Is the service effective?

Our findings

People were supported by trained staff that had sufficient knowledge and skills to enable them to care for people. A person said, "Staff are good at giving me the support I need." A relative said, "Staff know what they are doing, The manager is very knowledgeable about people and their needs."

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.

At Sapling people had varying capacity to make decisions for themselves. They were not able to go out on their own if they wished, because they may not understand the dangers, such as traffic and the harm that could come to them. We checked whether the home was working within the principles of the MCA. Staff received Mental Capacity Act training and were able to explain what consent to care meant in practice. Mental capacity assessments had been carried out for individual people when appropriate, to ensure they were involved in decision making as much as possible. Where a person was unable to understand a decision, and a best interest decision had taken place, this had been clearly recorded in line with the Act. Staff asked for people's consent before giving care and support throughout the inspection.

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 are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had completed applications for people whose freedom was restricted, or who were under constant supervision, as required under DoLS. The restrictions in place seen during the inspection, matched with those listed on the DoLS application.

Staff had training to undertake their roles and responsibilities to care and support people. The induction process for new staff was robust to ensure they would have the skills to support people effectively. When staff had started at the home their induction had been based on the common induction standard (Which has now been replaced by the Care Certificate). This set out all the things that a worker should know to enable them to do their job safely and effectively. The induction also included shadowing more experienced staff to find out about the people that they cared for and safe working practices. Ongoing training and refresher training was well managed, and the registered manager ensured staff kept up to date with current best practice, such as supporting people who live with dementia, and epilepsy awareness.

Staff were effectively supported. Staff had regular one to one meetings (sometimes called supervisions) with the manager, as well as group team meetings. This enabled them to discuss any training needs and get feedback about how well they were doing their job and supporting people. Staff told us they could approach management anytime with concerns, and that they would be listened to and the management would take action.

People had enough to eat and drink to keep them healthy. Lunch was observed to be a positive experience, with people given plenty of time and support by staff. Staff had friendly interaction with people during the meal and made it a positive experience for everyone involved.

Individual preferences and choices were reflected in the food that people ate. People had a varied menus and were able to have different meals from those around them if they wished. For example during one meal, two people had fish pie and vegetables, while the third person had chicken and bacon tortellini. Both meals had been cooked fresh on the day by staff.

People's special dietary needs were met. People's preferences for food were identified in their support plans. Where a specific need had been identified, such as food presented in a particular way to aid swallowing this was done. Staff were able to tell us about people's diets and preferences. Menu plans, and food stored in the kitchen matched with people's preferences and dietary needs and showed they had the food they enjoyed. People were protected from poor nutrition as they were regularly assessed and monitored by staff to ensure they were eating and drinking enough to stay healthy.

People received support to keep them healthy. Each person had a health action plan in place. This detailed when they had check-ups, and how often these should be done. Where people's health had changed, such as changes in swallowing, or epileptic seizures appropriate referrals were made to specialists. This helped them get better or enabled staff to give effective care to meet the newly identified need. People's health had improved due to the effective care given by staff, for example overcoming colds and flu, or a decrease in epileptic seizures due to the care and support given.

Good

Is the service caring?

Our findings

We had positive feedback about the caring nature of the staff. One person said, "The staff are okay, they listen to me." Another person smiled and nodded when we asked if staff were nice to them. A relative said, "The staff are all so nice and caring." Staff were focussed on caring for people. A staff member said, "We are a family here."

The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. People looked well cared for, with clean clothes, tidy hair and appropriately dressed for the activities they were doing.

Staff were very caring and attentive with people. They knew the people they looked after and involved them in making decisions about their life. A relative said, "They know us and our family member." Throughout our inspection staff had positive, warm and professional interactions with people. The staff talked to people, asking their opinions and involving them in what was happening around the home.

Staff communicated effectively with people. People were given information about their care and support in a manner they could understand. This included people who could no longer verbally communicate. Staff would sit by the person and touch their hand while speaking, so the person knew it was them the staff were addressing. The staff looked at the person's eyes, face and body movements to understand the person's responses. The responses given matched with those recorded in the person's care plan for how they communicated.

When providing support staff checked with the person to see if that was what they wanted. Staff spoke to people in a manner and pace which was appropriate to their levels of understanding and communication needs. Information was available to people around the home. It covered areas such as local events that people may be interested in.

Staff were knowledgeable about people and their past histories. Care records recorded personal histories, likes and dislikes. Throughout the inspection it was evident the staff knew the people they supported well. Staff were able to tell us about people's hobbies and interests, as well as their family life. Their knowledge covered people's past histories, down to a person's favourite food. The information staff shared with us, was confirmed as correct when we spoke with the people who lived here, and their relatives.

Staff treated people with dignity and respect. Staff were very caring and attentive throughout the inspection, and involved people in their support. When giving personal care staff ensured doors and curtains were closed to protect the person's dignity and privacy. Staff also understood that some people who needed support to use the toilet preferred to do this alone. They respected this by supporting the people into the toilet, and then left them to respect their privacy and dignity.

People's rooms were personalised which made it individual to the person that lived there. Family pictures, posters of favourite films and Hollywood film stars reflected people's interests. People's needs with respect

to their religion or cultural beliefs were met. Staff understood those needs and people had access to services in the community so they could practice their faith. People told us they could have relatives visit when they wanted, or go out with them on trips and meals out. Staff made sure people had the maximum amount of time with relatives when they came to take them out. A relative said, "Our family member is always ready for us when we arrive to take them out." Another relative said, "They always arrange the transport so it is ready for us when we visit."

Good

Is the service responsive?

Our findings

People's needs had been assessed before they moved into the service to ensure that their needs could be met. This enabled staff to get to know people and give a good standard of care that was responsive to people's needs. Assessments contained detailed information about people's care and support needs. Areas covered included eating and drinking, sight, hearing, speech, communication, and their mobility.

People were involved in their care and support planning, as much as possible. Care plans were based on what people wanted from their care and support. They were written with the person by the registered manager or key worker. Family members, health or social care professionals were also involved to ensure that the person's choices and support were covered for all aspects of their life. Reviews of the care plans were completed regularly with people so they reflected the person's current support needs. A relative confirmed they were kept up to date and involved in their family members care, "He has a care plan, and they talk to us about things when we visit." They went on to say, "They take relatives views into consideration, but listen to my family member as well."

People's choices and preferences were documented and were met. Person centred care plans contained pictures and photos to detail information concerning people's likes and dislikes and the care they needed. The files were well organised so information about people and their support needs were easy to find, and read. The files gave a clear and detailed overview of the person, their life, preferences and support needs. Care plans were comprehensive and were focused on the individual needs of people. People received support that matched with the preferences recorded in their care file, for example being supported to do activities they enjoyed, or helping them to have food and drink in a consistency to reduce the risk of choking.

Care plans addressed areas such as how people communicated, and what staff needed to know to communicate with them. Other areas covered included keeping safe in the environment, personal care, mobility support needs, behaviour and emotional needs. The information matched with that recorded in the initial assessments, giving staff the information to be able to care for people. There was also a section that gave very specific important information about people's support needs. This would go with them if they needed to be admitted to hospital so that hospital staff would have clear guidance on the person's preferences and choices, and how they liked to be supported.

People had access to a range of activities, based on their interests and abilities. Each person had an activities plan in place, that gave guidance and suggestions for activities they may like to take part in. These included art and crafts, gentle exercise, bike exercise, ball games, music sessions, and helping around the house with chores. People were also able to take part in activities outside the house, such as going to day centres, meals out, and trips to the pub. No one was left for long periods of time without some form of positive interaction from the staff during our inspection. The registered manager also responded to help people if external activities were cancelled by outside agencies, to ensure this did not happen regularly, or if the person needed additional support to attend. During our inspection everyone went out for lunch, and to enjoy the warm weather.

People were supported by staff that listened to and would respond to complaints or comments. All the people we spoke with said they had never had to make a formal complaint. One person said, "I could complain if I wanted. Staff would listen to me."

There was a complaints policy in place. It was on display in the lounge area, so people and visitors could see it. The policy included clear guidelines, in an easy to read format, on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission. Staff had a clear understanding of the complaints procedure and understood that they had a duty of care to report any complaints to the registered manager so they could put things right. There had been no complaints received at the home since our last visit.

Good

Is the service well-led?

Our findings

There was a positive culture within the home between the people that lived here, the staff and the registered manager. When we arrived at the home, the staff ensured that we were introduced to the three people who were at home; because they understood it was the people's home, and not just a place they stayed to get support. A relative said, "The manager and staff are all very nice." Another relative said, "The home has a friendly feel, the staff are always upbeat and the manager is approachable and we are able to talk to him."

The registered manager was clear on the values of the home – that they provided a home for life for people, and to ensure people lived in a positive and caring environment. Staff understood these values, and they were confirmed by the people and relatives we spoke with. The values were displayed by staff during our inspection, as they were all friendly, caring and attentive to the people they supported.

People lived in a home where the owners constantly checked if a good standard of care was given. It was a small family run business and the registered manager (who was also the provider) had a hands on approach to care and support, and was in the home on a daily basis. They were in constant contact with the people and the staff, so could see that people's support needs were met by staff in a safe environment. This made the registered manager accessible to people and staff, and enabled him to observe care and practice to ensure it met the provider's standards. The registered manager had a good rapport with people and knew them as individuals.

Regular checks on the quality of service provision took place and results were actioned to improve the standard of care people received. Audits were completed on all aspects of the home. These covered areas such as infection control, health and safety, and medicines. The audits generated improvement plans, if needed, which recorded the action needed, by whom and by when.

People were included in how the service was managed. A relative said, "The manager and his deputy always check that we are happy when we visit. People had access to regular house meetings where they could discuss items they would like to buy, any issues they wanted to raise, and what activities they would like to take part in. Minutes of the meetings showed that people had the opportunity to raise any concerns. They were encouraged to tell the staff what needed to be done around the house, or in relation to their care and support needs. The registered manager also ensured that various groups of people were consulted for feedback to see if the service had met people's needs. These included local healthcare professionals, and commissioners of the service. This was done annually by the use of a questionnaire. All the responses from the last survey were positive about the home and staff. People and their families were involved in these questionnaires, which covered all aspects of care and support provided at the home.

Staff felt supported and able to raise any concerns with the registered manager, and the provider. Staff understood what whistle blowing was and that any concerns needed to be reported. They knew how to raise concerns they may have about their colleague's practices. Staff told us they had not needed to do this, but felt confident to do so. Staff were involved in how the service was run and improving it. Staff meetings discussed any issues or updates that might have been received to improve care practice.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken. The information that the manager provided on the Provider Information Report (PIR) matched with what we found and saw on the day of our inspection.

Records management was good and showed the home and staff practice was regularly checked to ensure it was of a good standard.