Somerset County Council (LD Services)

The Old Vicarage

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 11 May 2015 and was unannounced.

The service provides accommodation and support for up to eight adults with a learning disability or autistic spectrum disorder. At the time of the inspection there were six people living in the home with complex care and communication needs. People had profound learning disabilities and many had physical disabilities including mobility needs and sensory impairments. None of the people were able to engage in conversations and they had little or no verbal communication skills. People required staff support with all of their personal care needs and to go out into the community.

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

Summary of findings

As we were unable to communicate verbally with people, we relied on our observations of care and our conversations with people's relatives and staff to understand their experiences.

People received care and support in line with their individual care and support plans. They appeared to be very happy and at ease with the staff who were supporting them. We observed people regularly responded to staff approaches with smiles and happy facial expressions. Relatives were very happy with the care provided and felt this had greatly enhanced people's quality of life. One person's relative wrote "Words cannot express how pleased we are to see how well (their relative) is being cared for. We are so very thankful for the love and individualised care they receive". Another person's relative told us "They have a splendid team and the manager is very approachable".

People's relatives said they were always made welcome and were encouraged to visit the home as often as they were able to. They said the service was good at keeping them informed and involving them in decisions about their relatives care.

Individualised communication profiles were available to help staff understand the non-verbal ways in which people expressed their preferences. This included noise vocalisations, facial expressions, body language and physical gestures. We observed staff checked with people before providing care or support and then acted on people's choices. Where people lacked the mental capacity to make certain decisions about their care and welfare the service knew how to protect people's rights.

There were enough staff to meet people's complex needs and to care for them safely. People were protected from the risk of abuse and avoidable harm through appropriate policies, procedures and staff training. Staff received relevant training to effectively support each person's mental and physical health needs. Staff said they all pulled together as a supportive team and the management were very approachable and supportive.

People participated in a variety of social activities within the home and in the community. The service had good local links to promote people's involvement in the community and to encourage the general community to value and involve people with disabilities.

People were supported to maintain good health. People had regular health checks and the service received good support from a wide range of healthcare professionals. Local health professionals visited the home when this was requested. Staff from the service supported people to attend hospital and community appointments when needed.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were protected from abuse and avoidable harm.

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

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

Good

Is the service effective?
The service was effective.

People with profound learning and physical disabilities were supported to live their lives in ways that enabled them to have an improved quality of life.

People received effective care and support from staff trained in providing care for people with complex communication and support needs. People were supported to access specialist healthcare professionals when needed.

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

Good

Is the service caring?
The service was caring.

People were treated with kindness, dignity and respect. The staff and management were caring and considerate.

Staff understood each person's non-verbal means of communicating their choices and preferences.

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

Good

Is the service responsive?
The service was responsive.

People and their relatives were involved as much as possible in the assessment and planning of their care.

Each person had a key worker with particular responsibility for ensuring the person's needs and preferences were understood and acted on.

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

Good

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

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

Good

Summary of findings

People were supported by a motivated and dedicated team of management and staff.

The service had good links with the local community. The use of local volunteers helped promote increased social interaction and community involvement.

The provider's quality assurance systems were effective in maintaining and driving service improvements.

The Old Vicarage

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 11 May 2015 and was unannounced. It was carried out by one inspector. Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries and the Provider's 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 the improvements they plan to make. At the last inspection on 29 October 2013 the service was meeting the essential standards of quality and safety and no concerns were identified.

We were unable to have conversations with people who lived in the home due to their language and learning difficulties. We observed how staff supported people and relied on our conversations with people's relatives and the staff to help us understand people's experiences of the service. We spoke with three people's relatives, the registered manager, deputy manager, and six members of care staff. We reviewed six care plans and other records relevant to the running of the home. This included staff recruitment files, training records, medication records, complaint and incident reports and performance monitoring reports.

Good

Is the service safe?

Our findings

We were unable to have conversations with people living in the home due to their lack of language skills associated with their learning disabilities. We relied on our observations of care and our discussions with people's relatives and the staff to help us understand people's experience of the service.

People's relatives told us they did not have any concerns about their relative's safety. One of the relatives said "I have never had any concerns about safety and have never witnessed anyone in the home being ill-treated". People looked happy and relaxed with the staff supporting them. No one appeared anxious or displayed any sign of distress during the inspection. Staff told us they had never had any reason to raise concerns about any of their colleagues.

People were protected from the risk of abuse through appropriate policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff said they were confident that if any concerns were raised with management they would be dealt with to make sure people were protected.

The risks of abuse to people were reduced because there were effective recruitment and selection processes for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and references had been obtained.

Care plans contained risk assessments with measures to ensure people received care safely. Risk assessments covered issues such as support for people when they went into the community, participation in leisure activities and use of equipment to support people. This included equipment for repositioning people with mobility needs to prevent pressure sores from occurring. There were also risk assessments and plans for supporting people when they became anxious or distressed. Staff received training in positive behaviour support to de-escalate such situations and keep people and themselves safe.

Staff received guidance on what to do in emergency situations. Protocols had been agreed with specialists for responding to people who had epileptic seizures. Staff received training in providing the required medicines and when and who to notify if people experienced prolonged seizures. There was an emergency alarm in each person's room to enable staff to call for back up if required. Staff told us if they had concerns about a person's health they would call the emergency ambulance service or speak with the person's GP, as appropriate.

Each person had a personal evacuation plan in case they needed to vacate the home in an emergency. The service also had a crisis plan for ensuring people continued to receive care and support if the home had to be vacated for a longer period.

Records showed the service had relatively few accidents or incidents. The last incident occurred three months ago and related to a minor injury to a member of staff who had been grabbed involuntarily by a person who lived at the home. When an incident happened, details of action taken to keep people safe and prevent future occurrences were recorded. An online electronic incident form was completed for every event and was reviewed and signed off by the registered manager. Their line manager and the provider's health and safety department had access to the electronic incident records for monitoring and review purposes.

Regular health and safety checks were carried out to ensure the physical environment in the home was safe for people to live in. The registered manager carried out a set programme of weekly and monthly health and safety checks. The provider's estates department also carried out periodic health and safety checks, maintenance and repairs. A range of health and safety policies and procedures were in place to help keep people and the staff safe.

There was enough staff to meet people's complex care needs and to keep them safe. We observed staff were available to support people whenever they needed assistance or wanted attention. Relatives and staff told us there had been some recent staff turnover but they all felt the staffing numbers were fine. There was an agreed minimum staffing level to support the six people currently living in the home. This was four care staff on the morning shift and three on the afternoon shift. At night there was one waking night staff and one sleep in staff.

Some of the people received one to one staff support and other staff were brought in when additional assistance was needed. For example, when people were supported to go out on trips or attend appointments in the community.

Good

Is the service safe?

Short notice absences were usually covered by existing staff working additional shifts or through use of external agency staff if needed. The registered manager said the established staff were always very flexible and dedicated to supporting people's needs.

Systems were in place to ensure people received their medicines safely. The registered manager said care staff received medicine administration training and had to be assessed as competent before they were allowed to administer people's medicines. This was confirmed by staff and in the training records. Staff had an annual medicines competency review involving direct observation of one of their drugs rounds and satisfactory completion of a medicines questionnaire.

People's medicines and their medicine administration records (MAR) were kept in a locked drawer within each person's room. Medicines were always administered by two members of staff, one read out the prescription and dose from the MAR sheet and the other gave the medicine to the person. This double check helped ensure the correct medicines were administered.

Good

Is the service effective?

Our findings

People's relatives told us the service was effective in meeting people's needs. They said the staff had a good understanding of their relative's needs and understood their behaviours well. One person's relative said "I am extremely pleased and very happy with (their relative's) care". Another person's relative who told us "They are very good and look after (their relative) very well". We observed people looked relaxed and happy with the staff supporting them.

Staff were knowledgeable about people's individual support needs. We observed they provided care and support in line with people's care plans. Staff told us they received training to ensure they knew how to effectively meet people's learning and physical disability needs. Most of the training was delivered by the provider's training department, either through face to face training or by online learning modules. Outside specialists were brought in where necessary to train staff in particular tasks, such as, percutaneous endoscopic gastronomy (PEG) feeds. This is where a special tube is used to provide liquidised nutrition and fluids for people who are unable to swallow. The local health team also provided training for staff to enable them to support people with certain routine nursing tasks. A member of staff said "The training here is excellent".

Staff told us the provider supported them to take further qualifications such as the diploma in health and social care. The registered manager said new staff received an extremely thorough induction programme and started by shadowing an experienced member of staff. Their competency was assessed over a six month probationary period against written standards of performance. New staff were assigned a designated supervisor and had individual supervision sessions on a six weekly basis. These arrangements helped ensure people received effective care from staff who had the necessary level of knowledge and skill.

Staff said everyone worked well together as a good supportive team and this helped them provide effective care and support. Care practices were discussed at regular one to one supervision sessions and at monthly team meetings with the registered manager. Annual performance and development appraisal meetings also took place. One recently appointed member of staff said "I have been so well supported by colleagues. Everyone is very accommodating and supportive".

Communication profiles were available for each person to enable staff to communicate effectively with people according to their individual needs. Some people were able to say a small number of words but lacked understanding due to their learning disability. Most of the people were unable to speak but communicated through facial expressions, body language, physical gestures or by making other vocalisations. We observed people making choices in ways that suited their individual communication methods. For example, some people showed they preferred a particular choice by smiling or alternatively refused things they did not want.

Where people were unable to make an informed decision the service followed a best interest checklist. Staff received training in the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The service followed the MCA code of practice to protect people's human rights. The MCA provides the legal framework to assess people's capacity to make certain decisions at a certain time.

Deprivation of Liberty Safeguards (DoLS) provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The service had made DoLS applications to the relevant officer in the local authority for each person living in the home. This was needed because people were unable to leave the home without staff support. This showed the service was ready to follow the DoLS requirements. The registered manager said they periodically reviewed restrictive practices with a view to reducing the number and impact of any restrictions on people's freedom and choices.

People had sufficient to eat and drink and received a balanced diet. People with special dietary needs were assessed by a dietician and a speech and language therapist. For example, one person who had difficulty swallowing had their own individual soft diet menu. Another person who was unable to eat or drink orally received nutrition through a special tube known as a PEG feed. Where necessary, people's food and fluid intake was

Good

Is the service effective?

recorded to check they received sufficient nutrition and hydration. People at risk of malnutrition were weighed weekly and received regular nutritional advice from the speech and language therapist.

Staff said they planned menus for the week ahead based on people's known preferences and always included a choice of at least two options. They were happy to change and be flexible to meet people's preferences on the day. We were told they planned to move to individual menus over the next 12 months. We observed the lunch time meal and saw people received good portions and appeared to enjoy their meal. Staff supported people to eat their food at an appropriate pace to avoid the risk of indigestion or choking. No one was rushed during their meal and staff checked to see if people wanted any more to eat or drink before clearing the table. Some people had individual crockery and mugs to help them eat and drink independently whereas others required one to one staff support to eat their meal.

Staff carried out regular health checks to ensure people maintained good health and any changes in their health were detected. The registered manager said the local GPs and district nurses were very supportive and visited whenever requested. Other health professionals provided input and advice as needed. This included specialist nurse advice on epilepsy, skin viability, and PEG feeds as well as speech and language therapy advice. Care plans contained records of hospital and other health care appointments. There were health action plans and hospital passports providing important information to help hospital staff understand people's needs.

Adaptations were made to the premises to support people's needs. The home's entrances, hallway and lift were all suitable for wheelchair access. Upstairs there was a large communal bathroom with assisted bathing equipment and a separate wet room for people who preferred showers. Downstairs there was a sensory/ relaxation room with equipment to stimulate people's senses using lights, sounds, music, and touch. It also contained a large screen and projector for showing people films. The home had a spacious comfortable lounge, large kitchen dining room and a large private garden. People with sufficient mobility were able to access the various parts of the home independently without any restrictions. Others needed staff support due to their disabilities.

Good

Is the service caring?

Our findings

People's relatives told us they were very happy with the way staff cared for their relatives. One person's relative said "The manager and staff are all very polite and caring and (their relative's) key worker is brilliant". We saw a feedback card from another relative who wrote "Words cannot express how pleased we are to see how well (their relative) is being cared for. We are so very thankful for the love and individualised care they receive".

The interactions observed between people and staff were friendly, caring and considerate. Although people had very limited communication and language skills they appeared to understand when staff spoke with them and often responded with smiles or happy noises. People appeared happy and at ease with the staff supporting them.

During the lunch time meal we observed people received the staff's full attention. Staff attempted to interact positively with people on a regular basis and people also initiated some of the interactions with the staff. For example, one person got up from the table and held a member of staff's hand to indicate they wanted to be taken to the toilet. Staff responded immediately and in a friendly and caring manner whenever people wanted their attention. Another person with a PEG feed was brought into the dining room during the meal time. Staff said the person enjoyed the company and they did not want them to feel isolated.

Staff understood people's needs and preferences and engaged with each person in a way that was most appropriate to them. People had little or no verbal communication skills and lacked understanding due to their learning disability. People communicated mainly through physical forms of expression or other vocalisations. The people had lived in the home for many years and staff had become very familiar with their preferences and individual ways of communicating. Staff told us people in the home were unable to relate to the concept of pictures or symbols and could not use these techniques to help them express themselves. This was confirmed in people's care plans.

Each person had a designated key worker with particular responsibility for ensuring the person's needs and preferences were known and respected by all staff. This helped ensure people's daily routines and activities matched their individual choices. People were offered activity 'taster' sessions to see what they enjoyed. The service offered and supported people to access independent advocacy services when further representation or advice was needed on certain important issues.

Staff treated people with dignity and respect. We observed staff spoke to people in a respectful and caring manner. For example, at lunchtime we heard staff asking people if they wanted any more to eat or drink or whether they had had enough. We saw a member of staff discreetly wiping excess food from around one person's mouth. Each person had their own individual bedroom where they could spend time in private if they wished. Some people experienced seizures and had assistive sound technology in their rooms. This meant they could be monitored without staff being present in their room and intruding further on their privacy. When people needed to use the bathroom staff assisted them in a discrete and respectful manner. When personal care was provided this was done in the privacy of people's own rooms and access by other staff was restricted.

Staff respected people's confidentiality. Confidential information about people was kept securely in the office and was only shared with appropriate people on a need to know basis.

People were supported to maintain relationships with their relatives wherever possible, although some people did not have any close relatives. People's relatives were encouraged to visit as often as they were able to. One relative said "I always call in when I am in the area. Last time I visited the home they gave me Sunday lunch". Another relative said "I have visited every month for years. I like to feel I visit everyone in the home not only (their relative). I make a point of saying hello to everyone".

Good

Is the service responsive?

Our findings

People had very limited mental capacity to contribute to the assessment and planning of their care. However, each person had a designated key worker who understood the person's communication needs well and took responsibility for ensuring the person's needs and preferences were understood by all staff. People's relatives were also encouraged and supported to express their views. One relative said "They tick all the boxes as far as I am concerned". Another person's relative said "I'm usually kept informed and have a say in what goes on".

Each person had a personalised care plan based on their individual learning and physical disability needs. Care plans included clear guidance for staff on how to support people's individual needs. As well as detailing people's support needs, care plans identified each person's personal likes and dislikes, daily routines and activity preferences. They also included information on how each person made choices and decisions.

Care plan reviews were undertaken by each person's key worker and plans were updated on a regular basis. Care plans were also audited by the registered manager to ensure they accurately reflected people's current needs. The service was in the process of introducing the new standard format local authority Support for Living Plan covering all aspects of a person's support and care needs. An annual review was planned for each person with the involvement of a close relative or other appropriate representative to assist with making decisions in the person's best interests. At reviews the person's individual support needs, preferences and experiences of the service would be considered. The most important issues to the person at the time of the review would be discussed and key personal outcomes agreed. An action plan would then be prepared to implement each of the agreed outcomes.

Where people or their relatives expressed a preference for support from a particular member of care staff the service tried to accommodate these preferences. For example, one female generally responded better to support when it was provided by female care staff and we saw staff respected this preference. Staff members of the same gender were usually available to assist people with personal care if this was their preference.

People had their own large individualised bedrooms. Each room was furnished and decorated to the person's individual tastes and preferences. For example, one room was decorated and furnished around the theme of the person's favourite football team. Another room contained pictures and models of classic cars which reflected the person's interest. Another person's room had paintings with seaside views.

People were supported to spend time in the community and to participate in a range of activities in line with their personal interests. This included visits to the neighbouring pub, attending local church services, shows, concerts and day trips to places of interest. Activities available within the home included use of a range of sensory equipment, weekly massage and aromatherapy sessions, and a large private garden and summer house for outside activities weather permitting. The service organised garden fetes and regular parties with music played by a local jazz band. People from the provider's other care homes were also invited and in return they organised similar events at their homes. This provided opportunities for people to socialise and make new friends.

People's relatives and the staff told us the registered manager operated an open door policy and was accessible and visible around the home. Relatives were encouraged to feedback any issues or concerns directly to the manager or to any other member of staff. One relative said "If I have any worries about anything I point it out to the manager or the person in charge on the day and they deal with it". People were supported by their key worker or their relatives to express any issues or concerns they appeared to have.

The provider had an appropriate policy and procedure for managing complaints about the service. This included agreed timescales for responding to people's concerns. However, no written complaints had been made about the service in the last 12 months. One relative said "I've never had to make a complaint. I've always been very pleased with the care provided".

Good

Is the service well-led?

Our findings

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. The registered manager told us the service ethos was "To provide as individualised and person centred care as possible". To ensure staff understood and delivered this philosophy, they received training specific to the learning and physical disability needs of the people living in the home. There was a comprehensive induction programme for new staff and continuing training and development for established staff. The philosophy was further reinforced through monthly staff meetings, shift handover meetings and one to one staff supervision sessions. One experienced member of care staff said "This is one of the best homes I have worked in for personal care and the interaction between staff and the service users".

Staff and people's relatives told us the registered manager encouraged an "open door" culture and was very approachable and supportive. Staff said they felt highly motivated and all were dedicated to ensuring people received the best possible care and support. A recently appointed member of staff said "I haven't heard one derogatory comment about staff or the manager since I've worked here. He should be very proud of the way everyone in the team pulls together. I feel very valued and I'm so happy here". A relative of one of the people living in the home said "They have a splendid team and the manager is very good at his job".

Decisions about people's care and support were made by the appropriate staff at the appropriate level. There was a clear staffing structure in place with clear lines of reporting and accountability. The registered manager and deputy supervised the support team leaders and they supervised the support workers. All of the staff we spoke with said they worked well together as a good supportive team. Care plan records showed more specialist support and advice was also sought from external health and social care professionals when needed.

People's relatives and other representatives were able to give their views on the service directly to management and staff and through care plan reviews. One person's relative said they once commented that their relative looked uncomfortable in their wheelchair and the registered manager "pressed ahead and got a new wheelchair measured and moulded to (their relative's) needs". Feedback cards were available for relatives and visitors to comment on the service. Completed cards were returned to the provider's central office and results were collated on a quarterly basis. The results of feedback with any written comments were then fed back to the home. The latest quarterly feedback results showed the service received a high overall satisfaction score of 9.25 out of 10.

The provider had a quality assurance system to check their policies and procedures were implemented and effective. The registered manager carried out a programme of weekly and monthly audits and safety checks. A monthly service review was carried out by the registered manager's line manager (service manager) to check the home's compliance against the provider's learning disability service requirements. Where action was needed this was noted on a service action plan and progress was checked again at the next service review.

The registered manager participated in a number of forums for exchanging information and ideas and fostering best practice. This included attending the council's provider managers meetings, meetings with the safeguarding team and other council departments. The registered manager and staff attended multi-agency meetings, conferences and seminars and accessed a range of online resources and training materials from other service related organisations, including the Care Quality Commission's website. University based learning disability nurses had placements at the home from time to time. This provided an opportunity to share ideas and evaluate current service provision.

People were supported to get involved with the local community. Staff supported people to go out into the community most days of the week. For example, one person was being supported to attend a community event at a neighbouring church on the evening of our inspection. Volunteer students from a local college also visited the home and provided additional social contact and support for people in the home.