J C Care Limited

# Woodhouse Hall

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

This inspection took place on 19 September 2017 and was unannounced. At the last inspection in August 2016 we rated the service as requires improvement. At this inspection we found the required improvements had been made.

Woodhouse hall is registered to provide accommodation and personal care for up to 19 people who have a learning disability and or autism spectrum disorder related conditions. The service is divided into two units and is located in the East Ardsley area of Leeds with good access to transport and local amenities.

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

People told us they felt safe living in the home, and staff were aware of their responsibilities to protect people's health and wellbeing. The property was secure and appropriately decorated, with all relevant maintenance documents and certificates in place.

There were enough staff to deliver care safely, and staff were recruited appropriately. Staff received good support through induction, training and continuous supervision and appraisal. Staff knew how to deal with challenging behaviours appropriately and demonstrated good knowledge of the Mental Capacity Act 2010. All incidents were recorded and investigated as required.

People were supported to access healthcare professionals appropriately and this was clearly documented in people's care records. People were supported with their nutrition and hydration needs and were encouraged to get involved with food preparation.

People were cared for by kind and attentive staff who clearly understood how to communicate with people, and knew and understood their individual needs.
The service promoted people's independence and respected their choices. Staff were trained to recognise and protect people's rights under the Equality Act 2010.

Care plans were written in a person centred way which meant that their care was delivered in accordance with their preferences, interests and diverse needs. People and their relatives were encouraged to get involved with care, and people were supported to maintain relationships with those who mattered to them.

The service had recently appointed a registered manager to the service. Staff told us there was a positive working culture with strong leadership from senior staff. All staff we spoke with recommended the service as a place to work.

There were effective quality assurance systems in place to continually review and improve the service, including medicines administration, incidents, safeguarding concerns and daily notes.

## 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.

There were enough staff to deliver care safely, and staff were recruited in a safe way.

Staff knew how to identify signs of abuse and report concerns appropriately.

Incidents and accidents were managed appropriately, with all incidents of restraint reviewed by the manager.

### Is the service effective?

Good

The service was effective.

Staff received training that gave them the knowledge and skills to meet people's needs. Training needs were monitored through supervision and appraisal.

Staff were knowledgeable about mental capacity and how to make best interests decisions effectively.

People were supported to access healthcare professionals to maintain their health and wellbeing.

### Is the service caring?

Good

The service was caring.

People were cared for by kind and compassionate staff who knew how to meet their needs.

Staff supported people to live independently and with privacy and dignity.

### Is the service responsive?

Good

The service was responsive.

Care plans were person centred and contained detailed guidance for staff on how people liked to be cared for.

There was an activities programme in place and people were able to choose what they wanted to do.

People knew how to complain and there were systems in place to respond to complaints.

## Is the service well-led?

Good

The service was well-led.

The service was monitored through effective quality assurance processes to drive improvement.

Staff enjoyed working at the service and found the working culture was positive.

There were opportunities for people to meet and give feedback on the service which was acted upon by staff.

# Woodhouse Hall

**Detailed findings**

## Background to this inspection

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

This inspection took place on 19 September 2017 and was unannounced. One inspection manager, one adult social care inspector and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed all the information we held about the service. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service.

At the time of the inspection there were 15 people living at Woodhouse Hall. During the visit we spoke to five people who used the service and three relatives. We spoke with the registered manager and four members of staff; including senior carers and care assistants. We also reviewed relevant documents and records related to people's care, such as medicine administration records (MARs) and care records. We checked how the service was working under the principles of the Mental Capacity Act 2005 to ensure capacity assessments were conducted appropriately and relevant best interest decisions were made on people's behalf.

We also looked at documents relating to the management and running of the service. These included three staff recruitment files, training records, staff meeting minutes and quality assurance audits.

Good

# Is the service safe?

## Our findings

All people we spoke with told us they felt safe living at the service. One person said, "I'm safer here than out there, and safe in my flat." A relative we spoke with said, "[Name] is much safer there than outside where they may be taken advantage of." The premises had secure keypad entry and all visitors were required to sign in to ensure people were kept safe.

The service had clear procedures and guidelines to ensure people were safe, and staff we spoke with were confident they understood safeguarding. All staff had completed safeguarding training. Staff were able to tell us how they would raise concerns and what they would consider to be a safeguarding matter. For example one staff member told us about a time they noticed bruises on someone's arm that were not there earlier in the day so they reported this to the safeguarding team. Another staff member told us safeguarding meant, "Making sure people are safe and not subject to abuse. The policy is available and the safeguarding team number is on the wall if we want to escalate things higher." The registered manager was aware of their responsibilities and told us they took advice from the local authority safeguarding team whenever they had concerns.

There was a whistleblowing policy in place, and information on how to raise concerns confidentially was available on notice boards in the staff rooms and offices across both sites. Staff told us if they felt an issue could not be brought to the attention of the manager they would ring the provider's whistleblowing team.

We found people were protected from risks associated with their care and appropriate measures were in place to mitigate these. People's care plans held risk assessments across a range of areas specific to each person such as family contact, personal care, finance, road safety and communication. All risks were recorded with clear actions to minimise them. Risk assessments were regularly updated with progress and evaluation notes.

There were systems in place to protect people from financial abuse and manage their monies safely. People who had monies held at the service, had risk assessments in place, and some senior staff had become appointees responsible for making and maintaining benefit claims for people. Receipts for purchases made and monies withdrawn were recorded in triplicate format and balance checks were made monthly by senior staff and submitted to the provider.

The premises were maintained appropriately. The service had a housekeeper who conducted deep cleans, and staff were responsible for keeping communal areas tidy. There were records which showed there was a valid electrical safety certificate and gas safety certificate. There was a thorough fire risk assessment in place. The service conducted regular fire drills and checks of fire safety equipment. Each person had a personal emergency evacuation plan, which included details for staff on how to evacuate people quickly and safely. For example, '[Name] needs verbal prompts and support to evacuate'. We saw a leak had caused a hole in the roof of the kitchen, and a temporary solution had been in place for some time. When we raised this with the registered manager, a maintenance staff member was called out and we were assured work would begin on a permanent solution.

We reviewed staff rotas and found that there were enough staff on duty to provide care. Rotas clearly indicated where staff had taken annual leave or were absent due to sickness, and staff were given overtime to fill in where any gaps were found due to absence. Staff told us they felt confident there were always enough staff to provide safe care and engage in activities. One relative we spoke with said, "I visit twice a week and there always seem to be enough staff on."

Staff were recruited safely. We reviewed three recruitment files and found t a range of checks were carried out to ensure staff were safe to work with vulnerable people. Staff were required to provide two forms of photo identification and references from previous employers. Any gaps in employment were discussed at interview. Staff were required to submit to a disclosure and barring service (DBS) check. The DBS is a national agency that holds information about criminal records. Staff told us they were currently recruiting an administration team member who would help ensure any gaps in paper records were filled.

We looked at systems in place for managing medicines in the service. Medicines were stored safely and where medicines had to be stored in fridges, checks were carried out to ensure the temperatures were safe. Medicines were audited weekly by senior staff and reviewed by the manager. The medicines audit checked documents and policies were available and up to date, storage was appropriate, accurate recordings had been made and administration of medicines was safe. The service also conducted regular staff competency checks on medicines management as part of staff supervision and continuous improvement processes. Information on medicines and their side effects was available in easy read formats so people were informed about what they were being given. Policies followed Nursing and Midwifery Council guidelines and there was an up to date British National Formulary book available to enable staff to have up to date information on what people's medicines were and why they were taking them.

Incidents were responded to and recorded appropriately. The service took the lead from the local authority safeguarding team on how to report incidents. We reviewed one incident which recorded the time, duration and people involved in the incident. We saw that staff were able to record analysis of what led to the incident, if restraint was used and if there were any delayed consequences. Staff we spoke with were able to describe what restraint techniques they had been trained to use, and care plans contained detailed instructions on what restraint techniques could be used when proactive strategies such as diversions had failed to prevent harm. Where restraint was used, we saw that each incident had been reviewed by the manager to ensure that this was carried out appropriately and that all other options had been taken or considered before restraint was used. Incident forms included body maps where injuries had occurred, and recorded whether support was offered to staff if they were emotionally or physically affected by the incident. CQC was appropriately notified of all incidents where necessary.

Good

# Is the service effective?

## Our findings

Staff we spoke with told us they were well supported with their training and induction needs.

New staff received a two week induction which included working through people's care plans and then shadowing experienced staff to get to know people. One staff member told us, "It's the best way to learn. The two weeks can also be extended if people don't feel confident." There was also a separate welcome pack available for staff with photos of each person who used the service and a profile, written in the first person, about who they were and what they liked and disliked. This pack also included information about the service's values and key policies such as safeguarding and fire safety.

There were systems in place to highlight training needs and ensure staff had completed mandatory training. Mandatory training included life support training, fire safety and safeguarding vulnerable adults. We saw life support training had been scheduled in the near future because the system had indicated some staff were due for renewal. Staff were also supported to attain additional NVQ (National Vocational Qualification in Health and Social Care) levels to further develop their skills. Training needs were also monitored through individual, regular supervisions and annual appraisals. During these, staff were encouraged to talk about what was working well and what support they might need. One member of staff said, "Supervisions are a two way conversation, they are useful as a good chance to gain feedback and also raise any concerns."

The Mental Capacity Act (MCA) providers 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 interest and as least restrictive as possible. People can only be deprived of their liberty so that they can 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)

All staff we spoke with were knowledgeable about the MCA and DoLS and understood their responsibilities. Staff were able to describe the principles of the MCA. One staff member told us, "Never assume a person lacks capacity. If they make a bad decision, it doesn't mean they don't have capacity to make other kinds of decisions. Best interest decisions we make; where we assess people who don't have capacity and they must be the least restrictive possible." We also found DoLS applications were made appropriately and reapplied for in a timely way.

People were involved in decisions about what they ate and drank. We saw staff followed guidance from the speech and language therapy team where people had problems swallowing and presented with a choking risk. This guidance was detailed in their care plan. We observed a midday meal and saw staff guided a person on eating safely to mitigate this risk. Staff were knowledgeable about people's dietary needs and were able to describe people's allergies. People's nutritional preferences and guidance for staff to support was found in their care plans. One nutritional care plan we read said, 'Support with healthy diet. Food to be cut up into bite sized pieces. Loves fish and chips, can participate in meal preparation. Able to make own

drinks – staff must be present.'

We asked people about the food, and people generally said the food was good most of the time. However if they wanted other things they were supported to go shopping for what they liked or eat in restaurants and cafés. One person told us, "The food is alright; sometimes it is not good, but I can go out and eat. Staff get me drinks when I want them and I can have a few snacks." Another person said, "The food is okay, I make my own food most of the time. Staff can make me food when I need it." A relative we spoke with said, "[Name] seems to enjoy the food."

Senior staff carried out checks which monitored what people had eaten and that temperature checks were carried out on food that was served. People were encouraged to get involved in mealtimes, for example in one care plan we saw it said, 'Offer [Name] opportunities to cook – make kitchen time fun!'

People were supported to access appropriate care from health professionals. One staff member told us, "For example, a service user's anxiety increased over time and we noticed that PRN protocol medicines were being used more often, so we consulted the psychologist who was able to help reduce their use." A person told us, "Staff help me see my doctor down the road, and I see the diabetic nurse there too." We saw detailed instructions for accessing health professionals written in people's care plans, for example in one care plan it said, "Staff are to make medical appointments. Refer to community learning disability team if support is required with physical aggression. Chiropodist to be arranged every six weeks." This meant people's health and wellbeing was promoted and maintained.

Good

# Is the service caring?

## Our findings

The service had a warm and homely atmosphere. Staff were caring and comfortable with people and treated them as individuals. One person told us, "I like [staff name], she is like my mum." Other comments included, "They are okay, I like [Staff member], she is really nice. They are caring some of them." A relative we spoke with said, "They are always nice to [Name] when he is there, it's hard to say if he likes it as he would prefer to go back living on his own but he was so vulnerable I know he is looked after and safe."

We observed good, positive interactions between people and staff. We saw staff communicating with people in the way they wanted or needed to be communicated with. For example, one person liked to communicate through role play, and when they asked staff to join in they responded positively and engaged with that person. When we read that person's care plan, we saw this was clearly reflected in the communication care plan as a way to positively engage them and something they liked to do.

People were supported to engage socially and see their loved ones when they wanted. A person we spoke with said, "Staff take me to church in turns, and I like going home." One relative said, "I visit twice a week. Staff come and pick me up to visit. We go and we have as much time as we want, there is no problem with us visiting anytime." Another relative said, "When we do visit we are welcomed and treated with respect by staff."

People were supported to be as independent as they wanted to be. One person told us, "I do my own cleaning and keep my room tidy." Another person said, "I go out and about when I want, and I go shopping with friends and into the town." Staff demonstrated good knowledge about how people liked to be independent, for example one staff member told us, "[Name] doesn't appear to care about getting dressed in the morning, however he does. We just have to help make the choices easier for him to understand, for example I'll get two t-shirts and ask him to choose and he will choose what he wants to wear."

Staff were encouraged to maintain people's privacy and dignity. We saw written in a person's 'personal care' plan, 'Support [Name] in a dignified way to bathe on an evening. [Name] gets up when he wants to.' In another care plan we saw written, '[Name] needs support with hair washing. Staff are to promote their dignity.'

All staff had completed training on the Equality Act 2010 as part of their mandatory training programme, and we found that people's diverse needs were supported by staff.

Good

# Is the service responsive?

## Our findings

All relatives we spoke with told us they were involved in people's care as much as people wanted them to be. One relative told us, "I couldn't make it to a best interests meeting but they always feed back to me everything that happened. I am informed and included in all care reviews."

We reviewed three people's care plans. Care plans were person centred and contained detailed and clear strategies to manage people's behaviours and care for them the way they wanted. Care plans had photographs of people (taken with their permission) as part of a profile including what they liked about themselves and how they wanted to be supported. Specific areas of support included communication care plans, personal care plans, health and medicine needs, safety care plans and behaviour support. We found that these included clear detailed instructions for staff, for example in one person's communication care plan it said, '[Name] communicates with Makaton (a language programme designed to support people who cannot communicate efficiently through speech) and their own signs. Communication is limited, brief and delivered in small chunks. Only one member of staff to speak at a time. Maintain quiet tone'. The care plan also had detailed information on what signs the person knew.

Staff signed care plans to indicate they had been read and understood. Care plans were evaluated monthly. We saw evidence action had been taken following reviews to update care plans, for example where one person was previously encouraged to get involved in meal preparation, this was now discouraged as '[Name] does not now like being involved in meal prep.'

The service had recently appointed a dedicated activities coordinator to focus on ensuring people received enough stimulating and meaningful activity throughout the day. Staff spoke very positively about the impact this person had on the service. One member of staff said, "We were much busier trying to set up and plan activities, and this impacted on other interactions. Its lots better because now we have time to properly engage." We saw there was a weekly plan of different activities for most people; however where people required familiar routines or unstructured activities a routine plan was written for them. One staff member told us, "For [Name], we don't do the same structured activities as this can cause distress."

Activities included arts and crafts, days out (for example to the seaside or local pub), pottery, knitting and games. The service also had a vegetable garden where food was grown and used in cooking. One person told us, "We do all sorts here, lots of things, just look at the activities board. I get to choose what I do each day I just have to let them know." Activities were recorded in a 'significant activity record'. These included details about the time and date of the activity, what they did, interactions made during the activity and the persons view on the activity. We reviewed two activity records. In one activity where a person was taken on a trip to York, staff noted, '[Name] was very happy clapping and smiling throughout the trip.'

There was a complaints process and an up to date complaints policy which included time scales for responses. There were no complaints in 2017. We noted there was no centralised complaints file, as staff had to search their intranet system to locate complaints. When we raised this with the registered manager, they told us they would create one for future use. People told us they were confident they could raise a

complaint if they wanted to. One relative told us, "I've never needed to complain, if I'm worried or [Name] is worried, we just speak with staff."

Good

# Is the service well-led?

## Our findings

People told us they felt confident in the leadership of the service and they were updated on changes to the service. One relative told us, "I know there is a new manager coming. I can only speak from experience and the last one was brilliant with my loved one, they managed a tricky situation and I suspect he may not be here if it wasn't for the manager. I hope the new manager will help settle things down." The new manager had been in post for eight days at the time of the inspection. One staff member commented, "[The change in management] hasn't affected us yet, because we work very well as a team. We are on the up. New staff are positive and I feel we support each other." We spoke to the registered manager who told us they felt well supported by the provider and were in regular contact with them.

We saw a system was in place to monitor the quality of the service people received. There was a programme of monthly and weekly quality assurance processes, including weekly medicines audits, monthly health and safety audits, care plan evaluations, incident reviews and weekly care note checks. We saw where issues were identified, actions were taken, for example in the medications audit it was noted that a new round of medicine competency checks for staff were due and would be scheduled.

The service also carried out unannounced 'benchmarking' inspections to assess whether the service was, in its view, compliant with CQC regulations. Inspections included interviewing staff and reviewing documentation. The service had carried out its most recent inspections in August 2017 and November 2016. At the last inspection, the provider found positive improvements had been made since the last benchmarking inspection, and made suggested improvements for example the documentation of Mental Capacity Act assessments and best interests decisions. The provider acknowledged the gap in leadership as there was no registered manager in post at the time of the inspection. Feedback was provided to senior staff at the conclusion of the benchmarking inspection.

The service held monthly staff meetings. We reviewed the latest staff meeting and saw there were five attendees. Staff told us minutes were made available to those unable to attend and staff signed a sheet to confirm they had read the minutes. Topics included a team building exercise, daily notes, supporting each other, updates about people using the service, safeguarding and a positive message to staff. Staff told us the quality of staff meetings had improved in 2017, with the positive message regarded as improving the culture of the service. One staff member said, "They could tend to focus on the negatives but now they focus on the positives as well." Another staff member said, "I feel like we have a voice and get listened to."

Staff told us they found the working culture very positive. One staff member said, "Other staff are so lovely; from where I was working previously to here, it's like a dream come true. We all support each other and work as a team. We all help with paperwork." Another member of staff told us, "People don't live in the place we work, we work in their home."

People who used the service attended 'Your Voice' meetings, where they were able to discuss their feelings about different aspects of the service and make suggested improvements. These meetings were held monthly. We reviewed the latest meeting where five people and six staff attended. The meeting was held

outside because of sunny weather. Actions completed from the last meeting were listed, and included decorations purchased for somebody's room, a person who was supported to go to the pub, and staff had helped a person plan their holiday. Topics discussed included people's relationship with their keyworkers, people's rooms, food, activities, safety and 'positive awards' for people. For the positive awards, it was documented that, 'Everyone received certificates and were really happy, and everyone clapped each other.'