# Exalon Care Limited

# Willow View

## Inspection report

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## Ratings

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

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

# Summary of findings

## Overall summary

This inspection was unannounced and took place on 20 and 28 March 2018. The service was last inspected in January 2017 when it was rated as Requires Improvement. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had been made.

Willow View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Willow View is a small residential home for two people with learning disabilities. At the time of our inspection, one person was living at the service. There were no plans for any other person to move into the service at this time. The home is detached with a private garden and situated in a quiet side street in the town of Warminster. The provider also had another service nearby. Both services shared the same manager.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was not 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. There was a manager in post who had applied to become registered for the service.

Activity provision was not as varied as it could be. Staff and the manager recognised this and had plans to improve and widen the provision. Key activities that were important to the person had stopped, the manager told us they would be resuming in the near future.

There was a complaints procedure in place however it was only available in one format, which the person would struggle to use.

At our last inspection we found that risk assessments were not always detailed enough to minimise the levels of risk and care plans lacked detail on the person's preferences. At this inspection, we found these areas had improved. There were a range of risk assessments in place that identified environmental risks and risks to the person such as nutrition and development of pressure ulcers. All risk assessments were completed in full and reviewed regularly. There were behavioural care and support plans in place that identified triggers and clear strategies for staff to deploy to keep people safe.

Staff were well supported. There were systems and processes in place to support lone working, and staff had regular opportunity to have formal supervision with their line manager. This meant they could discuss any concerns or training needs they might have.

Appropriate recruitment checks were undertaken before staff commenced employment. Staff were well trained and could ask for additional training if they wished.

The provider had systems and processes in place to safeguard people from the risk of abuse. Staff we spoke with were aware of safeguarding procedures and knew how to use the provider's policies to report any concerns.

Medicines were managed safely. All staff had received medicines training and were observed administrating medicines by the provider so that their competence could be checked.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. Where people had their liberty restricted, the service had completed the related assessments and decisions had been properly taken. Staff had been trained and understood the general requirements of the Mental Capacity Act (2005).

The premises were clean and in good repair and the risks of cross infection were minimised. Records demonstrated that staff received infection prevention and control training and food hygiene training.

A visiting director completed quality monitoring regularly and action plans produced if needed. Feedback from the person was sought regularly and the service had access to a local advocacy service if needed.

## 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 is now safe.

Risk assessments are in place for a range of areas and are reviewed and updated regularly or when needed in response to an incident.

Positive behaviour management plans were detailed and gave staff clear strategies to follow to keep people safe.

Staff were recruited safely and understood their responsibility in safeguarding people from harm. There were sufficient staff to meet needs.

Medicines were managed safely.

### Is the service effective?

**Good**

The service remains effective.

### Is the service caring?

**Good**

The service remains caring.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Activity provision did not always provide opportunity to regularly engage in key identified activities.

The complaints procedure was not accessible to people who required alternative formats to text.

The care plan was detailed and contained a range of information to guide staff in providing care and support. It was regularly reviewed and kept up to date.

### Is the service well-led?

**Good**

The service remains well-led.

# Willow View

**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 20 and 28 March 2018 and was unannounced. The second day was planned so that notice could be given to the person living at the service. They do not always tolerate visits from people that are not known to them. We completed a one page profile of ourselves so that the person could be supported with a social story of our site visit.

Before the inspection, we asked the provider to complete a Provider Information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We looked at the information that we hold about the service prior to our inspection. This included statutory notifications from the provider that they are required to send us by law about events that occur at the home such as deaths, accidents/incidents and safeguarding alerts.

We looked at two recruitment files, medicines administration records, a care and support plan, activity records, training records, supervision records and other records relating to the management of the service. We spoke with the manager, residential care director, team leader, two support workers, a relative and one healthcare professional.

The person living at the service was not able to give us their views but they did use some non-verbal communication to share feedback with us.

Good

# Our findings

At our last inspection in January 2017 we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risk assessments had not been developed on how to minimise all areas of risk and incident reports lacked detail following challenging incidents. At this inspection, we found the service had made the required improvement and were no longer in breach.

Risk assessments were in place for areas such as nutrition, pressure ulcer development and mobility. These were completed in full and regularly reviewed. There were also risk assessments relating to behaviours that might challenge the service, particularly when out in the community. There were potential triggers to escalated behaviour recorded and clear guidance for staff on how to support the person out in the community. The ratio of staff increased when supporting the person out in the community to 2:1. Records demonstrated that this ratio was consistently maintained.

Incident reports were detailed following all incidents or accidents with action taken immediately to keep people safe. Accidents and incidents were reviewed regularly so that improvement could be made if needed. There had recently been an incident regarding safety out in the community. Records demonstrated that lessons had been learned and changes made to risk assessments. The service had involved a local behaviour specialist nurse in order to support a review of systems, which would better support the person. Following any incident staff were supported to de-brief. The manager told us they encouraged staff to talk about incidents, episodes of behaviour that may have been challenging and intensive shifts. This supported staff to express their feelings and make sure they were ok.

When we met the person, they gave us the 'thumbs up' that they felt safe. Staff we spoke to told us they felt the service was safe for everyone. One member of staff told us, "I don't feel at risk at all, I have support from across the road if needed." Another member of staff said, "The management here are careful, the service feels safe."

There were sufficient staff employed to work at the service. Lone working arrangements had been reviewed and staff had clear strategies in place should they require support at any time. There was sufficient on call support so that staff could access management advice at any time.

Appropriate recruitment checks were undertaken before staff commenced employment. We saw checks in staff files included two references, a full employment history including a full explanation of gaps where

found, identification checks and a Disclosure and Barring (DBS) check. The DBS carry out a criminal record and barring check on people who have made an application to work with adults at risk. This helps employers to make safer recruiting decisions and helps prevent unsuitable staff from working with adults at risk.

The provider had systems in place to safeguard people from the risk of abuse and support them to stay safe. Staff we spoke with were aware of the safeguarding procedures and knew how to report any concerns. Records demonstrated that staff had received safeguarding training. We saw the topic of safeguarding had been an agenda item at staff meetings so that staff could discuss concerns.

Medicines were managed safely. Medicines administration records (MAR) reviewed had no unexplained gaps in the recording of administration. There were 'as required' (PRN) protocols for medicines that were given when they were needed. This gave staff guidance on when the medicine should be administered. A homely remedy protocol that had been signed by a GP was seen. All staff had received medicines training and were observed administrating medicines by the provider so that their competence could be checked.

Premises and equipment were managed safely. The service completed daily and weekly health and safety checks to monitor the environmental risks. The service was clean and there were no odours present. Staff had access to personal protective equipment. Staff had been trained in basic food hygiene and carried out safety tasks such as monitoring fridge and freezer temperatures. These were recorded and we saw they were all in a safe range.

Good

# Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found the service was working within the principles of the MCA. Mental capacity assessments had been completed and best interest meetings held prior to any restrictions being put in place.

People can only be deprived of their liberty so that they receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The service had applied to the local authority for DoLS authorisation, this was being processed.

Assessment of needs had been completed and were documented in the care plan. The service involved relevant health care professionals where appropriate and required. Records demonstrated that visits were timely and from a range of professionals such as behaviour support nurse, social worker or professionals from the learning disability team. The person had a detailed health plan and a 'passport to hospital care' for use should they need to go into hospital. This would make sure important information could be shared with other healthcare professionals in the event of any emergency.

Staff received training in a variety of topics and told us they had sufficient training for their role. Records demonstrated that all staff had completed positive response training which supported them to work with a person who may exhibit behaviours that were at times challenging. The manager was an accredited positive behaviour support trainer and had provided a two day course for all staff. The service had out-sourced autism training from the local authority. This supported the team to work with people who had autism. One member of staff told us, "I have had plenty of training, it is pretty good."

Staff had supervision with their supervisor monthly, this gave staff the opportunity to talk about any concerns they had, any development areas and training needed. There were also regular team meetings. All new employees had to complete an induction at the start of their employment. This included training, shadowing a more experienced member of staff and they had time to read policies, procedures and care plans. Staff told us if they needed more training they only had to ask.

The person living at the service chose what they wanted to eat. They planned their own menus and did shopping with support from staff. Records were kept of the person's weight, which demonstrated there were no concerns. The person liked to eat out of certain bowls and plates, this information was documented in their care plan.

The premises were well kept and in good repair. The service was in a bungalow all on one level. The property was detached with front and back gardens, which were easily accessible. There was ample space for one person to move about and enjoy a level of privacy within their own room.

Good

# Our findings

There was a continuity of care provided by a core group of four workers. This was important to the person as any changes in staff support could cause anxiety. The service had put in place shifts, which meant there was only one change of staff per day. This also supported the person to know who was working and when, which reduced anxieties. One member of staff told us, "I enjoy working 1-1 with [the person]; it helps to develop a good relationship."

Staff we spoke with respected the person and really enjoyed working with them. One member of staff told us, "I find my work fascinating, it can be intense but I like it." One relative told us, "The carers are brilliant with him." Relationships with family were maintained with regular visits and trips out together in the local community.

There were support plans in place, which promoted dignity. The manager told us that if dignity or any person-centred value was not promoted this may lead to an increase in the person's anxieties or distressed behaviours. We spoke to staff who told us they promoted dignity and privacy by respecting the person's need for time alone in their own room, supporting them with personal care when the person consented and at the person's pace.

We spent a short period of time with the person; they gave us their 'thumbs up' to tell us they were ok. They looked relaxed and we were able to observe them communicating well with staff using signs and sounds. One healthcare professional told us, 'The service have shown a desire to be person-centred and focussed on the improvement of quality of life. I believe this is due to the commitment and dedication of staff working with me in ensuring good outcomes'.

The service used 'social story' work to help communicate with the person. This is the use of pictures, one page profiles and a gradual build up to any events, changes to routine or visits from unknown people. Staff used communication techniques such as Makaton, which is a simple sign language, emotion cards and pictorial routine work. The person was encouraged to make their own choices wherever possible and the staff used pictures at times to do this. For example, the person could be shown or asked if they wanted to do an activity or visit a place, 'emotion cards' were then used to determine if the person wanted to do the activity or visit the place.

The provider retained a local advocacy worker who visited their nearby service monthly. The manager told us they could also visit this service at any time if needed.

There was a key worker system in place. This was a system where one member of staff was allocated to be the named worker. They wrote monthly key worker reports, which were stored in the care plan. These reports documented appointments, activities and any updates needed to the care plan. This provided a continuity of care and made sure daily recording was accurate and up to date. All records were kept secure so that confidentiality was respected.

The environment was personalised and we could see the person had their own belongings around the property. This included their own technology such as a games console and television.

Requires Improvement

# Our findings

At our last inspection in January 2017, we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because positive behaviour management plans were not kept up to date or reviewed. At this inspection, we found the service had made the required improvement to behaviour plans and were no longer in breach. However, we found there was improvement required in other areas.

There was an activity plan in place, which aimed to give structure to activity provision. Feedback received from a relative was that they felt activity was not always as good as it could be. We discussed this with the manager and staff during our inspection. They felt that this was an area that could be improved and there were plans to do so. The manager had identified additional activity that could be introduced but told us this needed to be done slowly using 'social story'. They explained any change to routine or new routine had to be introduced carefully. Staff told us they hoped with the warmer weather they might be able to introduce activity such as gardening. The person had been going horse-riding regularly at local stables. This had stopped for a period of time but was going to be re-introduced.

The service had a complaints procedure in place, which was comprehensive. We saw that it was solely in text format. We discussed with the manager whether the person living at the service would understand the procedure. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The manager agreed that a pictorial complaints procedure would be of benefit to the person.

There was a comprehensive care plan in place, which covered a range of needs. It was updated regularly and changes were made if needed. We saw that the positive behaviour support plan had been re-written recently due to an incident in the community. The plan detailed the behaviour that may cause concern, who might be at risk and outlined the strategies that may be employed by staff. A health plan outlined the person's health needs and what 'ill health looked like'.

An electronic care recording system was used to record day to day events, activity and care delivery. This enabled staff to share information between each other on how the person's day had been, how their mood was and any episodes of anxiety.

The service was not providing end of life care and it was not appropriate to discuss this with the person at

this time. The manager told us they would be able to respond and provide end of life care should this need arise.

Good

# Our findings

There was a manager in post who had applied to become registered. 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.

In addition to managing Willow View, the manager was also the manager at a nearby small service. The manager told us they had a senior team structure in place that enabled them to do this. Willow View was overseen day to day by the Team Leader who met with the manager daily to share information. The manager also visited Willow View regularly to meet with the person and to do management checks.

Staff we spoke with felt supported by the manager. One member of staff told us, "I feel very supported, [the manager] often texts me to say thank you, that is nice." Staff also told us the management team were visible at the service. They often saw the residential care director and could approach them at any time. Staff told us they felt there was teamwork at the service supporting each other where needed. One member of staff told us, "We work as a team, we all work together."

Staff were aware of the provider's values and told us they were always encouraged and supported to work in line with them. For example, staff talked to us about how they always tried to maintain the person's independence supporting them to do as much as they could for themselves.

The manager had a clear vision to provide good quality, person-centred care. They planned to make improvements to the service, which were endorsed by the provider. They told us that they wanted the service to continually evolve and always look to do things better. The service worked with other agencies such as the community learning disability team. Records demonstrated that the service was open, honest and transparent with outside agencies and other healthcare professionals. One healthcare professional told us, "They [Willow View] are keen to work with professionals to reflect on their practice and make improvements where needed."

A residential care director who visited the service weekly supported the manager. The residential care director completed monthly quality monitoring in a range of areas such as infection prevention and control, medicines and health and safety. We saw that they themed their checks to make sure all areas were covered. For example, in January 2018, the theme was personnel files, we saw that the director had checked each staff file to make sure all the necessary information was present. If an audit hi-lighted shortfalls then

action plans had been produced and were signed off by the residential care director at their next visit.

Feedback from the person was sought as much as possible without causing any undue anxiety. The manager told us they used 'emotion cards' to gain the person's thoughts and feelings. They also used recognised signs such as 'thumbs up' to gain immediate feedback.

The person regularly accessed the local community using facilities in the immediate area. To access the wider community the service did have use of a vehicle but this required planning, as the person did not always travel well. The person was regularly invited to events at the provider's nearby service as they were not tolerant of people coming into their home.

The rating from the previous inspection was displayed at the service and on the provider's website. The manager also notified us of important events that happened at the service, which they are required to do by law.