The Wilf Ward Family Trust

Grayling

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 30 December 2014 and was unannounced.

We last inspected Grayling on 10 December 2013. At that inspection we found the home was meeting all the regulations that we assessed.

Grayling provides personal care and accommodation for up to four adults who have a learning disability, some of whom may have a physical disability. Grayling is a bungalow situated close to the market town of Pickering. It is located near to local amenities and public transport.

When we visited there was an acting manager in post. The acting manager had submitted an application to the Care Quality Commission (CQC) to become the registered manager. A registered manager is a person who has

Summary of findings

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.

Despite the recent management changes we found an effective and committed staff team who provided good, consistent care. There was a clear emphasis on the promotion of staff development and learning, which demonstrated a culture of continuous improvement. Staff were recruited safely and had received training to fulfil their roles and responsibilities appropriately. We found that staff understood local safeguarding protocols and knew what action they should take to safeguard people in their care. Suitable arrangements were in place to make sure people were protected from the risks associated with taking medicines.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs). Policies to manage risk were in place and staff applied these consistently to make sure that people remained safe without being unduly restrictive.

People's nutritional needs were met. Meals were cooked using fresh produce and we saw that people were offered choice in the food they were offered.

People received the health care support they required and had access to a range of healthcare professionals such as dieticians, tissue viability nurse specialists and doctors.

We found that the staff understood the key principles of the 'Dignity Challenge'. This initiative sets out a clear statement of what people can expect from a service that respects dignity. We saw staff treated people with dignity and respect. People were supported to make choices about their lives and to maximise their independence. Care was provided in accordance with people's values and beliefs.

We saw that staff were attentive and provided prompt support to make sure people remained comfortable and at ease. Staff knew people's preferred communication style and supported people to make choices as far as they were able. The complaints procedure had been produced in an easy read format to aid people's access and understanding.

Effective managements systems were in place to assess the quality of the service and promote people's safety and wellbeing.

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?

Good

The service was safe. People were protected because the provider made sure staff received safeguarding training. Staff knew how to respond appropriately if they had any concerns about people's welfare.

Effective recruitment and selection procedures were in place.

Risk was identified and action was taken to minimise risks without undue restrictions.

People were given their medicines at the times they needed them, and in a safe way.

Is the service effective?

Good

The service was effective. People were cared for by staff who were appropriately trained and supervised.

People who lacked capacity were protected under the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

People's nutritional needs were met. The menus offered variety and choice and provided a nutritious, well-balanced diet for people living in the home.

People were supported to maintain good health and access to health and social care professionals such as dieticians, tissue viability nurse specialists and doctors.

Is the service caring?

Good

The service was caring. Staff treated people with kindness and were knowledgeable about people's care needs. People were supported to live in a way that met their needs and supported their rights.

Feedback from families was positive. Staff listened to people's views and acted on them.

We observed that staff were respectful of people's privacy, dignity and beliefs.

Is the service responsive?

Good

The service was responsive. People's wishes and preferences were taken into account in the way that care was planned and delivered.

There was an effective complaints procedure, which was provided to people in an accessible format.

Is the service well-led?

Good

The service was well led. Effective management systems were in place to promote people's safety and welfare.

Quality assurance questionnaires gave people an opportunity to share their views about the service.

Audits were carried out to check the quality of the service, identify shortfalls and drive improvement. Audits covered areas such as personal care and support, health and safety, and staffing.

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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 30 December 2014 and was unannounced.

The inspection was carried out by one inspector. Before the inspection the provider 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. We also reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

We contacted the local authority contracts and compliance team to ask for their views on the quality of the service provided by the home.

On the day of the inspection we spoke with the acting manager, the organisation's learning and development manager and three support workers. We spent time observing how people were supported in the dining room and attended a staff team meeting. We observed staff administering medicines to one person. We looked at records including care plans for two people, recruitment and training records for two staff, maintenance records and policies and procedures. We looked at the written feedback in surveys completed by families and professionals. We spoke with a team manager in the local authority learning disability team and with a relative to gain their views about the service.

Good

Is the service safe?

Our findings

People looked comfortable and at ease with the staff who supported them. One person indicated to us by nodding and smiling that they liked the staff and felt safe. Staff told us that they could see by people's body language or by their facial expressions if something was wrong. They said that they would not hesitate to take their concerns to managers and knew who to speak to outside the organisation if needed. Staff told us that people's welfare was discussed at handover and during staff meetings held each month.

The learning and development manager said staff received training so that they knew about different types of abuse and how to safeguard people. All staff had received safeguarding training. The home had notified the local authority and the Care Quality Commission (CQC) of safeguarding and other incidents which may have affected the welfare of those living at the home so that suitable steps could be taken to protect them. People could therefore be confident that staff followed local safeguarding protocols to keep them safe.

Risk assessments recorded information for staff on how to manage risks without unduly restricting people. We saw that care plans had been completed for a variety of areas depending on the individual risks of the person concerned such as moving and positioning, and pressure care. We saw in the PIR that risk assessments were reviewed when there was a change to the risk. The acting manager told us they planned to introduce more positive risk taking surrounding daily activities and life style to enhance people's experiences. At the staff meeting we heard concerns about people's welfare were highlighted and follow up action was debated and agreed. For one person we saw this included updating their risk assessment when they accessed the community to make sure they were kept safe and had an enjoyable experience.

Environmental risk assessments had been completed for each of the people who lived at Grayling. We saw in the PIR that risk assessments were reviewed at least annually unless someone's needs changed sooner. All of the accommodation was provided on the ground floor and some people used wheelchairs, hoists and tracking systems to be able to move around the home safely. Staff were trained in the use of lifting equipment and this minimised the risk to both people and staff.

We saw evidence in staff files that recruitment checks including Disclosure and Barring Service (DBS) checks were obtained for staff working at the home. This meant that appropriate systems were in place to protect people from unsuitable staff. Staff told us there always needed to be a minimum of two staff on duty in the home and two people with a person whilst accessing the community. There were two staff on duty throughout the night. The rotas showed that the staffing numbers were maintained at these levels.

The acting manager told us that staffing levels were based on the needs of the people living there. We saw information in people's care plans that indicated what level of support they required at different times of the day. For example, when people used the hoist there always had to be two staff assisting for reassurance and safety.

During our visit we looked at records relating to the management of medicines for people who used the service. We found suitable systems were in place for the storage, recording and administering of medicines. Medicines were stored in a lockable cupboard and controlled drugs were stored separately. A record of regular temperature checks of the medication storage area was seen. No-one was able to manage their own medication, however lockable cupboards were provided in their rooms for the storage of topical creams and eye drops. This allowed staff to access these medicines whilst attending to someone's personal care.

Staff told us two members of staff administered medicines, one person who handled the medicine while the other checked that the dosage and time of administration were in line with the care plan. We observed staff followed this procedure in practice. Staff told us that they were not allowed to handle medicines unless they had completed safe handling of medication training. They carried out a weekly audit of the medicines and records to ensure they remained up to date. Two people had an emergency medicine box which staff took out with them when they went out. Instructions from the doctor in the use of this medicine were found to be clear and follow up instructions were also available. This showed us that people were protected against the risks associated with medicines because the provider had appropriate arrangements in place to safely manage them.

Good

Is the service effective?

Our findings

We observed staff checking people's preferences with them before they carried out an activity with them. For example, at mealtimes staff spoke slowly and clearly to people and waited until the person responded by means of body language or known method of communication such as eye movements or a cough to indicate their preferences.

Records showed us that staff received training on a range of issues including safeguarding of vulnerable adults, control and restraint training, first aid, fire, manual handling, conflict resolution, the safe handling of medication, and food hygiene. They had also received client specific training such as autism, dementia awareness and epilepsy. We also saw evidence in records that staff had regular supervision and an annual appraisal. Staff told us these sessions allowed them to discuss their role and to look at further training they may want to do.

We saw in the PIR that new staff attended a class room based induction during their probation period. They shadowed more experienced staff and completed an in house induction to give an insight into supporting people. The learning and development manager told us that wherever possible staff were matched to work in houses with people who shared common interests. They said this helped people to socialise and interact as well as form meaningful relationships and having fun.

We saw in the PIR about further plans to enhance induction training for new staff. This included the implementation of a video support guide from a person using services to explain what they expect and want from an excellent support worker.

The learning and development manager told us that training was offered in a variety of ways, e-learning, workbook and hands on training. Managers kept individual staff training records and reported on training and development needs each week. The learning and development manager showed us a spreadsheet which they used to monitor staff training across the organisation which gave them an overview of training needs. This showed us that satisfactory arrangements were in place to make sure staff received updated training in a timely way.

Staff had received training on The Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff told us that they had this training each year and this ensured they remained up to date with any changes in legislation or recognised practices. The acting manager and staff could explain their responsibilities in relation to the MCA and DoLS to ensure people's rights were upheld. Mental capacity assessments and deprivation of liberty safeguarding checks were carried out.

There was a record in care plans about the level of decision making a person was capable of. Staff clearly knew people very well and understood how someone might look when they responded in a positive or negative way. Staff knew about areas that might cause distressed behaviour and the approach that should be taken in those circumstances. This meant that staff knew how to respond to people in a helpful way to reduce any anxiety or distress.

Consent forms included evidence of best interest meetings. These are meetings that bring together health care professionals, care staff and relatives to make a decision on behalf of a person who lacks the capacity to make that decision themselves. For one person for example, a best interest meeting had been held in relation to medical treatment. This made sure that decisions were not made on behalf of a person who had capacity to decide for themselves and that people were not unlawfully deprived of their rights.

Care records included details of people's food preferences including likes and dislikes and the support people required in order to promote their dietary intake. Staff told us about those people who required an adapted diet. Although there was nobody who had dietary requirements relating to their cultural or religious needs people did have specific dietary requirements related to their health conditions. Staff also explained that for some people the focus of support from staff was to encourage healthy choices. Records showed that people had received input from dietetic services as needed.

Food was prepared by the care staff. They told us they prepared food using fresh ingredients and that menus were changed to suit the strengths of those people responsible for meal preparation and seasonal availability. We saw people were offered choices, based on what staff knew they liked and what they had eaten at other meals.

Each person had a nutritional assessment and details of on-going support from the speech and language therapy team had been recorded. At the staff meeting we discussed the food and fluid charts which were routinely kept for each

Good

Is the service effective?

person. Staff told us they thought this was a useful record to make sure everyone had adequate nutrition and fluid at suitable intervals. They said these records also enabled them to report clearly on people's dietary intake to their doctors and other healthcare professionals such as dieticians.

Staff told us they worked closely with health and social care professionals to support people's health care needs. We saw in the PIR that external professionals consulted included speech and language therapist (SALT), district nurses, wheel chair centres, dentists and GPs.

Appointments with professionals such as dieticians, tissue viability nurse specialists and doctors were recorded in people's care plans. Advice from these appointments was also recorded so staff could provide consistent care.

We saw people had been provided with mobility equipment and pressure relief cushions and mattresses to support their health and well-being. There were clear procedures for staff to follow when people needed medical attention including the use of medicines given in emergency situations. This showed there were appropriate arrangements in place to support people's health care needs.

Good

Is the service caring?

Our findings

We spoke with a relative who confirmed that they received timely information about their family member. They said their relative was "quite happy and settled, they (the staff) do very well." We saw positive comments in surveys families had completed such as 'treated like royalty and happy' and 'keep up the good work'.

People were cared for in a courteous and considerate manner throughout our visit. Staff made sure that people knew a visitor was in their home, explained the reason for our visit and made sure people were willing to speak with us. We saw that staff delivered care at the pace of the person they were assisting and were kind and patient. For example, some people could not mobilise independently and we saw staff took care to position them in their preferred area in the home and to offer alternatives throughout the day. This gave people who could not mobilise independently the opportunity to enjoy different experiences.

Staff were attentive and we saw how they responded quickly to one person who was experiencing discomfort. Staff recognised this quickly and took prompt action to make them comfortable by changing their position.

We saw that staff listened to people to put them at the centre of the care they received. Staff spent time with people and clearly understood their body language and facial expressions. People who required communication aids had these provided so that they could make an informed decision about options open to them.

The acting manager told us that they encouraged people to maintain established links with their family and facilitated home visits. For one person for example, this included making sure that transport was provided to drop off and pick up so that the person could have weekends at home.

At the team meeting staff talked confidently about people's goals and the progress they were making on these. Staff were knowledgeable about diversity and human rights although they remained open to developing this aspect of their learning. They spoke positively about specific training they had received so they could be confident they were providing support in line with people's values and beliefs.

We saw in the PIR that all staff were encouraged to participate in the Dignity Challenge. This sets out key principles of what constitutes a service that respects dignity and focuses on aspects of dignity that matter to people the most. During our visit we saw numerous examples of staff good practice that met the dignity challenge. For example, we saw staff protected people's dignity when they were receiving personal care. One person took an active part in the team meeting and we observed staff protected other people's confidentiality whilst including the person in the discussions.

We saw in the PIR that the staffing levels supported staff to provide good quality care and allowed them to respond flexibly to support people to meet their needs, wishes and aspirations. Staff confirmed this and said that they had good support from the provider and from the acting manager. They were able to give us examples of how the provider and acting manager promoted respectful care. They said for example, that they had time to reflect on their practice through regular training, staff meetings and supervision sessions. The acting manager had designated care hours to oversee the care and support people received, to feedback on staff skills and enhance people's care and support.

Good

Is the service responsive?

Our findings

Care plans included information about people's life history, previous lifestyle and family involvement. Information gathered at the time of a person's initial assessment was incorporated into an individual plan of care. For one person their admission was made after a lengthy introductory period to make sure they were comfortable and happy with the support. Feedback from the local authority learning disability team in relation to this work was positive. A family member told us staff had worked with their relative at a 'gentle' pace to gradually introduce them to the service and this transition period had worked well. They said, "(Name) is quite settled, loves it there." The admission process had also provided staff with a good insight into the person and how they could support them to live their chosen lifestyle.

People's likes and dislikes and their preferences for assistance with personal care was recorded. There was also detailed information about how each person communicated with staff. One person used vocalisation and facial expressions, another person used pictorial prompts to aid their understanding. We observed staff were proficient at communicating with people in their preferred style and people were supported to make as many choices about their day to day activities as possible. This showed us that people's care and treatment was planned and delivered in line with their individual care plan.

People had a daily diary that covered their daily activities. Diaries showed people accessed community activities such as horse riding, swimming and shopping. In addition staff recorded the person's responses and this information was used to identify changes in the person's care needs and inform reviews. Staff told us that clear accurate records were essential to ensure people received the care and support they required.

We also saw that the team meeting provided staff with a forum in which they could debate complex issues and agree changes to care plans which were recorded. This made sure that people received consistent care that met their needs.

Throughout our visit we observed people being offered choices at all times. Staff were sensitive to people's body language and expressions and ensured they were included in activities that were going on. We saw in the PIR that the acting manager planned to send staff representation to the Wilf Ward 'service user group' to enable people's views to be represented and to have a say on the organisation and proposals that have been put forward for change.

We saw there was a complaints procedure in place. This was available in several different formats including easy read to ensure it was accessible to everyone. It provided clear guidance on what to do if someone had a complaint. There were also clear guidelines of how the organisation would respond to any complaints received. People who used the service had a copy of the complaints policy in picture format in their rooms. Leaflets with 'How to Complain' were on display in the entrance hall. A relative said they had not had cause to complain but would speak to the social worker or the home manager if they had any issues

A record was kept of any complaints made along with any compliments received. There had been no complaints received in the last twelve months.

Good

Is the service well-led?

Our findings

Before we visited the provider informed the Care Quality Commission (CQC) that the registered manager had left their post in August 2014. When we visited a new manager (the acting manager) was on induction to the service and had applied to CQC to be the registered manager.

We found effective management systems were in place to ensure the service was well led.

There was a motivated staff team who were respectful towards one another and the people they supported. The acting manager told us that the assistant manager was an experienced member of staff who had worked in the home for a long time. They said the assistant manager had provided them with valuable management support since they had started working at the home.

Staff were enthusiastic about their role and they told us they worked well together as a team to provide people with a high standard of care. Staff confirmed they were encouraged to bring in new ideas and were supported to implement and lead any of their ideas into working practice. Individual members of staff had responsibility for specific roles and giving feedback to other members of the team. One example of this was liaising with external care coordinators. The acting manager attended registered managers meetings which provided managers with a forum in which they could share best practice and ideas and keep up to date with new legislation.

Good communication tools were used and staff participated in daily handovers, team meetings and training sessions. Each shift had a shift leader who was responsible for key tasks being completed and managers operated an on call system to make sure staff could access additional support and advice. This ensured people received safe, consistent, person centred care.

Staff completed monitoring checks so issues could be highlighted and addressed in a timely manner. Staff told us for example, that they completed regular bedroom checks to make sure equipment such as a ceiling track hoist, an independent hoist, electric wheelchair and profile beds were in good working order. We saw evidence that any issues raised were dealt with in a timely manner. Regular maintenance checks, portable appliance tests, fire checks and hot water temperature checks were also completed.

There was a business plan that outlined the targets for the home and when the targets should be met. We saw that a monthly audit was carried out by a manager from another service. Audits covered areas such as personal care and support, health and safety, and staffing. A list of action points was compiled following the audit. Quality surveys were sent out on an annual basis to give relatives and external professionals the opportunity to give their views. Results were analysed and plans are put in place to improve the quality of the service.

People who used the service were included in the development of the service when possible. Staff worked with them to ensure they had an opportunity to develop their own interests and lifestyle choices. We saw in the PIR that further identified improvements included increasing the one to one time to support people with their chosen activities and enhance their care. This work involved allocating staff to work with individual people and their families according to people's needs, wishes and preferences.