Community Homes of Intensive Care and Education Limited

Wey View

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

Wey View is a residential care home for upto 10 people with learning disabilities, physical disabilities and mental health conditions. Care is provided within one adapted building, with two annexes. At the time of our first visit, there were seven people living at the home.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service Good.

Why the service is rated Good

People benefitted from a proactive approach to risk management and staff responded appropriately to incidents. Where there had been some recent concerns about staff culture, the provider had learned from these and identified plans to resolve them. People's medicines were managed safely and the home was clean, reducing the risk of the spread of infection. There were enough staff working at the home to keep people safe and the provider carried out appropriate checks on new staff to ensure that they were suitable for their roles.

The food on offer matched people's preferences and dietary needs. 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 supported this practice. People's had access to healthcare professionals and the home environment was adapted to ensure it met people's needs. Staff had received appropriate training and support for their roles.

People were supported by caring staff that they got on well with. Staff took time to involve people in their care and care was planned in a way that encouraged people to be independent. Staff were respectful of people's privacy and dignity when providing support to them.

Care was planned in a person-centred way and staff knew what was important to people. People had access to a range of activities that were personalised to their needs and interests. Care plans were regularly reviewed and any changes were actioned by staff. There was a complaints procedure in place that was accessible to people and complaints were investigated and responded to appropriately.

People interacted well with the registered manager and staff had regular meetings to contribute to the running of the service. Regular checks and audits were carried out to identify improvements to people's care. People were regularly involved in the running of the home through meetings and surveys. Where appropriate, the provider had notified CQC of significant events in line with their statutory duty to.

Further information is in the detailed findings below

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Wey 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 was a comprehensive inspection that took place on 25 May 2018 and 26 June 2018 and was unannounced.
The inspection was carried out by two inspectors.

This inspection was brought forward due to concerns shared with CQC by the local authority safeguarding team and the provider. There had been three safeguarding incidents that had raised concerns with staff culture and practice. This inspection found that whilst there was evidence there had been shortfalls in staff culture, the provider had already taken action to address them and the improvements were in the process of becoming embedded.

Because we brought this inspection forward, the provider was not asked to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

As part of the inspection, we spoke with two people and observed interactions and care for people who could not provide us with verbal feedback. We spoke with the registered manager and three care staff. We looked at care plans for two people, records of incidents, complaints and records of checks and audits. We looked at risk assessments, mental capacity assessments an applications to the local authority DoLS team. We checked three staff files and records of staff meetings and service user meetings.

Good

Is the service safe?

Our findings

People felt safe living at the home. One person said, "Yes its safe." We observed staff supporting one person to move through the home and they looked safe and comfortable with staff. Another person nodded when we asked if they felt safe and we observed they looked comfortable with the staff member who was supporting them.

Risks to people were assessed and plans were implemented to keep them safe. Care plans contained risk assessments that showed the provider considered the potential risks people faced in areas such as behaviour, activities, health and nutritional risks. For example, one person was at risk of becoming anxious and could sometimes display behaviours that might place them at risk. There was clear guidance for staff on how to identify changes in the person's behaviour and how to respond. Staff were knowledgeable about these measures when we spoke with them. Another person had epilepsy and their care plan contained detailed guidance for staff on how to respond in the event of a seizure. There was information about triggers and how equipment and medicines were used to support the person safely.

Staff responded appropriately to accidents and incidents. The provider kept a record of all incidents that occurred and staff recorded the actions that they had taken. The actions taken were appropriate and measures were identified to prevent an incident from reoccurring. Records also showed that staff had been escalating safeguarding concerns to the registered manager and these had then been shared with the local authority safeguarding team.

Lessons were learned when things went wrong. Before our inspection, there had been concerns raised about staff culture at the home. The provider had received concerns through their own whistleblowing systems and had shared these with CQC and the local authority. Following this, some staff had left and the provider had recruited new staff. Work was undertaken with existing staff to remind them of their responsibilities and to develop a more positive culture. At the time of our visit, we noted that staff had recently been recruited and had recently been through induction. Staff told us they had started to see an improvement in morale and we received positive feedback form the local authority about the improvements. We will follow up on the progress of these improvements at our next inspection.

There were sufficient staff present to safely meet people's needs. During the inspection we observed staff with people at all times. People living at the home had needs that required ongoing supervision and we observed that this was fulfilled. The provider calculated staffing levels based on the needs of people and people told us that there were always staff around. The provider carried out appropriate checks on all new staff. Records showed the provider obtained references, full work histories, health declarations and a check with the Disclosure & Barring Service (DBS). The DBS holds a record of staff that would not be appropriate to work in social care.

People received their medicines safely. Medicines were stored securely and the temperature of the storage area was checked daily to ensure that medicines were stored in line with the manufacturer's guidance. Staff had been trained medicines and had to pass a competency before administering medicines to people.

Medicines records contained important information about people's medical conditions and any allergies. We noted that there were photographs of people on medicine administration records (MARs) to enable staff to identify who they were administering medicines to. MARs were up to date with no gaps, where people had not received their medicines for any reason staff had recorded the reason why on the MAR.

People were protected against the risk of the spread of infection. The home environment was clean and staff completed cleaning tasks each day. Staff completed checklists to account for the cleaning that they had done and management regular checked this. We noted that people's care plans contained details of support from staff to clean their own rooms and we looked at one person's room and saw it was very clean and tidy. The provider carried out regular audits of infection control to ensure standards were maintained in this area.

Good

Is the service effective?

Our findings

People told us that they liked the food that staff supported them to prepare. One person said, "The food is nice here."

People's care plans contained information about their food preferences and dietary needs and these were met. For example, one person was assessed as at risk of choking because they often ate quickly. To manage the risk, staff cut up the person's food to make it easier to eat. They also sat with the person and supported them to eat by providing prompts when they ate too quickly. Care plans also recorded people's favourite foods and staff worked with people, using pictures, to write menus and go shopping for ingredients for meals.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether staff were following the guidance of the MCA and found that the correct legal process was being followed. For example, one person was assessed as unable to consent to staying at the home. A best interest decision as documented that involved the person's relatives, staff and healthcare professionals. As restrictions were being placed upon the person in their best interests, an application was made to the local authority DoLS team.

People benefitted from a thorough assessment before they came to live at the home. The provider completed an assessment document for all new admissions and also enabled a period of transition to ensure people could get to know staff. For example, one person had recently come to live at the home from another service. The provider gathered information and a member of staff went to stay with the person at their previous home to meet them and the staff that cared for them. The person then came to stay at the home to get to know staff and the home environment. Relatives and healthcare professionals were involved throughout the process and records showed that the information gathered was used to implement a detailed care plan for the person.

The home environment was tailored to people's needs. Communal areas were bright and spacious to allow those that used mobility aids to move safely around the home. Signage was on display around the home that used pictures to help people to orientate themselves within the environment. People were observed making use of the garden area which had clear pathways to enable people to move around this area of the home.

Staff supported people to meet their healthcare needs. Care plans included evidence of ongoing involvement from healthcare professionals. The provider employed a psychologist that regularly visited people and we saw evidence of their involvement in setting up care plans for people's behaviour and wellbeing. Where another person was under the care of the community mental health team (CMHT) we saw evidence of visits and information about their prescribed medicines in their care plan.

People were supported by staff that had the right training and support for their roles. Staff told us they completed mandatory training and records confirmed this. There was a clear induction for staff that involved shadowing experienced staff members. Staff had training specific to the needs of the people that they supported and we noted staff had completed specialist training in how to respond to risks associated with people's behaviour. Staff had regular supervision and appraisals and told us that they found these beneficial.

Good

Is the service caring?

Our findings

People told us that they got on well with the staff that supported them. One person said, "Staff are all very good here, they are available when I need them."

During the inspection we observed pleasant caring interactions between people and staff. For example, one person was sitting in the lounge playing a game with another person. Staff were joining in and encouraging both people in the game. People were smiling and looked happy in the presence of staff. Throughout the day staff and people engaged in humour together and it was evident that staff knew how to make people laugh.

People's independence was encouraged by staff. One person told us, "I need less support with some things and they [staff] give me freedom." Care plans reflected people's strengths and any goals that they wished to achieve. For example, one person was becoming used to going out in the local community. This was in their care plan and the person told us that they liked going out. There were measures in place to check the person was safe when they went out independently. Staff regularly encouraged people to complete personal care tasks themselves and people were involved in household chores and cooking to enable them to develop skills.

Staff involved people in their care. People were observed being given choices by staff, such as with food, drinks and activities. For example, in the morning we observed one person being supported to prepare breakfast. Staff said to the person, "Do you want some breakfast?" The person used gesture and vocalisation to select a cereal and staff helped the person to put it in a bowl.

Care plans contained evidence of people being asked about their preferences and this was regularly checked at reviews. Care documentation and signage around the home used pictures and social stories to ensure that they were accessible to people. Staff had regular review meetings with people and these were used to give people opportunities to make changes or new suggestions. Records showed that at a recent review, a person had asked for some summer activities to be added to their activities timetable and staff had actioned this. The provider had systems in place to allow people to express their culture, faith or sexuality. The provider's assessment process asked questions relevant to this and we saw evidence of social stories being used when supporting people in this area.

Staff were respectful of people's privacy and dignity. Throughout the day we observed staff knocking on people's doors and waiting for permission before entering. Where people required personal care, we observed people were taken to their rooms or bathrooms and personal care was delivered behind closed doors. Staff were knowledgeable about how to respect people's privacy when we asked them.

Good

Is the service responsive?

Our findings

People told us that they were supported to engage in activities that they liked. One person said, "I go out a lot, to the shops or to the pub."

People had individual activity timetables that included a variety of activities and clubs. Daily notes showed that people went out every day with staff or independently where they were able to. We noted that activities reflected people's interests. For example, one person liked historical buildings and was regularly supported to attend National Trust homes. They had pictures of these in their room and we observed staff talking to them about a recent outing. Another person's care plan documented that they had an interest in gardening. The provider had built the person their own shed in the garden and they regularly spent time outside working on the garden. People went out each day either independently or with staff and we observed them doing so on our visits.

Care was planned in a person-centred way. Care plans contained detailed guidance for staff on people's needs, routines and what was important to them. We observed staff following the guidance in people's care plans to achieve positive outcomes. For example, one person had a care plan with information for staff on how to support them if they become anxious. During our inspection, we observed that the person became anxious and required support from staff. Staff supported the person to a different part of the home and reminded the person about 'social rules'. Staff used a calm slow tone when speaking with the person and allowed them time to feel better. We checked this person's care plan and it clearly reflected the interactions we had observed, which showed that staff knew and followed this person's care plan.

People living at the home were of a young age so care plans did not contain detailed information about end of life care. The registered manager told us that should a person reach this stage of their lives, care plans would be put in place and they would work alongside healthcare professionals, such as the local hospice, to ensure personalised care continued throughout this stage of a person's life.

People's care plans were regularly reviewed. Each month people had a review of their care needs in which staff went through their care plans with them to identify any changes. The reviews involved people, relatives, staff and any relevant healthcare professionals. For example, one person's recent review had input from a psychologist to increase the support for a person to achieve goals by going out within the community.

Complaints were investigated and responded to. Information on how to complain was displayed in the home and was available in an accessible format for people. Staff regularly asked people for feedback through reviews and surveys and relatives had the information needed to raise a complaint. There was a complaints policy in place that provided the details of who to contact and the provider's timescales for responding to complainants. The service had dealt with one complaint since the last inspection and this had been investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

People got on well with the registered manager. During our visits, we observed people interacting with the registered manager and this was positive. People came to the registered manager to speak to them and were observed looking happy and smiling in their presence.

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

Regular audits were carried out to check the quality of the care that people received. The provider carried out a variety of audits that covered important areas such as health and safety, infection control, documentation and care delivery. The provider also carried out regular visits where holistic audits were carried out to monitor the quality of the care that people received. Where audits identified improvements to be made, these were actioned by management. For example, a recent provider visit identified that changes to the numbers of people living at the home meant more group activities were possible and these had then been added to the timetable. Actions from audits fed into an overall improvement plan for the home which meant that actions could be tracked and signed off when completed. The action plan was detailed and showed recent improvements in areas such as communication, staff appraisals and documenting people's healthcare appointments.

People were involved in the running of the home. Regular meetings took place in which people could express their views and make any requests or suggestions. The most recent meeting showed staff had spent time with each person individually to identify any actions and these were documented and reported back on at the next meeting. For example, one person had expressed a wish to attend an event being put on by the provider and so this was arranged in response to their request. There were also regular surveys as well as review meetings to provide people with opportunities to give their feedback.

Staff were supported and had opportunities to improve the home. As reported in 'Safe', staff told us that there had been a negative culture at the home but that this had improved following changes to the staff team. In response to these issues, management had increased supervisions of staff and held meetings and discussions in order to ensure staff views were taken into account. New staff had been recruited and were becoming settled into their roles at the time of our visit. We spoke to a new member of staff who said they had been given a lot of support whilst familiarising themselves with their new role. They said, "I did an induction and have had weekly supervision. The management have been so supportive, I can ask them anything."

The provider understood the responsibilities of their registration. Providers are required to notify CQC of important events such as injuries, police contact and any allegation of abuse. We found that wherever required, the provider had notified CQC of these events. For example, the police had been called to recent incidents involving one person and CQC had been notified appropriately on each occasion.