Community Integrated Care

Cherryvale

Inspection Report

Acrefield Road
Gateacre,
Woolton,
Liverpool,
L25 5JN
Tel: 0151 428 4458
Website:

Date of inspection visit: 01/04/2014
Date of publication: 23/07/2014

Contents

Summary of findings

Overall summary

Cherryvale is a residential care home that provides accommodation, care and support for three adults with a learning disability and other complex needs. The building is a three bedded bungalow situated in the Woolton area of Liverpool and is close to shops and pubs.

A registered manager had not been in place at the service since May 2013. The previous registered manager appears on this report, because at the time of the inspection they were still listed as the registered manager on the Care Quality Commission register. The registered manager of another Community Integrated Care service had taken the manager role of Cherryvale alongside their own post. This manager was present during the inspection visit.

People living at Cherryvale were receiving good care and support that was tailored to meet their individual needs. Overall, staff ensured they were kept safe from abuse and avoidable harm.

Staff recruited underwent robust recruitment checks to ensure they were suitable to work with vulnerable adults. A comprehensive induction programme was in place and staff were well supported through supervision and training. Training levels were low. We found plans were in place to increase staff access to training with a number of staff booked on forthcoming training courses.

We found staff were caring and treated people with dignity and respect. People had access to the local community and were supported to go out for lunch or shopping.

The culture in the service was positive. From listening to people's views we established that the leadership in the home had strengthened over the time the current manager had been covering the post. We found the acting manager took steps to ensure the service learnt from mistakes, incidents and complaints.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People living at Cherryvale were safe because they were protected from bullying, harassment, avoidable harm and potential abuse. Staff understood what abuse was and had reported incidents of potential abuse appropriately. Where people experienced behaviour that may challenge the staff working at Cherryvale, plans were in place to allow staff to manage this safely.

The manager had a good understanding of the Mental Capacity Act 2005 and had ensured capacity assessments were undertaken when required. However, staff working in the home had not had training in this area and had a limited understanding of the legislation. Risk assessments were in place in the service and restrictions were minimised. However, in one case, the restrictions in place for one person had been identified as requiring consideration under the Deprivation of Liberty Safeguards but had not been correctly reported to the local authority.

There were sufficient staff members on duty to meet people's personal care needs and keep people safe during the day. Robust recruitment checks were in place to ensure staff were suitable to work with vulnerable adults.

Are services effective?

People's care needs were assessed when they came to live at Cherryvale. We found people's care records were personalised and provided clear guidance on how their care needs should be met. We found minor recording errors in people's care records, which were resolved on the day of the inspection. People were supported to access healthcare from a range of professionals.

Cherryvale was accessible to the people who lived there and was clean and tidy.

Staff members had access to a comprehensive induction programme when they started work at Cherryvale. Staff received good support through supervision and all members of staff had received their yearly appraisal. Training levels were low. We found plans were in place to increase staff access to training with a number of staff booked on forthcoming training courses.

Are services caring?

We saw that staff were caring and treated people with dignity and respect. Relatives told us that people were treated with dignity and

Summary of findings

respect. This was supported by the relatives we spoke with. Staff had a good knowledge of people's care needs and preferences and tried different approaches to establish what people liked and didn't like through their body language and behaviour.

Are services responsive to people's needs?

People living at Cherryvale could not verbally express their views. We found staff made efforts to interpret people's behaviour and body language to involve them as much as possible in decisions about their day to day care. Relatives we spoke with worked with staff from Cherryvale to ensure information about people's preferences was understood and could be used to inform day to day decision making. None of the people living at Cherryvale had an advocate.

Overall, we found people received personalised care that was responsive to their needs. People were supported to access the community and go for lunch or go shopping. One person attended a local day centre three days per week. A mini bus had been rented so people could go out more regularly.

Are services well-led?

From our observations and speaking to staff and relatives of people using the service we found that the culture in the service was person centred and open. From listening to people's views we established that the leadership in the home had strengthened over the time the current manager had been covering the post.

The manager had placed a focus on improving continuity of staffing, and the delivery of supervisions that incorporated the values expected by the provider. We found the manager took steps to ensure the service learnt from mistakes, incidents and complaints.

Emergency plans were in place. Plans for people being evacuated at night time required review as they could not be implemented with the current staffing levels in place.

Summary of findings

What people who use the service and those that matter to them say

The three people living at Cherryvale at the time of the inspection had learning disabilities and other complex needs. They could not verbally express their experiences of living at Cherryvale. Therefore, we spent time observing care in a lounge area and used the short observational framework (SOFI), which is a specific way of observing care to help us understand the experience of people who could not talk with us. Our observations supported that people were treated with respect and dignity. We found that staff tried to involve people with day to day tasks.

We spoke on the telephone with one close relative of each of the people living at Cherryvale. We found people's relatives had been closely involved in discussions about people's care and support.

Relatives we spoke with told us that people were treated with dignity and respect. One person told us they felt staff were very kind to their relative and their personal care was "looked after beautifully" and they were always clean and tidy. They went on to say that "staff interact and sing" which was important to meet their relative's individual needs.

All three of the relatives we spoke with were very positive about the care provided by staff at Cherryvale and told us if they had any significant concerns they would be happy to raise those with the manager. All described an occasion where they had brought something to the manager's attention and this had been acted upon. However, two of the relatives we spoke with highlighted that they don't always feel comfortable in highlighting the need for minor improvements in care to all members of the staff team. We discussed this with the manager who told us they would explore this further.

We found staff made efforts to interpret people's behaviour and body language to involve them as much as possible in decisions about their day to day care. Relatives we spoke with worked with staff from Cherryvale to ensure information about people's preferences was understood and could be used to inform day to day decision making. One relative said ""We feel happy with the contact, they have always contacted us over decisions and things. Decisions are made as a team."

Cherryvale

Detailed findings

Background to this inspection

The inspection was carried out as part of the first testing phase of the new inspection process we are introducing for adult social care services. The inspection team consisted of a Care Quality Commission Inspector and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Cherryvale provides care and support to people with a learning disability and other complex care needs.The people living at the home were unable to tell us about their views and experiences. Due to this we spoke with three relatives of people living in the home. We spent time observing care in the lounge and used the Short Observations Framework for Inspection (SOFI) tool, which is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with the manager of the service, the regional manager, and the support workers on shift on the day of the inspection. Following the inspection, we spoke with one person's social worker. We viewed a range of records including: people's care records; staff records; and the home's policies and procedures.

The last inspection took place in December 2013 and no concerns were identified.

Are services safe?

Our findings

The three people living at Cherryvale at the time of the inspection had a learning disability and other complex needs. They could not verbally express their experiences of living at Cherryvale such as whether they felt safe or if they were involved in making decisions about any risks they may take. We were instead able to speak on the telephone with one close relative of each of the people living at Cherryvale. We found people's relatives had been involved in discussions about any risks and the care and support in place relating to those risks. From our observations, staff were taking steps to ensure people living at Cherryvale were safe.

The home had a corporate safeguarding policy in place, which had last been updated in June 2013. This stated that the policy should be used in line with Local Authority safeguarding policies and procedures. A flow chart about how to make a safeguarding alert was displayed on a noticeboard in a communal area of the home. We spoke to a support worker about safeguarding. They had a good understanding of what abuse was and were able to clearly describe how they would respond if they identified potential abuse. Over the last year, the manager had raised two safeguarding alerts with the local authority and notified the Care Quality Commission. In addition, we found staff had appropriately identified, recorded and responded to incidents and accidents that had taken place in the home. This meant that steps were taken to keep people safe and protect them from abuse and avoidable harm.

Where people may exhibit any behaviour that may challenge others, there were care plans in place to advise staff of how to provide suitable care and support. The manager said staff communicated daily at handover to discuss any issues or concerns and to pass on what had worked well. The manager and support worker we spoke with explained that restraint was not used in Cherryvale.

The manager and regional manager demonstrated a good understanding of the Mental Capacity Act 2005. Staff had access to the code of practice through the company intranet page. However, support workers had not accessed training on the Mental Capacity Act 2005. A good understanding of the Mental Capacity Act was of particular importance to support workers at Cherryvale as the people living at Cherryvale did not have the capacity to make significant decisions. The manager told us they had identified this as a training gap, staff had been due to attend a local authority course, which was cancelled. The manager was awaiting another date for the training.

We found that the manager had correctly identified that measures in place to restrict one person's movements could mean they were being deprived of their liberty. The manager had raised this with the person's social worker as requiring consideration for a Deprivation of Liberty Safeguarding order to consider the restriction in place. However, the manager had not made the application for a Deprivation of Liberty Safeguards order in line with Liverpool City Council guidelines. Due to this it had never been considered. Care homes are responsible for making such applications. We discussed this with the manager who acknowledged they had not understood the process as had not made an application before. The manager told us they would liaise with the person's social worker to make the application. The failure to correctly refer meant there had been a breach of the relevant legal regulation (Regulation 11 (2)) and the action we have asked the provider to take can be found at the back of this report.

The two toilets, (one upstairs and one downstairs) did not have any hand washing facilities. This meant that people needed to go into the shared shower room to wash their hands. No hand gel was present in the areas of the home we visited. This presented a barrier for staff members maintaining good hand hygiene practices.

The manager showed us the staff rota in use at the time of the inspection and explained how many members of staff were allocated to each shift. There were routinely two support workers on shift during the day, and one support worker on a waking night. On four days per week, there was an additional member of staff on the day shift (as one person living in the house was at day centre or with their family three days per week). In addition, the manager worked in Cherryvale for 18.5 hours per week supernumerary. Six support workers were employed by Community Integrated Care, and three members of staff were bank workers that routinely worked at Cherryvale.

From our observations of the care delivered, two staff members were sufficient to keep the two people in the house safe and meet their personal care needs during the day. The manager told us they considered skill mix and experience and always ensured there was one permanent

Are services safe?

member of staff on shift. Relatives we spoke to told us that there had been at times a reliance on agency staff. The manager told us a focus had been placed on reducing this and that staff continuity had improved.

We asked the manager what would happen if the home needed to be evacuated in the event of a fire. The manager showed us the Personal Emergency Evacuation Plans (PEEP) for the three people living at Cherryvale. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people safely who cannot get themselves out of a building unaided during an emergency situation. There were not enough members of staff present to follow the emergency plans in place; as for two people, the plans required two to one support for moving and handling needs. Only one member of staff was on the premises overnight. The manager acknowledged that with the current night time staffing they could not implement the evacuation plans and said they would contact the fire service for advice.

We looked at the recruitment record of a recently appointed member of staff. Appropriate checks were undertaken before the staff member began work. We found a completed application form, evidence of identification taken, references received and evidence that a Disclosure and Barring Service (DBS) check was carried out prior to the new member of staff working in the service. (The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults). The manager showed us documentation that evidenced they had followed disciplinary procedures following an incident of unsafe practice.

Are services effective?

(for example, treatment is effective)

Our findings

The manager told us all three people had been supported by Community Integrated Care from the late 1980s when they had come out of a long stay hospital. Two people had lived at Cherryvale for a number of years. Another person had moved from another Community Integrated Care home to Cherryvale last September. The manager explained to us how they had supported the person to move into Cherryvale; this included a number of transition visits to establish whether the move would be appropriate. We spoke with the person's social worker and they said, "The move was vitally important to ensure it was the right place and it all went really well."

People's assessed needs were clearly reflected in their care records. We found people's care records were personalised and provided clear guidance on how their care needs should be met. People's support plans included information about their personal preferences. For one person we found an inconsistency in the documentation about their moving and handling needs, with some documentation stating they required two to one support and other parts of the documentation stating they needed one to one support. The manager told us they needed two to one support and amended this on the day of the inspection. Staff we spoke with were aware of this. A date was planned for this person's moving and handling needs to be reassessed.

People's healthcare needs were monitored by the staff team. As people living in Cherryvale had a learning disability, each person had received an annual health check with their GP to ensure their health could be reviewed each year. We saw evidence of people attending routine appointments with a range of health care professionals including opticians, dentists and podiatry. For one person, we found that at a hospital appointment in November 2013, it had been identified they would require a further diagnostic test in three months time, and that the hospital would write to the GP to arrange this. At the time of the inspection, the home had not been contacted by the GP. The manager contacted the GP who confirmed they would organise this. As as result of this, the manager told us they had spoken with staff and reviewed the use of the home diary so staff would know when to chase up expected health appointments or diagnostic tests, if they were not contacted in expected time frames.

Each person had an 'information passport' in their care records. This would be used to provide information to health staff if a person required a hospital admission. The manager told us that in all cases, if an admission was required Cherryvale staff would accompany the person to the hospital to ensure care and support was delivered in line with their needs. We viewed one person's information passport. We found this was not fully accurate, the moving and handling needs identified were incorrect, and it stated the person had 'no allergies.' This person did have an allergy to penicillin. The manager acknowledged this and made amendements to the information on the day of the inspection. Following, the inspection the manager told us they had checked the information passports for the other two people in Cherryvale and had found these to contain an accurate reflection of their care needs.

On arrival at Cherryvale on the day of the inspection, we found that the outside of the house required some improvements to make it appear more welcoming. We found the home to be clean and tidy, although the décor was tired and in need of updating and greater personalisation. The house was fully accessible for all people who used a wheelchair. There was available space for people to spend time together or to spend time alone. Each person had their own bedroom and shared a single showering facility.

New staff employed by the home undertook an induction programme. We spoke with one support worker, who had been employed by Community Integrated Care for 18 months. They told us "I shadowed people for two weeks and started working alongside staff as I already had a lot of care experience. It was mainly about getting to know the people I was supporting. The induction was a three day training course and this covered all the different aspects of what our job involved." The manager told us that the induction course had now been extended and took place over six days and included work books to complete and competency checks. We looked at the induction record of one member of staff and found this had been fully completed. This meant that staff when starting work at Cherryvale were well supported to adjust to their new role.

Each new member of staff was subject to a probationary period of employment. This concluded with a meeting to determine whether the staff member was suitable to

Are services effective?

(for example, treatment is effective)

receive a permanent role. Therefore steps were taken to ensure the people employed were fit, and had the appropriate skills and values to undertake their roles in the ethos of Cherryvale.

We found staff received good support through supervision. All staff had received their yearly appraisal. There were gaps in people's mandatory training where it had expired. A new regional training officer had recently been appointed and had put in place clear plans to address mandatory training requirements in areas such as safeguarding, first aid and moving and handling. In addition, the previous e-learning system was being replaced by Community Integrated Support training, which was due to be rolled out to Cherryvale.

Are services caring?

Our findings

Cherryvale provides care and support to people with a learning disability and other complex care needs. The people living at the home were unable to tell us about their views and experiences. Due to this we spoke with three relatives of people living in the home. We spent time observing how people were supported by the staff and made use of the Short Observations Framework for Inspection (SOFI) tool. This tool is used to help us evaluate the quality of interactions that take place between people living in the home and the staff who support them.

We undertook our SOFI observations in the communal lounge during the early evening, for a 20 minute period. At the start of the observation, two people were in the lounge with the television on, which was playing music on MTV. One staff member was also present and sat on the sofa. In the first half of our observations there were limited direct interactions between the staff member and the two people present. At this point, one person started to become distressed and the staff member responded promptly and asked them if they would like to go to their bedroom and shortly after this took them through. This was in line with their care plan.

The other member of staff came into the room with the evening meal for the person remaining in the lounge. The staff member was warm and caring and demonstrated concern for the person's wellbeing while assisting the person. When they declined their food they gave them a minute and then offered the food again. Following this they took the food away and brought back a hot drink and offered the person a drink, which they accepted. The staff member demonstrated a clear understanding of the person's individual needs throughout the observation period.

Relatives we spoke with told us that people were treated with dignity and respect. One person told us they felt staff were very kind to their relative and their personal care was "looked after beautifully" and they were always clean and tidy. They went on to say that "staff interact and sing" which was important to meet their relative's individual needs.

Our observations supported that people were treated with respect and dignity. We found that staff tried to involve people with day to day tasks. For example, one support worker took one person with them into the kitchen whilst they were making the evening meal and talked to them about what they were doing whilst they cooked.

We found that staff had a good knowledge of people's care needs and preferences. The manager explained how the team tried different approaches and observed people's behaviour and body language to establish what people liked and didn't like, and what worked well. For example, for one person with specific nutritional needs close monitoring had been put in place to observe any patterns that related to the person's willingness to eat.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People living at Cherryvale could not verbally express their views. We found staff made efforts to interpret people's behaviour and body language to involve them as much as possible in decisions about their day to day care. Relatives we spoke with worked with staff from Cherryvale to ensure information about people's preferences was understood and could be used to inform day to day decision making. One relative said ""We feel happy with the contact, they have always contacted us over decisions and things. Decisions are made as a team."

People did not have capacity to make significant decisions relating to their care and support needs. We found people's capacity had been considered as part of the proposal to change the status of Cherryvale from a residential care home, to a supported living house where each person would have their own tenancy. As part of this each person's capacity had been reviewed by the Court of Protection, as the provider was acting as the appointee for all three people living at Cherryvale.

The manager told us that none of the people living in Cherryvale had an advocate, although the information about advocacy services was available if needed. This was because all three people had active family involvement in their care. One relative we spoke with told us that they would benefit from the involvement of an advocate to aid them when discussing changes or issues with their relative's care. They were uncertain of how they could obtain this and said they would like this to be an option.

Overall, we found people received personalised care that was responsive to their needs. For example, the manager had facilitated consultation with families and conducted a best interests process to reach the decision for a mini bus to be rented. This meant that staff could support people to access the community and trips out more regularly. The manager told us they had just recruited another support worker who would be able to drive the mini bus.

We found that staff at Cherryvale were regularly assessing people's individual needs and responding to changes in their needs. For example, one person indicated they did not wish to eat solid foods by declining to accept the food when it was offered. The manager had made a referral to the Speech and Language Team (SALT) and the person's care needs around their nutrition had been assessed and a new care plan put in place. The manager told us that now the person was offered solid foods at each meal time and if these were refused then a liquid food substitute was offered as an alternative.

On the day of our inspection, one person was out at the day centre they attended three days per week. The other two people went out with their support workers for a pub lunch in the middle of the day. We found people did have access to activities outside the house they enjoyed. In addition, we were told that there were links between Cherryvale and other CIC services. For example, one person like to attend the 'music man' entertainment at another house. Another person, enjoyed the company of a person living at another Community Integrated Care service and the manager told us their friend was brought over to visit a few times a year.

We did observe there did not appear to be much to do in Cherryvale that was not directly related to day to day care tasks. We asked one of the support workers about this and they told us the complex needs of the people living at Cherryvale meant it was difficult for them to interact with many activities beyond speaking with them and engaging them in everyday tasks. We did not see recorded evidence of staff engaging people in 'active support' in the care records. Due to this, it was not possible to determine the extent to which people spent time engaged in activities they enjoyed.

Cherryvale used the organisation's corporate comments, compliments and complaints policy. The manager told us there had been no recorded formal complaints in the last twelve months. Due to this, we did not review any complaints to ensure they had been investigated and responded to appropriately.

All three of the relatives we spoke with were very positive about the care provided by staff at Cherryvale and told us if they had any significant concerns they would be happy to raise those with the manager. All described an occasion where they had brought something to the manager's attention and this had been acted upon. However, two of the relatives we spoke with highlighted that they don't always feel comfortable in highlighting the need for minor improvements in care to all members of the staff team. We discussed this with the manager who told us they would explore this further.

Are services well-led?

Our findings

At the time of the inspection a registered manager was not in place at the service. The previous registered manager appears on this report, because at the time of the inspection they were still listed as the registered manager on the Care Quality Commission register. The registered manager of another Community Integrated Care service had instead been managing two locations spending 18.5 hours per week in each home.

From our observations and speaking to staff and relatives of people using the service we found that the culture in the service was person centred and open. From listening to people's views we established that the leadership in the home had strengthened over the time the current manager had been covering the post. The manager had placed a focus on improving continuity of staffing, and the delivery of supervisions that incorporated the values expected by the provider.

Community Integrated Care had a whistleblowing policy, which was available to all staff through the company intranet page. The support worker we spoke with was aware of the policy and told us they would feel able to raise any concerns they had. We saw evidence that a staff member had promptly highlighted a safeguarding concern to the manager that related to the practice of another staff member, and that this had been actioned immediately to protect the safety of the person concerned.

Staff at the home used an electronic incident and accident system that was in place across all Community Integrated Care services. The manager showed us how they would enter details of an incident into the system. At the time of the inspection, the link to log in and view previous incidents, was not working correctly. Therefore the manager could not access or show us previous incidents they had entered onto the system. The manager was able to explain to us in detail the action they had taken following a recent incident involving medication, which had included staff re-training and competency assessment. Following the inspection the manager confirmed they had been able to access the system. They sent us a summary of the seven incidents that had taken place over the last year and actions taken. We reviewed this summary of incidents, which demonstrated incidents had been correctly identified, reported and action taken when necessary.

Regional leadership meetings were held, where managers from each Community Integrated Care home met monthly to discuss care provision. We were shown the minutes of two recent meetings where a number of topics were discussed including: training; appraisals; payroll; and incidents. This demonstrated that arrangements were in place to consider and learn from information arising from safeguarding, concerns and incidents.

Alongside the project to move to supported living houses, the company was also undergoing a staffing restructure that will be completed by June 2014. The regional manager told us that managers of the residential care homes would be eligible to reapply for posts in the new structure. Each manager would be likely to cover a number of the supported living houses. We asked if there was to be a senior support worker role in the new structure and were told this was under consideration but a final decision had not yet been reached. The manager told us the company had held consultation events to communicate the changes and what they would mean for staff and reported that this had been helpful. This meant that information had been communicated from provider level to staff working in Community Integrated Care services.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 11 (2) HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding service users from abuse.** Suitable arrangements were not in place to protect service users against control measures being unlawful or otherwise excessive.