The Royal National Institute for Deaf People

RNID Action on Hearing Loss Watery Lane Cottage

Inspection report

Poolemead Centre
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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

Watery Lane Cottage is a care home providing accommodation and personal care to a maximum of three Deafblind people with additional complex care needs. At the time of our inspection there were three people living at Watery Lane Cottage.

The service was all on one level and was well suited to the needs of the people who lived there. Accommodation included three ensuite bedrooms, a staff sleep-in room, office and open plan kitchen, living and dining area. The wide corridors and open plan living area enabled people to move around independently where possible.

At our last inspection in August 2016, the service was rated Good. At this inspection we found the service remained Good. 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.

Why the service is rated Good:

Risks to people were assessed, recorded and actions were taken to minimise or manage risks. People's medicines were administered as prescribed and managed safely by suitably trained staff. The provider planned to resume regular medicines audits.

Policies, procedures and checks were in place to manage health and safety. This included the reporting of incidents and accidents, as well as regular equipment checks and maintenance. Systems were in place to ensure that the quality of the service was monitored, and that improvements were made where necessary.

Effective recruitment procedures were followed to ensure prospective staff were suitable to work in this service. Sufficient staff were employed, and they received training in a range of subjects to make sure people received safe and effective care. Staff were warm and caring, and there were positive interactions between staff and people using the service.

People's wishes and preferences were considered, and the design and decoration of the service promoted people's independence and reflected their needs and interests.

People's needs were assessed and regularly reviewed, and people received personalised, effective care. People had access to a wide range of personalised activities.

Staff liaised with other professionals as needed. For example, regarding finances, advocacy or when there were concerns about a person's health. Routine health checks and monitoring were arranged as required.

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.

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**

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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 was a scheduled, comprehensive inspection, and it was unannounced. The inspection was carried out by one adult social care inspector and one 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 service. The inspection team was supported by a registered sign language interpreter during the inspection. This was because people living at the service and some staff communicated using different types of sign language.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We looked at the care records of all the people using the service. We also reviewed the personnel files of three members of staff, as well as training records, rotas, audits and other records relating to the management of the service. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints, mental capacity, recruitment and medicines. We reviewed all of this information to help us to make a judgement about the service.

During the inspection we spoke with two of the three people who used the service. We talked with five staff,

including the registered manager and deputy manager. A registered interpreter supported us in talking with people and some staff. After the inspection we contacted four relatives of people who used the service. We received written feedback from three health and social care professionals who worked with the service. You can see what they told us in the main body of the report.

Good

Is the service safe?

Our findings

People continued to receive a safe service. Staff had received training in safeguarding and were able to describe how they kept people safe and what actions they would take if they had concerns for people's safety. Comments included, "I've never had any concerns, and all the staff notice everything," and "I would check if the person was ok, and report it to a senior. I'd take it higher if needed, and make sure something was done." Policies, procedures and guidance supported staff, and the management team met their responsibilities regarding safeguarding.

Systems were in place to identify and manage risks to people living in the home. People's care plans had risk assessments which were individualised and provided staff with clear descriptions of specific risks and guidance about how to manage these. Risks assessed included mobility, finance arrangements, and specific physical and mental health needs. A professional told us, "Risk management is effective and responsive." Staff told us that they were updated about risks and said the management team supported them to ensure people were safe.

The people who used the service required at least one to one support from staff. There were enough staff available to meet people's needs when we visited. One staff member told us, "Here there is more time to spend with people." There were some staff vacancies within the team. Shortages were covered by permanent and relief staff, and agency staff were never used. One staff member said, "The management team always check if there's enough staff. There's always cover."

A recruitment programme was in place, and there were effective processes to ensure suitable staff were employed. Checks were carried out before people were employed. This included obtaining references and a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any past convictions that may mean they are unsuitable to work in this kind of service.

Systems were in place to ensure people's medicines were managed safely by staff. Medicines were obtained, stored, administered and disposed of appropriately. New medicines administration records (MAR) had recently been introduced by the local pharmacy. These were clear and up to date, but did not detail known allergies or include a body map for topical medicines. We highlighted this to the management team, who stated they would make changes following the inspection. We checked people's medicines against their records. This confirmed they were receiving their medicines as prescribed.

People living at the service did not have any medicines with additional security or specialised storage requirements. No-one at the service had been prescribed medicines on an 'as required' (PRN) basis, and non-prescription medicines used for simple complaints were kept safely and used appropriately. Medicines audits had been completed each month until May 2018, but not since that date. We discussed this with the management team, who planned to restart medicines audits.

Staff were trained in health and safety matters including infection control, food hygiene and fire safety, although some staff required update training. The registered manager planned to address this. Regular

checks were carried out on the environment, and equipment was serviced, monitored and repaired to ensure people were safe.

Systems were in place to keep people safe in the event of an emergency. For example, in the event of a fire there were a range of alarm systems including lights and vibrating bed alarms, and people had emergency evacuation plans which described their individual needs. Deaf staff had access to pagers which alerted them to incidents and emergencies. Accidents and incidents were recorded and monitored to ensure lessons were learned and risks managed as needed. This all helped the provider to ensure people were safe in the service.

Good

Is the service effective?

Our findings

People continued to receive effective care. Relatives told us, "[Name] is well cared for and is offered choice in [their] meals, clothing and outings. [They have] a full and active life and is supported to do the things [they] enjoy. A professional told us, "Residents have a person-centred service to enable them to live an active, independent and meaningful life."

A one-page summary sheet in each person's care record provided information about individual needs and preferences. This supported staff to deliver personalised care which was effective.

Staff supported people to share their views and opinions about how care and treatment was provided. Individual choices and preferences were respected and people were encouraged to make day to day decisions, for example about food and activities. A range of communication methods were used, and staff had clear information about people's needs. Care plans stated, "If [Name] asks to buy snacks, [they] tend to choose unhealthy crisps. Staff can suggest healthier alternatives, but it is [Name's] choice," and, "If you want [Name's] attention, tap [their] hand, but if [they are] finger spelling, please let [Name] finish and be patient with [them]." This supported people's choices and consent when possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, this is usually through Mental Capacity Act application procedures called Deprivation of Liberty Safeguarding (DoLS). Appropriate DoLS applications were in place to ensure people were only deprived of their liberty for their own safety. For example, the continuous supervision of people and the use of sensor mats in bedrooms. Some DoLS applications were due to be renewed, and there was evidence that the provider had checked and updated these. Training, policies and procedures supported staff in this area.

A training plan was in place for all staff, and records showed that most staff were up to date with training which was relevant to their role, although some staff required update training. Staff said that training was useful, and they could ask for specific training which reflected the needs of the people they supported. One staff member told us that they were due to attend training about diabetes soon, and another staff member said they had received epilepsy training. Deaf staff told us sign language interpreters supported training sessions. This ensured all staff had the knowledge and skills to support people effectively.

People's nutritional needs were met by the service. Weight monitoring, preferences and specialist support needs were detailed in care records. Staff prepared meals that people chose, and were aware of people's nutritional needs and preferences. For example, one person liked spicy food, whilst another enjoyed more simple meals. One person said, "I have pork, and curry, and sometimes rice, and that's really nice", and another person told us that they particularly enjoyed, "Chicken and chips in London, and pork scratchings."

People had access to healthcare services and received regular health and medication reviews. The service worked with a range of health professionals to meet people's needs including GPs, specialist deaf services staff, mental health staff and physiotherapists. A health professional told us that they were confident that the service met people's complex needs, stating, "They put their clients first and…ensure their medical

management is put as priority."

The design and decoration of the service promoted people's independence, and their needs were taken into account. For example, the large open plan communal living area was free from obstruction and enabled people to move around more safely. People were familiar with the environment, and were supported to move around it as independently as possible.

People had been involved in the decoration of their rooms, and there were many good examples of people's hobbies and preferences reflected in individual's bedrooms. For example, one person had photographs of them enjoying theme park rides, and another person's room focused on their love of transport and travel. This person's room contained tactile maps of the London underground which used different textures and objects to support their understanding and recall.

Good

Is the service caring?

Our findings

People received care from staff who were kind and who knew them well. The service continued to provide care that was person centred. For example, staff talked sensitively about recent changes they had noted in one person's health and wellbeing and described the plans the service had to ensure the person's needs were met in the best way. This included consulting specialists and considering the person's short and long term needs.

Staff were warm and caring and there were positive interactions between staff and people using the service. For example, staff guided people around the service in the way that they preferred, and people joked with staff at times. Staff took time in their interactions with people and told us in detail about people's communication needs, as well as their preferences and abilities. A staff member said, "I look forward to coming to work. I like these people. I know them. I enjoy it." One person told us, "Support workers here support me. I have supported staff to learn sign language."

Health professionals gave positive feedback about staff. They made comments including, "[Name] is well cared for, feels safe and secure, and trusts staff members," and, "I have only ever seen excellent care from this team." Relatives told us, "[Name] always appears well cared for and gets on well with [their] support workers."

People's dignity was respected, and staff told us that they gave people as much privacy as possible. Guidance was provided in care records, for example about how to promote a person's dignity when changing a continence aid, or the importance of covering someone when supporting them to change clothes. A professional involved with the service said, "Residents are treated as individuals and with dignity and respect." We saw staff supporting people with care and concern.

People's wishes and preferences were described in care records in detail, and information was personalised. Care plans reflected people's needs and abilities and addressed areas including communication and behaviour, activities and cultural needs, and personal care preferences. Staff told us that they could access care records at any time, and received up to date information at shift handovers. This meant that staff could provide individualised care which met people's needs and promoted their independence.

People were not able to be involved in all aspects of reviewing their care, but families were actively involved and advocates supported people and their families in decision making and planning where needed. Advocates are independent people who can give support and advice, and can represent the person about decisions in matters such as care, finances and health. One health professional said the service provided, "Very strong advocacy for the service user." Visiting professionals said that they were always made to feel welcome at the service. One relative told us that they felt sometimes staff weren't prepared for their visits, but added that they were kept informed and involved between visits.

Good

Is the service responsive?

Our findings

People continued to receive care that was personalised and responsive to their needs. People's needs were assessed and regularly reviewed. Staff told us that care plans were up to date and useful, and that they could access information at any time. One staff member said, "It's one of the best things. The paperwork is covered; care plans and folders. It's up to date. New staff know what's needed."

To meet people's complex communication and sensory needs, the service had embedded personal and meaningful ways of meeting the Accessible Information Standard. The Accessible Information Standard aims to ensure that people who have a disability or sensory loss receive information that they can access and understand. People had communication passports in their care records which identified and recorded their specific needs and abilities. Staff knew about people's abilities, and provided information which was meaningful and understandable. For example, during our inspection, staff told us about the best times to communicate with one person, and supported us to understand the unique signs that people used.

People made choices about some aspects of their day-to-day lives. This included activities and routines, personal care and appearance and food choices. Staff told us that people were asked for their feedback in different ways depending on their abilities and needs. This included the use of tactile feedback tools, as well as through discussion in one to one conversations.

Staff provided care which was individualised and met people's needs. They gave examples such as describing how one person's routines structured their day, and how important it was for another person to prioritise regular trips to visit their family. People's hobbies and interests were described, including going swimming, church attendance, travel and enjoying time outdoors. Staff had a good understanding of people's needs and continued to find creative ways of supporting them to have a good quality of life.

People had access to a wide range of personalised activities. These were within the service, at local specialist resources, or in the wider community. For example, people attended a range of workshop activities including woodwork, music and art; enjoyed going shopping and to cafes; and going on trips and holidays.

One person had a tactile monthly programme of activities in their bedroom. Tiles with meaningful objects of reference were inserted on a large board; these enabled the individual to recall and predict routines and activities. For example, the day after our inspection the person knew that they were going horse riding, and highlighted the symbol showing their birthday. Guidance about how and when this calendar should be used was in the person's care record.

People were in contact with family or friends, and the service welcomed visitors. Staff regularly supported some people to visit family elsewhere in the country. People told us that they enjoyed these visits and that they were important to them.

The service had not received any complaints in the last 12 months. A complaints policy and tactile feedback

tool were available at the service. Relatives told us that they knew how to complain and said that any concerns had been dealt with promptly in the past. Staff told us that they felt able to raise concerns or complaints, and a whistleblowing policy was available.

Good

Is the service well-led?

Our findings

A registered manager was in post at the service. 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.

The registered manager worked closely with the deputy manager and senior care staff. Together they formed a management team who were a visible presence throughout our inspection. Staff told us that the management team were approachable and supportive. One member of staff said, "The management team know what they're doing and how to support staff." Another staff member described the management team as, "Supportive, fair. They treat everybody the same and they listen."

Meeting minutes showed that staff were encouraged to discuss various aspects of the service and ways of developing and improving. Matters such as staffing, people using the service, training and new ideas had recently been discussed in staff meetings.

The management team told us that some staff had not received regular one to one supervision recently because of staff shortages. This is when staff meet with a senior staff member to discuss work or other issues affecting people who use the service. However, staff told us that they felt well supported and a health professional felt that staff met the needs of individuals effectively because they had, "effective management and supervision." All staff had received an appraisal of their performance within the past 12 months. The registered manager planned to review supervision provision in line with the provider's policy.

The provider had clear aims and objectives, which focused on 'people, passion and participation.' Staff told us, "People seem very happy here. People are very positive. It's definitely a good place to work. We know what we're doing and how to support the clients." The provider's aim was embedded in the service and reflected by staff in their work.

Systems were in place which assessed and monitored the quality of the service. These included checks of health and safety issues, fire and medicines. These were usually completed regularly and action plans were developed from completed checks and audits. Progress was monitored and this ensured that the service maintained high standards and continued to improve.

Policies and procedures were available in the service. Some policies referred to best practice or professional guidelines. Staff could access policies, and local information was available at the service.

The last CQC rating was on display. This rating was also clearly shown on the provider's website. The provider is required to display their latest CQC inspection rating so that people, visitors and those seeking information about the service can be informed of our judgments.

The service worked closely with a wide range of external stakeholders and agencies both locally and

nationally. The management team had links with other services and organisations. This supported them to keep up to date with local and national issues and developments.