# Isle of Wight Council

# Saxonbury

## Inspection report

Heathfield Road
Freshwater
Isle of Wight
PO40 9SH

Tel: 01983755228

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## Ratings

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

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

# Summary of findings

## Overall summary

Saxonbury is a care home run by the local authority, which provides accommodation for up to seven people who have a learning disability. At the time of our inspection there were seven people living in the home.

The inspection was unannounced and was carried out on 01 March 2016.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People and their families told us they felt the home was safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. Healthcare professionals such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people, when necessary in a patient and friendly manner.

People who were not able to communicate verbally showed that they understood what was being said and

were able to make their wishes known to staff. Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. They were patient when engaging with people who could not communicate verbally and who used a variety of signs, noises and body language to express themselves. Staff were able to understand people and respond to what was being said.

People's families were involved in discussions about their care planning, which reflected their assessed needs. Each person had an allocated keyworker, who provided a focal point for that person and maintained contact with the important people in their lives.

There was an opportunity for families to become involved in developing the service and they were encouraged to provide feedback on the service provided both informally and through an annual questionnaire. They were also supported to raise complaints should they wish to.

People's families told us they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

There were systems in place to monitor quality and safety of the home provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

## 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 experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people.

People were protected from individual risks in a way that supported them and respected their independence.

People received their medicines safely, at the right time and in the right way to meet their needs.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

### Is the service effective?

Good

The service was effective.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

### Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and important

relationships.

## Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on individual needs and preferences.

People were allocated a keyworker who provided a focal point for their care and support.

The registered manager sought feedback from people, their families and health professionals and had a process in place to deal with any complaints or concerns.

## Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff. The registered manager adopted an open and inclusive style of leadership.

People, their families, health professionals and staff had the opportunity to become involved in developing the service.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment.

# Saxonbury

**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 checked 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.

The inspection was unannounced and was carried out by one inspector on 01 March 2016.

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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with four people living at the home and engaged with two others who communicated with us verbally in a limited way, we spoke with two relatives and a visiting health professional. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three members of care staff, a senior care staff member and the registered manager.

We looked at care plans and associated records for four people using the service, staff duty records, four staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in April 2014 when no concerns were identified.

Good

# Is the service safe?

## Our findings

The people told us and indicated they felt safe. One person told us staff "look after me". Another person said they were "not worried". Family members told us they did not have any concerns regarding their relative's safety. One family member said, "Yes [my relative] is very safe there. He is very happy there". Another family member told us their relative was "always happy to go back to the home when he had been visiting with them". A visiting Health professional said "I think really highly of the home. I have no concerns regarding people's safety".

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff and the registered manager had received appropriate training in safeguarding. Staff knew how to raise observed concerns and to apply the provider's policy. One member of staff told us if they had any concerns, "I would go to [the registered manager]. I know I can go to different contacts such as safeguarding if I need to; their details are on the wall". The registered manager explained the action they would take when a safeguarding concern was raised with her and the records confirmed this action had been taken when a safeguarding concern had been identified. The registered manager had reported this to the appropriate authority in a timely manner.

People were protected from individual risks in a way that supported them and respected their independence. The registered manager had assessed the risks associated with providing care to each individual; these were recorded along with actions identified to reduce those risks. They were personalised and written in enough detail to protect people from harm, whilst promoting their independence. For example, one person had a risk assessment in place in respect of their ability to make a cup of tea for themselves and included the support staff may need to provide if required. During the inspection we observed staff monitoring this person as they made themselves a cup of tea, in line with their risk assessment. A family member told us their relative had, "been at the home a long time, so staff know him and understand the risks." They added "He likes to watch the traffic, so they [staff] got a gate pad [to lock the gate] so he can watch safely".

Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring. Where an incident or accident had occurred, there was a clear record of this, which was sent to the provider. This enabled analysis to take place, both from the home's perspective and provided the opportunity for learning and risk identification across all of the services owned by the provider. Each person's care plan contained a 'Vulnerable Adult Form' and a 'My Life, a Full Life' care passport, both of which provided the information necessary for health professionals to support that person should they be taken to hospital in an emergency.

People and their families told us there were sufficient staff to meet people's needs. One person said staff, "always take me out when I want to go to the shops". A family member told us, "There always seems to be staff around when I visit". A visiting health professional told us there was enough staff to look after people safely. They said, "Whenever I came to the home I have never seen less than three members of staff interacting with people".

The registered manager told us that staffing levels were based on the needs of the people using the service. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. Staff responded to people's needs promptly. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime, staff employed by the provider at other homes, the provider's bank staff and agency staff. The registered manager was also available to provide extra support when appropriate.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The registered manager had a process in place to review the DBS checks annually to identify whether staff circumstances had changed.

People received their medicines safely. Staff had received appropriate training and their competency to administer medicines had been assessed by the registered manager to ensure their practice was safe. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. There were suitable systems in place to ensure the safe storage and disposal of medicines. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. There was a medicine stock management system in place to ensure medicines were stored according to the manufacturer's instructions and a process for the ordering of repeat prescriptions and disposal of unwanted medicines. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary. Evacuation Ski sheets, which are an aid to assist staff to evacuate people with limited mobility in an emergency, were also available for each person who may require them.

Good

# Is the service effective?

## Our findings

People and their families told us they felt the service was effective and that staff understood people's needs and had the skills to meet them. One person said, "They look after me and help me with my room". Another person told us staff, "help me, yes they do". A family member said the staff were, "pretty good. They understand [my relative] and tell me when there is something wrong". A visiting health professional told us the staff were knowledgeable about the people they supported and they did not have any concerns about the staff's ability to look after people effectively. They said, "They [staff] provide the highest quality care to the clients".

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. For example, a best interest decision had been made in respect of one person who was diabetic, regarding the management of their nutrition. People were also supported by an independent advocate or an independent mental capacity advocate (IMCA), when appropriate, for important decisions that affects their lives. For example one person was supported by an advocate in respect of the decision to move them to the home.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. DoLS applications had been made to the supervisory body with the relevant authority for all of the people using the service. The registered manager carried out a review of the applications on a regular basis to ensure they were still required. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests and the least restrictive option.

People and their families told us that staff asked for their consent when they were supporting them. One family member said their relative "will let everybody know if he does not want to do something. He is not slow in coming forward". A visiting health professional told us the staff always sought consent before providing care.

Staff sought people's consent before providing care or support, such as offering to provide support to help them mobilise. One member of staff told us, "I always tell the residents what I am about to do and ask them

if it is okay. It they so no, that is their choice. I might wait a while and ask again". Daily records of care showed that where people declined care this was respected.

There were arrangements in place to ensure staff received an effective induction into their role. Each member of staff had undertaken an induction programme based on "Skills for Care Common Induction Standards" (CIS). CIS were the standards employees working in adult social care should meet before they could safely work unsupervised. New staff, who were recruited after April 2015, received an induction and training which followed the principles of the Care Certificate. The Care Certificate is the new set of standards that health and social care workers adhere to in their daily working life. The registered manager had arranged for all staff to undertake the care certificate training as a way of refreshing their knowledge and a means to encourage discussion within the team.

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicine administration, safeguarding adults, mental capacity act and first aid. Staff had access to other training focused on the specific needs of people using the service. For example, epilepsy awareness, autism and dementia awareness, down syndrome awareness and use of a hoist. Staff were supported to undertake a vocational qualification in care. Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example how they supported people who were living with a cognitive impairment to make choices and maintain a level of independence.

Staff had regular supervisions. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the registered manager and senior staff. There was an open door policy and they could raise any concerns straight away. One member of staff told us they had regular supervisions, "but if I have any problems I just speak to [the registered manager] who is very approachable". Another member of staff said, "I have regular supervisions, every three months, where I can raise any concerns, request training or discuss other things such as problems with other staff".

People were supported to have enough to eat and drink. People told us they enjoyed their meals. One person said "I like the food, my favourite is scampi and mushy peas". Another person said "food is good". Family members were complimentary about the food and told us their relatives were supported to eat the food they liked. One family member, whose relative was diabetic, told us "Staff are very careful with his diet. Food is important to him and staff test his blood regularly". Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences. The menu for the week was published on a noticeboard in the dining area and was supported by pictures to help people understand what meals were being planned for them. Meals were appropriately spaced and flexible to meet people's needs. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. Staff were aware of people's needs and offered support when appropriate. One person told us "I enjoy cereal for breakfast and will prepare it myself". We observed this person making their breakfast and saw a member of staff supporting them with the amount of milk they needed. Staff encouraged people to drink throughout the day.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. A visiting health professional told us that staff's "basic health care was good and they monitor people all the time. I recently did a health care plan for one person and they [staff] were really good at following it. If they are unsure they will ask".

Good

# Is the service caring?

## Our findings

Staff developed caring and positive relationships with people. People's comments included "I like the staff", "[named member of staff] is nice" and "happy yes". Family members told us they did not have any concerns over the level of care provided or how it was delivered. One family member said the staff were "very nice people and very respectful". Another family member said, "oh yes staff are very caring". A visiting health professional told us, "It is always a pleasure coming here and I always leave with a smile on my face. The clients respond to the staff so well. They can be difficult clients but staff have become their family".

People were cared for with dignity and respect. Staff spoke to them with kindness and warmth and were observed laughing and joking with them. One member of staff sat down next to a person and asked them whether they would like their nails done the person indicated "yes". The member of staff then gently moved the person's chair, explaining what they were doing and patiently encouraging them to participate in the process, offering a choice of different nail polish colours. Staff were attentive to people and checked whether they required any support. For example one person, who had limited mobility, had been sat at the dining table for a long period of time. Staff regularly checked with the person to make sure they were comfortable, whether they needed anything or whether they wanted to move to the lounge.

Staff understood the importance of respecting people's choice and privacy. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. Choices were offered in line with people's care plans and preferred communication style. Where people declined to take part in an activity or wanted an alternative this was respected. One person had told staff they wanted to go to film club and after the arrangements were made and they were due to leave, they changed their mind and wanted to go out for a coffee and a piece of cake instead. Staff quickly adapted to the change of plan. We spoke with the person on their return from the outing and they told us they had "had a good time" and "It was nice".

We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited before entering. A member of staff told us that when supporting people, "I always close the door, make sure the curtains are drawn and cover people up when helping them. We always knock on the door before going into the bathroom or someone's bedroom". A visiting health professional told us they did not have any concerns over how staff respected people's privacy and dignity. They said staff, "Knock on doors and ask people what they want. They empower their clients in every sense of the word and make sure their dignity is protected".

When appropriate, people's families were involved in discussions about developing their care plans, which were centred on the person as an individual. We saw that people's care plans contained detailed information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes. One member of staff told us they found the care plans useful in "helping me to understand how to support people".

People were encouraged to be as independent as possible. One person told us staff, "Help me shave and help me bath. They dry my back and I dry the rest". Other examples of people being encouraged to be independent included domestic tasks such as taking their crockery to the kitchen after lunch or putting their rubbish in the waste bin. Staff praised people's efforts and we saw their faces which reflected a sense of achievement.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identifies people who are important to the person. All of the families we spoke with confirmed that the registered manager and staff supported their relatives to maintain their relationships. People's bedrooms were individualised and reflected people's interests and preferences, one person had a fish tank in their room and another person showed us their collection of Sentinel steam lorry models and magazines. The bedrooms were personalised with photographs, pictures and other possessions of the person's choosing.

Good

# Is the service responsive?

## Our findings

People and their families told us they felt the staff were responsive to their needs. One person said staff, "take me to the shops when I want to go". Another person told us, "They [staff] help me". One family member said their relative was, "perfectly settled [at the home] they know his needs and how to look after him". A visiting health professional told us that staff were, "really knowledgeable about how the client is, what they have been doing, their moods and how to support them".

Those people who were not able to verbally communicate with staff, were able to demonstrate their understanding about what they were being asked and could make their wishes known. Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond. People's care plans contained a 'communication passport' which provided information about their communication style. For example, one person's passport stated 'I will push something away if I don't like it' and 'I will sit at the table if I am hungry'.

When appropriate, people's families were involved in discussions about their care planning, which reflected their assessed needs. One family member told us, "The manager always tells me what is happening with [my relative] and asks for my views".

People experienced care and support from staff who were knowledgeable about their needs and the things that were important to them in their lives. Staff's understanding of the care people required was enhanced through the use of support plans, which detailed people's preferences, backgrounds, medical conditions and behaviours. Each person had an 'easy read' health action plan supported by pictorial representations suitable for the needs of the person they related to. Where possible, this was used to encourage people to become involved in developing their care plan.

People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Handover meetings were held at the start of every shift and supported by a communication book, which provided the opportunity for staff to be made aware of any changes to the needs of the people they were supporting.

Each person had an allocated keyworker, whose role was to be the focal point for that person and maintain contact with the important people in the person's circle of support. They also supported them with their shopping, managing their clothes and maintaining their room. Each of the key workers carried out a monthly review with the person of the activities they had engaged with and the activities they might like to try. They discussed their health needs and asked for the person's views about their support. One person told us "[Name of a member of staff] is my keyworker, he helps me". A family member said "I talk to [my relative's] keyworker who tells me what [my relative] has been doing".

Staff were knowledgeable about people's right to choose the types of activities they liked to do, and

respected their choice. People had access to activities that were important to them. These included attendance at day centres, going to the pub, the theatre, film club and shopping. People were also able to go on holidays away from the home. One person told us "Last year I went on holiday with [name of a member of staff]. We are going to Salisbury this year". There were activities available for people in the home, such as helping with domestic duties like cleaning or washing up, watching DVDs and listening to music.

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. People were supported by advocates who were available to support them if they were unhappy about the service provided. An advocate had been involved in supporting one person with their decision to move into the home. The registered manager sought feedback from people's families on an informal basis when they met with them at the home or during telephone contact. A family member told us "When I visit [the registered manager] tells me what is happening at the home and asks my views".

The registered manager also sought formal feedback through the use of quality assurance survey questionnaires sent to people's families and health professionals. We looked at the feedback from the latest survey, from May 2015, which was all positive in respect of the care people received. Where concerns were raised, such as the state of the decoration in one of the bathrooms, this was responded to and we saw the bathroom had been upgraded.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided, this information was also available in an easy read format. The registered manager told us that people's keyworkers would support them to raise any complaints initially and people also had access to independent advocacy services if they needed them. All of the family members knew how to complain but told us they had never needed to. The registered manager told us they had not received any complaints since the home was last inspected and was able to explain the action that would be taken to investigate a complaint if one was received. A visiting health professional told us "If I had a concern I would have raised it with the management here. I feel [the registered manager] would be responsive".

Good

# Is the service well-led?

## Our findings

People and their families told us they felt the service was well-led. Family members also said they would recommend the home to their families and friends. One family member said the registered manager was, "very approachable. I talk with her every week". A visiting health professional told us "I would recommend the home to others, I haven't meet anyone here who isn't incredibly helpful".

There was a clear management structure, which consisted of a registered manager, senior care staff and learning disabilities group manager. Staff understood the role each person played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. One staff member told us the registered manager was, "a good boss; good at answering queries. She always listens and will give advice".

Care staff were aware of the provider's vision and values and how they related to their work. Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. A staff member said, "Yes, I get engaged in things, for example, we discuss people's eating management. [The registered manager] is open and approachable".

Family members told us they were given the opportunity to provide feedback about the culture and development of the home and all said they were happy with the service provided.

The provider had suitable arrangements in place to support the registered manager, through the group manager. They were also able to raise concerns and discuss issues with the registered managers of the other learning disabilities services owned by the provider. There were systems in place to monitor the quality and safety of the service provided and the maintenance of the buildings and equipment. The registered manager carried out regular checks of infection control, the cleanliness of the home, people's bedrooms, medicines management and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures and fire safety. The registered manager told us that if a concern was identified remedial action would be taken.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission (CQC) if they felt it was necessary.

The provider and the registered manager understood their responsibilities and the need to notify the Care Quality Commission (CQC) of significant events regarding people using the service, in line with the requirements of the provider's registration.