West House

West House - 3&4 Glebe Lane

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 9 November 2018. The service was last inspected in 2016 where there were no breaches in regulation seen and the home was rated as Good. We found at this inspection that the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going 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.

3 & 4 Glebe Lane is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The care home can accommodate up to eight people in a bungalow and a small house that are next to each other but have separate adapted facilities. there were seven people living in the home when we visited. People in the service were living with a learning disability and, in some instances, with a physical disability and complex health needs. The home does not provide nursing care.

The home had a suitably qualified and experienced registered manager who had a background in social care and in management. 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 staff team understood how to protect vulnerable adults from harm and abuse. Staff had received suitable training and spoke to us about how they would identify any issues and report them appropriately. Risk assessments and risk management plans supported people well. Good arrangements were in place to ensure that new members of staff had been appropriately vetted and that they were the right kind of people to work with vulnerable adults. Accident and incident management was of a good standard.

The registered manager kept staffing rosters under review as people's needs changed. We judged that the service employed enough support staff by day to meet people's needs. Staffing levels at night were being changed to meet people's needs.

We made a recommendation about continuing to review staffing at night.

Staff were appropriately inducted, trained and developed to give the best support possible. We met team members who understood people's needs and who had suitable training and experience in their roles.

People had reviews of their medicines on a regular basis. Medicines were stored safely. We noted that some, but not all, staff did not always sign the records in a timely manner but this was being addressed by the provider under their quality monitoring, supervision and disciplinary processes.

People in the home saw their GP and health specialists whenever necessary. The staff team had good working relationships with local GP surgeries, community nursing services and specialist health care professionals.

Good assessments of need were in place, and the staff team reviewed the delivery of care for effectiveness. They worked with health and social care professionals to ensure that assessment and review of support needed was suitable and up to date.

People told us they were satisfied with the food provided and we saw suitably prepared meals being served. Good nutritional planning was in place. Special diets and support needed to take enough nutrition and hydration were in place.

The home is situated in a quiet residential cul-de-sac and consists of a four bedroom house and a four bedroom bungalow. The bungalow is adapted to accommodate up to 4 people who have complex physical needs. Both buildings were clean, homely and suitable for diverse needs. There were suitable adaptations and equipment in place.

Where possible people were consulted about their preferences and choices. Where people lacked capacity advocates were used or, if appropriate, relatives were involved in decision making. We saw records of 'best interest' meetings held where people were unable to make their own decisions.

The staff team were aware of their responsibilities under the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People who lived in the home told us that the staff were caring. We also observed kind and patient support being provided. Staff supported people in a respectful way. They made sure that confidentiality, privacy and dignity were maintained.

Risk assessments and care plans provided detailed guidance for staff in the home. Some of the people in the service were aware of their care plans and had influenced the content. The management team had ensured the plans reflected the person-centred care that was being delivered. The registered manager was reviewing the format of care planning to simplify the process.

Staff could access specialists if people needed communication tools like sign language or braille but no one in the service used specialised ways of communication.

Staff encouraged people to follow their own interests and hobbies. We saw evidence of regular activities and outings.

The service had a comprehensive quality monitoring system in place and people were asked their views, where possible, in a number of different ways. Quality assurance was used to support future planning.

We had evidence to show that the registered manager and the operations manager were able to deal with concerns or complaints appropriately .

Records were well organised, easy to access and stored securely. Staff were being reminded about the importance of signing when they recorded interactions.

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 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.

This inspection took place on 9 January 2019 and was unannounced. The inspection was carried out by an adult social care inspector.

People in the home were living with a learning disability. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. This was received in a timely manner and in good detail. We also reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We also spoke with social workers, health care practitioners and commissioners of care during our regular contact with them. We planned the inspection using this information.

The lead inspector spent time with all of the seven people in the home on the day. The team spent time talking with people and the staff. We also spent time in shared areas simply observing the life of the home. We met an officer of the organisation who was meeting with the people who lived in the house.

We read four care plans in depth and looked at daily notes related to these care plans. We looked at charts

and other records of things like food and fluids taken. We saw moving and handling plans and risk assessments for other interventions. We also looked at records of medicines and checked on the stored medicines kept in the home.

We met the registered manager, the senior support worker and six care staff. We talked with them in small groups or individually and observed their practice. We looked at four staff files which included recruitment, induction, training and development records. We checked on the details of the supervision and appraisal notes on these files. We saw rosters for the four weeks prior to our visit.

We had access to records relating to maintenance and to health and safety. We checked on food and fire safety records and we had discussions about some of the registered provider's policies and procedures. We saw records related to quality monitoring. We routinely received copies of quality reports throughout the year.

We walked around all areas of the home and checked on infection control measures, health and safety, catering and housekeeping arrangements.

We received information related to staffing issues and quality audits during and after the inspection. We also had contact with the operations manager before and after the inspection in relation to staffing issues and to the plans for future activities.

Good

Is the service safe?

Our findings

We spoke with people who told us that they felt safe in "our house" and that the staff were "very nice...good to us". We also met some people who were unable to speak but we observed them in their own environment. They looked relaxed and comfortable with the staff on duty.

Staff were trained in understanding harm and abuse, individual rights and in how to protect vulnerable adults. Safeguarding matters were discussed in supervision and in team meetings. Staff told us they were encouraged to speak up about any concerns. They told us they could talk to the registered manager or to any visiting senior member of staff if they were concerned. Staff we spoke with were aware that people in the home could be vulnerable to abuse and said they were trained to be vigilant for signs of abuse. We noted in supervision notes that staff were trained to look at the subtleties of approach to ensure that any minor issue would be detected and dealt with. The registered manager understood how to make safeguarding referrals, if necessary.

We saw rosters for the four weeks prior to our inspection and spoke with staff who told us that for most of the time there were enough staff on duty in both parts of the home. However,staff did say that sometimes they had to "double up" if people with mobility issues needed to go out. This sometimes had an impact on work they wanted to do with more able people. The team were aware that the house might become a supported living house and this would give more dedicated time to individual activities. We spoke with a social worker who confirmed this was in progress.

We noted that there were two staff members who slept in the two parts of the home at night. Staff told us that things were "very quiet" in the house at night. People in the house said that it was "Nice and quiet at night ...no one is awake" and that having a person in the house was enough for their needs. We spoke with staff about night time in the bungalow. Staff told us that recently they had felt the need to get up in the night. Changes to the dependency of people in the bungalow had been noted by the provider and by the commissioning team. A trial run of having a waking person on at night was to be introduced to determine whether having one person awake and one asleep might meet people's needs more appropriately.

We recommend that night time arrangements be kept under review in the light of any changes.

There had been a few changes to the staff team because of retirement and other changes. Staff told us that background checks were made prior to them having any contact with vulnerable people. We looked at personnel records and recruitment arrangements were in order. Where possible people living in the service had a role to play in recruitment and had helped to choose new staff.

We had evidence to show that the registered provider dealt with matters of discipline in a fair and equitable manner which ensured appropriate care and services were delivered to vulnerable people.

Staff were trained in understanding human rights and matters of equality and diversity. This was reflected in the way staff worked with people and the way care plans and notes were written. Staff confirmed that they

could meet individual cultural preferences and we saw some examples of this in people's goal setting. Good risk management plans were in place to ensure people were treated equitably and measured risks were taken.

The registered manager analysed any on-going incidents or accidents and would risk assess things like falls, behavioural challenges or recurrent illnesses. We could trace the work done to lessen risks for people who had health issues or who had been unsettled and or had displayed behaviours that might be challenging. We noted good progress had been made to help people's well-being.

Medicines were kept securely and at the appropriate temperature. Controlled drugs were correctly managed. Staff were appropriately trained and their competence checked. Quality audits had shown that some staff had not signed for medicines given in a timely manner and this was being dealt with by the provider. The staff made sure that visiting GPs and pharmacists reviewed the medicines given to people so that medication was optimised. Sedative medicines were only used after consultation with health-care specialists and were carefully monitored.

Good infection control measures were in place. Staff had ready access to gloves, aprons and other equipment. Laundry systems were effective in reducing risk of cross contamination. There were no unpleasant odours anywhere in the buildings and all areas of the home were clean, fresh and orderly.

We walked around the building and found it to be safe and secure. The service had a good contingency plan in place for any potential emergency.

Good

Is the service effective?

Our findings

We looked at assessments for people on admission and as part of the on-going care delivery. We noted that the registered manager completed a care needs assessment, often with a social worker or other professional, before a person came to the home. All aspects of a person's needs and preferences were considered, without discriminating against them. General risk assessments for the building and activities in the building were also in place.

Assistive technology was used to allow staff to monitor people, whilst protecting their privacy. Good risk management plans were in place.

The Mental Capacity Act 2005 (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 made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. We found that these were in order and up to date.

We spoke with people who told us they followed the kind of lifestyle they wanted. People understood that they would be consulted and given choices. One person told us, "I go out with the staff and I go home. I can choose what I want to do". Do Not Attempt Cardio Pulmonary Resuscitation forms were in place, where appropriate. We observed staff asking people and giving them options about their lives.

We looked at staff training in the record of training that the provider deemed to be mandatory. This included training on safeguarding, equality and diversity, health and safety and person-centred thinking. We also noted that staff undertook training on looking at the subtleties of care delivery so that the small things that were important to people were always considered by the staff team. Staff had effective induction, supervision, appraisal and training. We met confident staff who had a good understanding of people's needs and knew how to work with people living with physical disabilities and with a learning disability.

We saw that people had a varied and nutritious diet. Where possible preferences and choices were adhered to. The people living in the house followed a healthy eating plan and had a box of recipes that they used to choose meals. The people in the house said that they cooked and shopped for themselves with the support of staff. All food was made 'from scratch'. The advice of dieticians and other professionals was followed and nutritional planning was in place for people who had dietary needs. Staff were trained to help people who had specialised needs. We saw people in the bungalow being suitably supported to take food and fluids.

The people in the home looked well and well cared for. People saw their GP, opticians, chiropodists, consultants and external specialist nurses when appropriate. We saw examples of the registered manager supporting people to get the right kind of health care. The team were good at ensuring that all options were explored when people had complex health care needs.

Glebe Lane is two properties next door to each other. The care home had been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. The properties were of a normal domestic standard and located in a residential area.

The house can accommodate up to four people who had no issues with mobility. The bungalow was specially adapted to meet the needs of people with complex personal care needs that also involved moving and handling. The bungalow was shortly to have an overhead tracking system installed to help with this. People had single bedrooms with a hand wash basin. There were suitable shared bathroom and toilet facilities. These were suitably adapted in the bungalow. The home was tastefully decorated and had good quality furniture and fittings. People were very relaxed in their own rooms and in shared areas.

Good

Is the service caring?

Our findings

People in the home were living with a learning disability. The care service had been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. The staff team ensured that people had choice, were supported to be as independent as possible and were part of the local community.

The people who lived in the bungalow needed full personal care and we noted that the staff team were very careful to ensure that dignity was maintained at all times. For example, the staff used screens when taking people to bathrooms and toilets. They were observed closing doors and knocking before entering, even when people found it difficult to respond. They were polite and caring when speaking with people and made eye contact and gave people reassurance when interacting or carrying out moving and handling, supporting with eating and delivering personal care.

Staff spoke warmly about everyone in the home and they knew their family members and understood their needs and personal histories. Very detailed notes were in place and these were written in a caring and respectful way. Where people couldn't articulate their needs staff had carefully noted responses so that they had built up a profile of each person's preferences, likes and dislikes and any anxieties people might show. They maintained confidentiality and did not 'talk over' or about people. We judged this was a caring, respectful and dignified way of caring for people with complex needs.

The people who lived in the other side of the home - referred to as "the house" - were much more able to talk about their lives and their experiences. All three people in the house were assertive and able to talk about staff. No one had any issues with the way the team treated them. They told us the staff were, "very good" and "nice and friendly". One person told us how the staff supported them with a worry they had and this person said, "[The registered manager] is very nice to me and listens to me".

We noted that, where possible, people were encouraged to be as independent as possible. For example, we saw that one person, who previously had not gone out alone, now went for walks around the local area. This had been done after risk assessment and staff encouraged and monitored these walks with discretion. People also told us that they chose what to eat and did the food shopping with staff. People also cooked meals and baked with support from staff. We also saw that, if possible, people looked after their rooms and shared other chores in the home. One person said, "I like doing this...it's my house and my room".

We also noted that a previous resident of the house felt that they wanted to move to a more age appropriate setting and had chosen an older person's home after being supported by staff to make this choice. Staff helped people in the home to visit this person and maintain their previous relationships.

People had access to advocacy and had visits from an advocate on a fairly regular basis. Families and advocates helped when decisions needed to be made on people's behalf.

Staff told us they had received training in equality and diversity. We noted that staff had also been trained in

dignity, respect and privacy. This was known as 'subtle training' and staff said it helped them to reflect on their practice.

Staff were aware that people living with a learning disability could be discriminated against and were vigilant when taking people out. Staff told us the home had good support from the local community and they were planning a fund raising event in the village where people could continue to be involved in the life of the village.

Good

Is the service responsive?

Our findings

Care files showed us that a full assessment of care and support needs had been completed for people in the home. Where people had complex needs assessments were done with health and social care professionals to ensure the staff could meet their needs. We also saw that where needs changed the staff would ask for health and social care professionals to help them with understanding the changed needs. Specialists in caring for people with learning disabilities were consulted when appropriate.

We looked at the care plans and associated charts, forms, daily notes and evaluations. The care files covered physical, psychological, emotional and social needs. People in the house told us they had been involved in the planning. The care assessments and plans were comprehensive, person centred and up to date. The plans had been reviewed and updated to reflect changing need and preferences. The registered manager and the senior support worker were reviewing the format of the care files to ensure these were easy for staff to use.

The people in the service went out regularly in the home's transport or went on foot or in a wheelchair into the village. Each person had their own activity planner which reflected their needs, wishes and abilities. People went swimming, to the gym and to entertainments. Where possible people went out for meals and also did their own shopping.

No one in the home at the time of our visit used specialist forms of communication like British sign language, Makaton or braille. The registered manager told us that they would assess the need prior to admission and could access training from local specialists if necessary. Some people in the home found communication very difficult but we noted that staff were very good at interpreting body language and pre-empting people's needs.

West House had a comprehensive complaints and concerns policy and we had evidence to show that the senior management team could all be involved in investigations if necessary. People told us, "No complaints from us".

Staff were trained in anti-discriminatory practice and we saw that they were aware of people's needs and preferences. Staff made no difference to the way they treated people or the choices they offered them. We saw that people were treated very much as individuals. Religious and cultural preferences were respected and followed.

The registered manager confirmed that they would have support from the local G.P practice and the community nursing service if a person was coming to the end of their life.

Good

Is the service well-led?

Our findings

The home had a suitably qualified and experienced registered manager. Staff and people in the home judged that the registered manager created an open culture where they were valued and respected. One person spoke at some length about how much they trusted and liked the registered manager. Our discussions with the registered manager showed us she was aware of up to date good practice in care of people living with a learning disability and other complex needs.

The operations manager and members of the quality team visited on a regular basis to support the registered manager. They met with people in the service and with the staff. We had been sent copies of the regular quality monitoring reports completed by the quality manager. These were comprehensive and the team were expected to work on any issues that arose. We also saw internal audits of all aspects of the service. These checks ensured that medicines administration, personal care delivery and recording of care practice were all audited and checked. We also saw evidence of good monitoring of food and fire safety, personal money and staffing matters.

Records were well maintained and easy to access. All paperwork was locked away and electronic records were password protected. Policies and procedures were readily available for staff to use. We saw that quality checks had identified some areas where staff had not always signed the record. This was being dealt with pro-actively by the registered manager.

Providers of health and social care are required to inform the Care Quality Commission [CQC] of important events that happen in the service. The registered manager of the home had informed us of significant events in a timely way. This allowed us to monitor the service and check that appropriate action had been taken. The provider's web site showed the rating for the home and a link to the last report. The service displayed the home's rating from our last inspection and a copy of the report was available in the home.