

The Disabilities Trust

Disabilities Trust - 128 Beech Hill

Inspection report

128 Beech Hill, Haywards Heath,
West Sussex. RH16 3TT
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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 

Overall summary

The inspection took place on 5 May 2015 and was announced.

The service is registered to accommodate up to four people with a learning disability and additional complex needs such as autism. At the time of our inspection, there were four people living at the service. 128 Beech Hill is a modern, detached house on a residential housing estate on the outskirts of Lindfield. People have their own bedrooms which are personalised in line with their

individual preferences. There are two bathrooms on the first floor and a downstairs WC. There is a large sitting room, dining area, kitchen and a rear garden, all of which are easily accessible to people using the service.

The service has a registered manager. 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The day-to-day management of the service was undertaken by the team leader.

People felt safe living at the service and staff knew how to keep people safe. They had been trained in safeguarding adults at risk and knew what action to take if they suspected abuse was taking place. Staff were trained in the use of physical intervention, to keep people safe who might exhibit challenging behaviour, although this was rarely used. Risks to people were identified and managed appropriately and people had personal emergency evacuation plans in place in the event of an emergency. Staffing levels were sufficient to support people and keep them safe. The service followed safe recruitment practices. Medicines were ordered, administered, stored and disposed of safely by staff who were trained in the administration of medicines.

Staff were appropriately trained in all essential areas and specific training was also arranged to meet people's care needs. Training was refreshed as needed. Staff received regular face-to-face supervisions every quarter from the team leader and attended group supervision or team meetings. Handover meetings between shifts ensured staff had up-to-date information about people's care needs. Staff followed the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice. Where people's freedom was restricted, the registered manager had applied for authorisation under the Deprivation of Liberty Safeguards (DoLS). People were supported to have sufficient to eat and drink and were involved in the preparation and cooking of their meals. They were able to choose their weekly menus and alternative choices were

also available. People were supported to maintain good health and had access to a range of healthcare professionals, including those from the provider's own multi-disciplinary team.

People were looked after and supported by kind, caring staff who knew them well. Care records provided detailed information for staff to follow about people's preferences, likes and dislikes. People were supported to express their views and met monthly with their keyworker, who co-ordinated their care. People's privacy and dignity were respected and promoted.

Care plans were person-centred and people had weekly planners that showed the activities and outings that were planned with them. These provided a daily structure to their lives. Care staff had comprehensive information about people including the support they required in communication, sensory needs and an autism profile. People were encouraged to stay in touch with people who mattered to them. The provider had a complaints policy in place but no complaints had been received in the last year. People knew how to raise a complaint and they were asked if they had any complaints at their monthly meetings.

People were involved in developing the service. They helped to plan menus and social activities. Staff knew what was expected of them and attended staff meetings which were held every seven weeks. Staff were asked for their views about the service and a questionnaire had recently been sent out. The provider had systems in place to audit the quality of the service and care provided. Monthly provider visits took place which enabled the service to identify areas which needed improvement and for action to be taken. Where accidents and incidents were recorded, the provider's main office analysed any patterns or trends.

Summary of findings

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 was safe.

People said they felt safe living at 128 Beech Hill. Staff had been trained in safeguarding adults at risk and in the use of physical intervention.

Risks to people were identified, assessed and managed safely and staffing levels were sufficient to meet people's needs safely.

Medicines were managed appropriately by trained staff.

Safe recruitment practices were in place.

Good



Is the service effective?

The service was effective.

People received care from staff who were trained in all essential areas.

People had sufficient to eat and drink and were involved in the planning of menus. They had access to a range of healthcare professionals.

Staff understood the requirements of the Mental Capacity Act 2005 and put this into practice when gaining people's consent. Where people had been deprived of their liberty, the registered manager had applied for authorisation from the local authority.

Good



Is the service caring?

The service was caring.

People were looked after by kind and caring staff who knew them well.

Care records provided information to staff about people's preferences and choices and people were supported to express their views.

Good



Is the service responsive?

The service was responsive.

People helped to plan their daily activities in a structured way.

People knew how to make a complaint. Complaints were dealt with in line with the provider's policy; no complaints had been received in the last year.

Care plans were person-centred and provided comprehensive information to staff about people's care needs and how they should be supported.

Good



Is the service well-led?

The service was well led.

People were involved in developing the service.

Staff knew what was expected of them and had been asked for their feedback about the service.

Good



Summary of findings

The provider had robust quality assurance systems in place.	
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Disabilities Trust - 128 Beech Hill

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.

The inspection took place on 5 May 2015 and was announced. As this is a small service accommodating only four people, we wanted to be sure that people would be available on the day of our inspection. An inspector undertook this inspection.

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 any improvements they plan to make. We checked the information that we held about the service and the service provider. This included

statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including four care records, seven staff records, medication administration record (MAR) sheets, staff rotas, staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with three people using the service. Due to the nature of people's learning disability, we were not always able to ask direct questions. We did, however, chat with them and were able to obtain their views as much as possible. We observed care staff supporting people. We spoke with the registered manager, the team leader and a support worker.

The service was last inspected in October 2013 and there were no concerns.

Is the service safe?

Our findings

People confirmed that they felt safe living at the service and one person added, “I like living here”. People were protected against the risk of potential abuse and staff were trained in safeguarding adults at risk, which was updated annually and training records confirmed this. Training was delivered face to face with staff and updates were completed electronically using the provider’s training software. Staff described the types of abuse they might encounter, such as verbal, physical or financial abuse and knew who to report to and what action to take. Staff followed the guidelines of West Sussex County Council’s pan-Sussex multi-agency safeguarding policy, the latest copy of which was available to staff in the office.

Staff were trained in the use of physical intervention, but this was rarely used. One support worker told us, “Each service user is individually assessed and I will redirect or ask them to go to their rooms”; he added that he had never used any form of physical intervention. Staff said that people did not display physically challenging behaviour, but some displayed mentally challenging behaviour on occasion. In the provider information return (PIR), the registered manager stated, ‘De-escalation, intervention technique training and risk assessments are in place ensuring that any physical intervention is a last resort. Any physical intervention technique has been signed off by a multidisciplinary team of professionals’. Care records confirmed this.

Risks to people were identified, assessed and managed appropriately. There was a range of risk assessments within people’s care records and areas such as personal care, nutritional needs and daily routines had been planned for. People had behaviour support plans in place which advised staff on what action to take in the event of people displaying negative or positive behaviour. Behaviour monitoring forms had been devised by the provider which were specific to people who had a learning disability or autism. Care records provided information for staff about people: , what to do if a particular behaviour occurred, how to react when the behaviour first emerged and then advice on what to do subsequently. People were involved in making decisions about risks. For example, one care record

stated, ‘[Name of person] is able to identify risks by himself and will inform staff when he finds them’. Accidents and incidents were recorded and risk assessments for people concerned were updated as needed.

There were personal emergency evacuation plans in place for people which provided advice to staff on their safe evacuation in the event of an emergency. The team leader told us, “We do our drills, test the alarms and a fire folder is kept by the front door”.

Staffing levels were assessed, monitored and sufficient to meet people’s needs at all times. There were always a minimum of two care staff on duty during the day and a sleep-in member of staff at night. Some people received 1:1 support during the day, for example, when they were out in the community. Staff rotas confirmed that safe staffing levels were in place. A support worker said that staff worked flexibly and some staff worked across the provider’s other locations. He thought that there were sufficient staff currently.

The service followed safe recruitment practices and relevant checks were made against new staff to ensure they were safe to work with adults at risk. Photo IDs had been checked and clearance from UK Immigration obtained for people who were non-EU nationals.

People’s medicines were managed so that they received them safely. Medicines were ordered, stored, administered and disposed of in line with current legislation and the provider’s medicines management policy. Care staff had been trained to administer medicines and training records confirmed this. There were capacity assessments for people which identified what medicines they were taking, whether they could manage their own medicines, the reason for taking and any possible side effects. People went to the staff office at the time they were due to receive their medicines; these were administered directly by trained staff from a medicines cupboard that was locked when not in use. Medication administration record (MAR) sheets had been completed and signed by staff appropriately. Some people took over the counter remedies occasionally for pain relief and colds which were administered and monitored by care staff. Where these were assessed as needed, appropriate checks had been taken to ensure that these remedies did not clash or interact with people’s prescribed medicines. People’s medicines were reviewed at least twice a year by healthcare professionals.

Is the service effective?

Our findings

People had their assessed needs, preferences and choices met by staff with the necessary skills and knowledge. Staff received training in areas such as fire safety, mental capacity, diversity, food hygiene, safeguarding, infection control, management of hazardous substances, health and safety and medication. Training was either delivered face to face with staff or they could access training on line from the provider. Staff thought they received all necessary training and that there were opportunities for continuous professional development. Some staff had achieved qualifications at level 2 or above in health and social care. Additional training was provided to staff to meet people's care needs. For example, Makaton training. Makaton is a system that uses signs and symbols to aid communication.

Staff received supervision with the team leader every three months and records confirmed this. All care staff had received an annual appraisal/performance development review within the last three months. Staff also attended group supervisions or team meetings every other month, as well as handover meetings three times a day between shifts. Handover meetings enabled staff to share information about how people had been and any issues or concerns that needed to be highlighted and staff made aware of. There was a half-an-hour overlap between shifts to allow staff time to communicate effectively. New staff undertook an induction programme, including essential training, and shadowed experienced staff whilst they got to know people's needs, preferences and choices.

Consent to care and treatment was sought in line with legislation and guidance. Staff had a good understanding of the relevant requirements of the Mental Capacity Act (MCA) 2005 and put this into practice. The team leader told us, "Everyone's presumed to have capacity until they prove that they don't. It can change. You can have capacity for some things and not others. There are different levels of it. For example, being able to handle a weekly spend of money, but not able to manage a whole bank account". A support worker said that the MCA was, "put in there to protect people. They have capacity unless proved otherwise and this may continually change. We involve them as much as we can in any decision". Capacity assessments were in people's care records and where people had been assessed as not having capacity to make

a particular decision, then a best interest meeting was held. This is where the person, health and social care professionals and family members come together and make a decision on the person's behalf.

Deprivation of Liberty Safeguards (DoLS) applications had been made to local authorities for everyone living at the service. DoLS protects the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. No authorisations had been granted yet, but three local authorities had confirmed receipt of the applications and these were being processed.

People were supported to have sufficient to eat, drink and maintain a balanced diet. People took turns to cook in the house and chose menus from recipe books. A support worker said, "Service users here are capable of choosing meals and cooking. They choose on a weekly basis". People had chosen what they wanted to cook, such as spaghetti Bolognese with garlic bread, tuna pasta bake and lemon chicken, with a range of vegetables. Where people did not like the menu choice for that day, then an alternative was on offer. Because people were out and about during the day, the main meal was eaten at suppertime. A blackboard in the dining area showed people what the food choice was for that day. A roast was available on a Sunday and people could also eat out occasionally or have a takeaway meal. Menus were discussed by people at their in-house meetings and they had decided to have a BBQ in the garden once a month during the summer. People were encouraged to eat a healthy diet. For example, healthier snacks had been discussed with one person and what he would like to eat. Drinks were readily available and people could help themselves to hot and cold drinks throughout the day or night.

People were supported to maintain good health and had access to healthcare services. The provider employed healthcare professionals who were part of a multi-disciplinary team (MDT), for example, psychologist, speech and language therapist. People were assessed at least twice yearly by the MDT or more frequently if needed and care records confirmed this. In addition, people had access to a GP, chiropodist, optician and dentist. One person did not wish to receive a checkup from the dentist and his wishes had been acceded to. There were health

Is the service effective?

action plans in place which included Makaton signs and symbols to aid communication. Health action plans provide information about people's health needs and the professionals involved to support them

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed that staff knew people well and communicated with them in a warm, friendly and sensitive manner that took account of their needs and understanding. A support worker thought that a challenge was, “The establishing of relationships with service users. Building trust and being approachable” and of the need to continually reassure people to build their confidence and self-worth. Care records provided detailed information to staff about people, their preferences and personal histories. Information was referenced using a ‘traffic light’ system and in a person-centred way. ‘Red’ was ‘things you must know’, ‘Amber’ was ‘things that are important’ and ‘Green’ was ‘likes and dislikes’. One care record showed that the person was interested in computers, satellites, TV, holidays and history. The service had arranged for him to take an IT course and to undertake visits to places of historical interest in line with his areas of special interest. One person said, “I’m going to the shops today” and told us that he enjoyed looking round charity shops.

People were supported to express their views and were actively involved in making decisions about their care, treatment and support where possible. Everyone had their own keyworker who co-ordinated all aspects of their care. The keyworker would meet with their allocated person

monthly to talk about their care plans. There was evidence within people’s care plans to show that they had been involved and some people had also appended their signature to show this had happened. A support worker told us, “Any changes to guidelines are discussed with [named person] in conversation”. He added that it was important to direct the conversation to areas or topics which the person was interested in and that he had areas of mutual interest with the person he was keyworker to, such as trains and old films. This provided a firm, friendly foundation on which to build discussion and rapport. He said that people at Beech Hill were “very capable” and that, “They are encouraged to be as independent as possible”.

People’s privacy and dignity were respected and promoted. One person’s care record stated, ‘If staff need to knock on his door, for example, when offering medicines, they should knock and let [named person] know what they want.’ If there was no response then, ‘Staff should then wait 15 minutes before knocking again’, because the person did not want to feel rushed or pressured. We observed this happen in practice. Staff knocked on people’s doors before entering. Everyone at the service was encouraged to be as independent as possible to maintain their personal hygiene. A support worker told us, “It’s about giving people a choice, to say if they just need moral support and encourage them to do as much as possible”.

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans provided comprehensive, detailed information about people, their personal history, individual preferences, interests and aspirations. Care plans were person-centred and designed to help people plan their life and the support they needed. A support worker described his understanding of person-centred planning. He said, “It’s where we look at previous experience and ask friends and families and the service user what their likes and dislikes are. We make their care as individual as possible”.

Everyone had a weekly planner which showed their activities every day of the week, including the times allocated to each activity. This enabled people to have a structure to each day which meant they knew in advance where they needed to be and what they would be doing. This is important for people with autism and provides them with security as many will find it difficult to cope with the everyday environment. People were actively involved in planning their days, choosing what they wanted to do in terms of hobbies and interests and how they would help around the house. For example, one person’s planner showed that they would receive their medicines and have breakfast at 7.30 am, have a bath at 8 am, Hoover the stairs, lounges and halls at 9.10 am, then visit one of the provider’s other locations during the morning to participate in activities such as sewing, drumming, gym or trampolining.

‘My autism profile’ was in place for people. This provided information for staff about people including social, communication, flexibility of thoughts, sensory needs, medicines, areas of strengths and specific or exceptional skills. There was information about people’s psychological wellbeing and health needs. When people met with their keyworkers, they discussed all elements of their care, including goals. For example, one person had ongoing goals of continuing to eat meals with others, planning and doing his own shopping and to go out more. Another

person was doing a money management course with the objective of being able to obtain and manage his own debit card. Keyworkers completed monthly reports for people which showed people’s involvement in the review of their care plan and a review of their goals. Care plans were reviewed monthly and positive behaviour recorded and responded to by staff. For example, one care plan had identified positive behaviour from one person who helped staff to move furniture for the fitting of a new stair carpet. The record stated, ‘[Named person] started helping staff when they were moving things around. Very careful when carrying and lifting, making sure no-one got hurt. Staff appreciated his help and said ‘thank you’.

In the PIR, the registered manager stated, ‘A diverse team of people collaborate with or on behalf of the individual to ensure the right people are on board in order to source and ensure the support required is achievable. This is from anything to healthcare needs, best interest decisions and transitions. These measures ensure that complaints or investigations have a planned response action plan with follow-up leads, evaluation and closure’.

People were encouraged and supported to develop and maintain relationships with people that mattered to them. One person had his own mobile phone so he could speak with his parents regularly. Some people visited their families at the weekend or at other times through the year and/or would be taken out for meals or outings from Beech Hill. A Saturday social club and other activities were available at one of the provider’s other locations, if people wanted to participate.

People were asked if they had any issues or wanted to make a complaint at the monthly service users’ meetings. People said they would talk with staff if they had any concerns, but no-one had made any complaints in the last year. There was a complaints policy in place. A support worker, when asked about how he would deal with a formal complaint said, “I would direct them to a more senior member of management. I would talk to the team leader or another member of house first”.

Is the service well-led?

Our findings

People were actively involved in developing the service. Service users' meetings were held on the first Thursday of every month and everyone attended. A recent meeting that was held showed regular agenda items that were discussed: 'Who is your keyworker? Who would you speak to if you had a complaint? Do you have any complaints or issues? What would you do if the fire alarm sounds? Any issues with the maintenance or running of the house? Food and cooking. Activities, planners and Saturday Social Club. Other'. Accessible notes from the last service users' meeting showed that the issue of a BBQ had been discussed, what food people would like to eat at the BBQ and menu planning generally and other activities that were planned or that people wanted to suggest. It was agreed that people would remove outdoor shoes in the house to maintain the new carpeting.

When asked about the culture of the service, a support worker said, "Very open. People have lots of choices and we try and give them goals to help progress them. We explain the goals to them and adjust them". Staff felt supported by their team leader and registered manager and, whilst the registered manager did not work from this location, she visited frequently. A member of the multi-disciplinary team was visiting on the day of our inspection. Staff felt that it was important for people to get to know people on an informal basis, not just on a professional level. A support worker told us, "Service users can be anxious and more regular visits help staff and service users".

Staff knew and understood what was expected of them. Staff meetings were held approximately every seven weeks, with the addition of group supervisions and thrice daily handover meetings. Staff meeting minutes showed that regular items were discussed such as menus, activities and people's care and support needs. One member of staff thought that a second house car would be a good idea because some people were apprehensive about using public transport.

Staff were asked for their feedback about the service and a questionnaire was recently sent out. This asked for staff's

views about people who used the service, staff attitude to work, communication between staff and management and communication between staff and relatives. The questionnaire had only recently been sent out and so results were not yet available. The team leader identified one priority saying, "I think being able to continue with our approach of person-centredness and give people skills to increase their independence". He said that this was also a challenge when faced with funding cuts from local authorities, whilst still maintaining the levels of support needed from staff to achieve this.

Staff were supported to question practice. The provider had a whistleblowing policy in place from the provider which was displayed on the staff noticeboard. There was a whistleblowing helpline and staff knew how to report concerns.

There were robust quality assurance and governance systems in place to drive continuous improvement. The provider undertook monthly visits to the location and the team leader said these were, "Like a mini CQC visit". Audits focused on different areas each month. For example, the monthly provider visit in April 2015 looked at areas that had been identified as needing attention from previous visits. The report stated that maintenance items such as the replacement of the stair carpet and a deep clean of one person's room had been completed. The audit looked at infection control, safeguarding notifications, medicines, Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013, HR issues, care plans, staff supervisions and service users' meetings. Accidents and incidents that had been reported were analysed by the provider, in order to prevent the re-occurrence of similar events. Reports showed that items requiring attention from previous visits had been dealt with in a timely fashion. In the PIR, the registered manager identified an improvement they planned to introduce within the next 12 months that would make the service better led. She stated, 'Monthly Provider Visit (MPV) actions need to be managed promptly and all staff have the opportunity to be involved in any remedial actions and reason and purpose. MPVs and feedback to form part of the agenda for staff and service user meetings to complement governance meetings, extracting information on a less formal basis'.