Walsingham

Walsingham - The Eyrie

Inspection report

Main Road
Moresby
Cumbria
CA28 8XG
Tel: 01946 599772
Website: www.moresbyparks@walsingham.com

Date of inspection visit: 13th and 14th April 2015
Date of publication: 29/06/2015

Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This was an unannounced inspection that took place over two days, the 13th and 14th of March 2015.

The Eyrie is a purpose built house that can provide a home for up to six people with a learning disability. It is operated by Walsingham who have a number of similar services in the country.

The house is on the main road in Moresby and is near to local shops and accessible by public transport. The home has transport so people can go out with staff.

All accommodation is in single rooms and the house has suitable shared facilities and a small enclosed garden.

The home 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 the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Summary of findings

Staff in the service had received suitable training and support in understanding and dealing with any safeguarding issues. There had been a delay in staff reporting an allegation of possible abuse.

There were suitable systems in place to recruit staff and to deal with any disciplinary matters.

The environment was safe and infection control procedures were in place. Some staff were a little neglectful in carrying out some routine tasks that kept people safe.

Medicines management was done well and staff had suitable training and checks on their competence. Despite all of this there had been some medication errors and the organisation was dealing with these problems.

Staff received suitable induction, supervision, and appraisal and were supported to develop in their role.

The registered manager and the staff were aware of their responsibilities under the Mental Capacity Act 2005. Suitable actions were taken if a person was judged to be deprived of their liberty.

All staff in the home were trained in managing any situations where restraint was needed. Suitable plans were in place to guide staff on restraining people safely.

People saw health professionals and both health prevention and treatment were being dealt with appropriately in the home. Specialists and consultants came to the service to help the staff support people with complex needs.

The home was adapted to meet people's needs.

The staff team provided people with good quality, home-made meals and snacks. People were encouraged to eat well.

People responded well to staff and we saw kind and caring support being given by staff.

Some people in the home needed specific support because they displayed some behaviours that were challenging. Staff were encouraged to look at how they supported people in this.

Staff encouraged people to be as independent as possible and one person went out unaccompanied.

People in the home had advocacy support when they found it difficult to speak for themselves.

We looked at care files that contained assessments of need, care plans and person centred plans. We found that some of these were not up to date. We also had evidence that staff were not following the written plans of care.

People had suitable and appropriate activities planned each week. The staff encouraged people to be as independent as possible.

Concerns and complaints were handled appropriately.

The home had a suitably experienced and qualified registered manager who was supporting a relatively new team. She was working on developing an open and transparent culture in the home.

The service had a quality assurance system and a plan for improvement. We saw that issues were identified through quality monitoring. We noted that some of the problems in the service had not been identified through quality assurance.

The service was good at working in partnership with other professionals.

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 not safe.

Suitable training and procedures were in place to protect people from harm but staff had not reported a potential safeguarding matter in a timely fashion.

Some staff were not following the daily routines appropriately which may result in risks in the environment.

Medicines management was done well and staff received training in this. Despite this and checks on competence there had been some errors in medicines administration.

Requires Improvement

Is the service effective?
The service was effective

Staff received induction, training and supervision to help them to develop.

The staff team understood their responsibilities under the Mental Capacity Act 2005.

People in the home had support from health care professionals. Good quality food was provided to help people stay as well as possible.

Good

Is the service caring?
The service was caring.

We saw kind and patient interactions between staff and people in the home.

Staff gave people respect and treated them appropriately so they retained their dignity.

People in the home had regular contact with advocates.

Good

Is the service responsive?
The service was not responsive.

Assessment and care planning lacked detail. Staff were not following care plans and this meant people were not always receiving suitable support.

Everyone in the home went out regularly to attend activities. Hobbies and outings were encouraged.

Complaints were handled appropriately.

Requires Improvement

Is the service well-led?
The service was not well led.

The home had an experienced and qualified registered manager.

Requires Improvement

Summary of findings

Quality monitoring and quality assurance systems were in place but not all of the issues in the home had been dealt with.

The service worked well with other professionals.

Walsingham - The Eyrie

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 13th and 14th of April 2015 and was unannounced. The inspection was carried out by one adult social care inspector.

We 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 to commissioners of care for the local authority and health. We planned the inspection using this information.

The inspector spoke to the six people in the home and spoke to six staff over the two days. We met with the registered manager and the operations manager for the service.

We spent time observing how staff supported people in the home and how they interacted with each other. We asked staff about the home and observed them going about their work.

We read six care files which included assessments, care plans and person centred plans. We saw records relating to staff recruitment, training and development. We looked at the staff rosters. We looked at arrangements for staff disciplinary processes.

We walked around the building and we also looked at records relating to maintenance and risk in the environment. We looked at policies and procedures and at quality monitoring records. We inspected medicines kept on behalf of people in the home, records of meals taken and we checked on money kept on behalf of people who used the service.

Requires Improvement

Is the service safe?

Our findings

Most of the people who lived in this service did not use verbal communication but we observed that people were relaxed in their environment and responded well to staff. One person told us they felt: “safe in my house.”

Walsingham had suitable policies and procedures about how to keep people safe. We spoke to the staff on duty about their responsibilities in keeping vulnerable people safe from harm and abuse. Staff were aware of their responsibilities and understood how to report any potential harm. They understood the arrangements in place for whistleblowing.

We had evidence to show that all staff were fully aware of their duty of care but there had been a delay in reporting a potential incident of abuse to the manager. We discussed this with the registered manager and she told us that all staff were trained in safeguarding and we had evidence to show that this was discussed in staff meetings and in individual supervision. The registered manager had discussed the late reporting with the staff involved and was taking advice from her manager and from other senior officers of the organisation.

We discussed discrimination, human rights and risks with staff on duty. We learned that staff had received training on these issues and that these were discussed in staff meetings and in supervision. We talked to the manager and her deputy about the need to continually talk to staff about these issues as some staff were confused about the duty of care to vulnerable people and their rights.

On the two days of our visit we looked at all areas of the home and we found the home generally to be safe. We noted that some members of staff were not always locking cupboard doors behind them. This might have caused a hazard to vulnerable people. We discussed this with the manager who was aware and we saw evidence that she was addressing this.

We asked for copies of the last four weeks rosters for the service and we saw that there were two or three support workers on duty by day, a waking night worker and a staff member asleep in the home. The manager told us that she was recruiting a domestic for the home. We also saw in rosters that the manager made sure that there was a good mix of skills on duty at any time. We judged that this service was suitably staffed.

We looked at staff files which showed how recent recruitments had been made. We saw that suitable background checks had been made before new staff joined the team.

We also saw evidence on the day that showed that Walsingham had suitable disciplinary policies and procedures. We were also aware of action that the organisation had taken when staff had been underperforming or displaying poor practice. We judged that disciplinary measures were put in place appropriately.

The home had not had any problems with cross infection and we saw that there were suitable measures in place to control any potential problems with infection when staff followed procedures.

We were aware that there had been some errors made with medication administration in this service. On one occasion a person in the service had received the wrong medicine. During the inspection we noted that two people always gave out medicines and that Medicines Administration Records were signed appropriately. We spoke with the manager and a member of staff who had made a medication error. Staff were aware that these issues could not be repeated.

The manager told us that she had informed the staff team that any future errors with medicines would be dealt with through the organisation’s disciplinary procedures. We had evidence to show that staff received suitable training and had their competence checked. We judged that suitable measures were in place to ensure that medicines would be administered correctly in the future.

Good

Is the service effective?

Our findings

We observed people in the home and had comments from people who told us the staff “know me and understand what I want.” People told us that they were happy with the way they were supported to eat and drink. One person said “I help with the cooking sometimes and I like the food…I go out for meals too.”

In the last 18 months before our inspection there had been major changes to the staff team in this home. Some people had left the service, others had moved to other services belonging to the provider. This meant that the home was staffed by a relatively new staff team and some of the staff lacked experience in working with people with learning disabilities.

We looked at staff files and spoke to members of staff. This confirmed that new members of staff received suitable induction and completed training that would give them knowledge and skills. Staff told us that they felt that they were learning all the time. We met individual members of staff who were keen and enthusiastic and wanted to learn.

We spoke with staff about their competence and they told us that this was checked by the manager and the deputy. One member of staff talked about making some errors and learning from this. We looked at staff supervision notes and saw that staff were given support and advice on a regular basis.

We saw that staff were given regular appraisals, that any member of staff who was finding the work difficult was given extra support. We judged that the management team were working very hard to develop individuals and encourage team work.

We asked staff about their understanding of the Mental Capacity Act 2005. Staff could discuss their responsibilities under this Act. They were also aware of the part they played in helping people who could not make decisions for themselves. We saw in people's care files that "best interest" meetings were held to help support people who lacked capacity to make their own decisions. The registered manager was fully aware of her responsibilities and had a good understanding of mental health legislation and how it might impact on some people in the home.

Training files showed that all staff in this service were trained in restraint techniques. At times staff did have to use restraint in the service. There was a detailed plan that gave staff step-by-step guidance on when and why they could use this technique. On both days we saw staff using de-escalation techniques with one person rather than restraint.

We spoke with one very enthusiastic member of staff who had an interest in cooking and nutrition. This member of the team told us that not everyone on the team was confident in the kitchen. This member of staff had created a nutrition file with step-by-step guidance for staff and people who lived in the home. The file contained details of individuals’ preferences and favourite recipes. We saw that people in this home were given good quality, home-made food and were encouraged to drink enough to keep them well. Staff were working towards healthy eating in the home.

When we looked at individual people's files we saw that everyone in the home was registered with the GP, dentist, optician and chiropodists. We saw that some people needed the support of a learning disability nurse, a clinical psychologist or a psychiatrist. There was evidence to show that people were referred appropriately to specialists where there were physical, psychological or mental health issues.

The Eyrie was a purpose built house with six individual bedrooms on two floors. There was a large dining and living room which people enjoyed spending time in. The home had a nicely laid out garden that people spent time in during the summer. The home was suitable for the people who lived there.

Good

Is the service caring?

Our findings

We spoke with one person who told us that the care staff team were very caring and treated them well. We judged how caring the staff team were by observing how they interacted with the six people in the home. We saw that the staff used humour and affection appropriately and that they were sensitive and patient with people.

We discussed staff approach with the manager and the deputy. They thought the staff team were caring and committed. They were aware that because the people who lived in the service had many challenges they needed to work more closely with the support workers to give them guidance about the balance of caring and managing any behavioural problems.

We had evidence to show that, where possible, people were involved with making decisions about day to day care, activities and routines in the house. We observed staff being guided by the manager when individuals in the home needed support. We heard staff explaining interventions to people in the home in a calm way. We noted that the staff team were good at communicating with people who lacked understanding and could not express themselves verbally. We saw that staff were able to pre-empt people's needs and they were quick to respond to any distress.

We looked at staff files and saw that there had been discussions with staff about confidentiality. This was also included in induction and staff were clear about how they handled confidential information about individuals.

We noted during both days that people were given their own personal space, when possible. Staff were quick to support people who needed help with retaining their dignity. We also saw that people were encouraged to be as independent as possible.

The home used two independent advocates who had supported people to make decisions.

Requires Improvement

Is the service responsive?

Our findings

We observed staff responding to people in a timely manner during our inspection. Some people could talk about their care plan and how staff had asked them about their interests and their personal goals. One person said: "They asked me and they know. Today I went to the library because that's what I want to do." People were able to confirm that they attended a range of activities every week.

We looked at all the case files for the people who lived in the home. Each person had a person centred plan and a care plan. The person centred plans gave details of individual preferences, activities and interests and goals for the year. The care plans gave details of the support people needed.

We looked at initial assessment of need. We found that some of these had been done in some detail and there had been input from social workers and health professionals. We did note that other assessments lacked detail. For example documents in one file showed that the person had potential problems with high cholesterol and pre-diabetic symptoms. The assessment said that this person should have a normal diet.

Some people in the home, due to their learning disability, made very poor choices about what they ate and drank. Helping people to have better nutrition was, in some cases, a very complex task and care planning was not detailed enough to meet these needs.

We noted that where people's behavioural challenges were extreme the staff had gained the support of learning disability nurses and a clinical psychologist. The staff had been supported to write detailed and complex care plans that helped to manage behavioural challenges. However there was one person who displayed behaviour that could challenge the service and the care plan did not deal with some of the reasons why this person's behaviour could be problematic. For example they had not looked at things like excessive sugar and caffeine consumption being linked to over activity.

We looked at another plan which looked at the management of continence. The plan only looked at management and did not look at improving this person's problems. Staff told us that they were not following the care plan.

We asked staff about how often they read the care plans and we were told that they read them when the first started in the home and if there were any changes. Staff could not give details of care plans and we had evidence, through observation, that staff were not following the care plans.

We found that the registered person had not protected people against the risk of inappropriate person centred care. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person in the home had a weekly activities plan. This included individual activities. For example every person in the home had one day a week when they went out to do their own personal shopping. One person attended the day centre. A number of people in the home went to different group activities with other people with learning disabilities. Every week people went out for meals. Some people went out for breakfast because they enjoyed having a cooked breakfast outside of the home.

People were encouraged to do some chores around the house where possible. We saw people bringing their washing down to the laundry. One or two people made their own coffee and put their crockery in the dishwasher. People were encouraged to keep their rooms tidy.

One person went on their own to the local shop and to the pub. People were supported and encouraged, when appropriate, to go to community events and people could go to church if they wanted. Another person enjoyed going out to local events and they had met a former neighbour who had put them in touch with family members. We saw photographs of a family reunion and it was obvious that this person was delighted to have found their relatives. The person centred plan showed that the staff were supporting them to visit their family.

There had been no formal complaints about the service. There was a suitable complaints policy and procedure in place which was accessible to service users and their visitors.

One person was having support from social workers and learning disability nurses because this person now needed to live in their own home. We saw that good joint working was in place to prepare this person for transition to their own home. We were also aware that social workers were assessing other people in the home and working with the

Requires Improvement

Is the service responsive?

management team on future planning for people who might benefit from living in their own house in the community. This planning was appropriate and good multidisciplinary team working was evident.

Requires Improvement

Is the service well-led?

Our findings

We observed people in the home responding well to the registered manager. We had evidence to show that people understood that she ran the home. It was evident that she was in the home on a regular basis and knew the people who lived there well.

The registered manager was an experienced and suitably trained person. She had relevant training and had managed care homes and supported living services for people with learning disability for a number of years. She had only managed the Eyrie for a little over a year.

This home had a relatively new staff team. The registered manager was aware that one of her main tasks was to develop the team. We saw evidence to show that the registered manager had spent a lot of time doing this.

On the first day of the inspection we met with the registered manager and the operations manager. They discussed some issues and concerns about the culture of the home. In the past the culture in the home had not been open or transparent. The registered manager had worked hard to try and develop a much more open culture. They provided us with an action plan that looked at individual and team development. The action plan also looked at ways to develop an open culture which would support people with learning disability. The registered manager was aware that there was more work to be done for the staff team to reach these objectives.

We spoke to staff, most of whom had not been in the home for more than a year. Staff felt very confident with the registered manager's ability and expertise. Some members of the team said that the home was not as well led when the registered manager was not around. Staff told us that there was a new plan in place so that the registered manager would be much more involved with the day-to-day work of the home to give more support to staff. The action plan we were given showed that this was to happen. We judged that this was necessary as members of this young and fairly inexperienced team needed a practical role model who had experience of this type of complex care delivery.

Walsingham had quality monitoring system that covered all aspects of the service. We saw detailed work instructions for staff on each shift by day and night. We also saw that there were good systems set up in the home to monitor the way staff worked, administration and all the other tasks in the home.

We noted that the monitoring of quality had highlighted errors in medication administration and suitable action had been taken about these issues. We also noted that senior management were dealing with issues around reporting concerns in the home. The operations manager had worked with the registered manager on a plan that would lessen or remove risks.

We judged that the monitoring of care planning and other quality assurance system needed to be improved on. Some of the gaps in care planning that we had noted had not been picked up in regular quality assessment.

When we talked to staff in the service we could see that the staff team were enthusiastic and keen to learn. We learned that there had been a lot of discussions amongst the staff about what was best practice in the home. Staff quoted different team members' opinions and those of one of the advocates of the home. We heard some opinions that were based on the staff training and on the policies of the company. We also heard some views that showed that the staff team needed more guidance on what was good practice in both general terms and specifically with the people who lived in the home. The registered manager agreed that this was a problem in the home and the action plan for the home included addressing these problems.

We looked at a wide range of records in the service. We saw that records were up-to-date and completed in a timely manner. We looked at care records. We saw that there were person centred plans, care plans, daily checklists, a diary for each person and various forms that were kept in different places in the home. Staff filled some forms out in a routine fashion but didn't reflect on the care plan. Individual care files contained a lot of paperwork and we found it difficult to access information. Support staff told us that they didn't have time to read all of the files.

We recommend that the recording of care delivery is reviewed and that staff are monitored in relation to how they follow care plans.

We looked at how the team worked with other professionals. We learned from health and adult social care

Requires Improvement

Is the service well-led?

colleagues that the management and the staff team worked well with them. We saw evidence to show that the manager was able to network across the organisation and with external professionals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use service were not protected against the risks associated with unsafe or unsuitable care because of inadequate assessment and care planning. Regulation 9 (3).