The Wilf Ward Family Trust

Isabella Court

Inspection report

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Ratings

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

Overall summary

This inspection took place on 20 October 2015 and was unannounced. At the last inspection on 25 September 2013 we found the service was meeting the regulations we inspected.

Isabella Court provides personal care for up to nine people who have a learning disability. On the day of the inspection there were nine people living in the home. The home is located in the market town of Pickering. The home is a large, purpose built dormer bungalow, set within its own grounds. Gardens have seating areas and attractive landscaped flower beds. All bedrooms are situated on the ground floor and rooms are wheelchair accessible. Staff offices are located in a small upper floor area which is accessed by a small flight of stairs.

The home had no registered manager in post. 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.

We were not able to communicate verbally with most of the people who lived at the home. We made observations about care, spoke with relatives and staff and looked at records to make our judgements.

Staff were able to tell us what they would do to ensure people were safe and relatives told us they felt people were safe at the home. The home had sufficient suitable

Summary of findings

staff to care for people safely and they were safely recruited. Risks were well assessed and the service promoted independence, although people were not always consulted about this sufficiently. We have made a recommendation about this.

Staff had received training to ensure that people received care appropriate for their needs. Training was up to date in mandatory areas, such as infection control, health and safety, food hygiene and medicine handling and also in specialist areas of health care appropriate for the people being cared for.

Staff had received up to date training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood that people should be consulted about their care and that they should assume that a person had capacity to make decisions. They understood what needed to happen to protect the best interests of people who lacked the capacity to make certain decisions.

People's needs around food and drink were met and appropriate professional advice had been followed.

People were sometimes treated with kindness and compassion, though the service was not consistent in this area. Some staff had a good rapport with people whilst treating them with dignity and respect. However, some people were not treated with as much care and compassion as they could have been which had a negative impact on their experience. For example, one person was not supported with sufficient care at a meal time. However, most staff had a good knowledge and understanding of people's needs. We have made a recommendation about this.

Care plans provided information about people's individual needs and preferences and how these should be met.

While we observed that people's care needs were met, at times they had insufficient to entertain and stimulate them or to make their lives meaningful and fulfilling. The manager was developing a plan to address this. We have made a recommendation about this.

Complaints and concerns were addressed, and the actions were recorded with plans for future learning.

Quality assurance systems were in place to improve the care offered in the home. However, people who were significant to those who lived at the home felt they were not sufficiently consulted about the way the home was managed or communicated with about changes which affected their relatives. We have made a recommendation about this.

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?

Good

The service was safe.

Staff had received up to date safeguarding training. Staff could tell us how to act if they suspected abuse.

People told us that they felt safe. There were sufficient staff, with attention to skill mix and experience, to care for people safely.

Staff told us and we observed that they carried out effective infection control procedures.

People were protected by staff who were safely recruited.

Staff had been trained in the safe handling of medicines. We observed medicines were handled safely and were audited to ensure safe practice.

Is the service effective?

Good

The service was effective.

Staff were trained and supported to meet people's needs.

People were protected by the way the service implemented the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff knew how to protect people around their mental capacity.

People had access to healthcare services when they needed them.

People were consulted about their meals, their nutritional needs were met and they had access to food and drink whenever they wished.

Is the service caring?

Requires improvement

The service was not consistently caring.

Some staff we observed had positive relationships with people and were reassuring and kind in their approach. Some staff gave more functional care, which could have been more caring.

Staff were not rushed and gave people the time and attention they needed

Is the service responsive?

Requires improvement

The service was not consistently responsive to people's needs.

People were supported to maintain relationships with family and friends and to make outings. However, they did not always have sufficient stimulation and interest in their lives.

Summary of findings

If those people who were significant to people who lived at the home raised concerns and complaints these were acted upon. However these people told us that they were sometimes not consulted or afforded the opportunity to contribute to care planning sufficiently.

Daily notes and monthly updates contained information about people's care needs and how these changed. Staff knew people and their needs well and responded to these.

Is the service well-led?

The service was not consistently well led.

There was no registered manager in place and leadership was not always effective throughout the home.

Communication between the manager and staff was regular and informative.

People's friends and families were not sufficiently supported to give their views to help improve the service.

An auditing system was in place, which was used to improve the quality of the service.

Requires improvement

Isabella Court

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 was 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 20 October 2015 and was unannounced. It was carried out by one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 planned the inspection using this information.

We received a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered more information on the inspection day to complement the information from the PIR.

On the day of the inspection we observed the care of all nine people who lived at the service. We were not able to gain a view from people verbally or by other means because of communication difficulties. We spoke with two people who were significant to the people who lived at the home, the manager, and eight support staff across the day. After the inspection we spoke with two health and social care professionals about the service.

We spent time observing the interaction between people who lived at the home and staff.

We looked at some areas of the home, including some bedrooms (with people's permission where this was possible) and communal areas. We also spent time looking at records, which included the care records for four people. We looked at the recruitment and supervision records of three members of staff, training records, rotas for the past two months, four care plans with associated documentation, quality assurance information and policies and procedures.

Good

Is the service safe?

Our findings

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People indicated that they felt safe living in the home and we discussed with staff how they supported them to live as full a life as possible. Staff described measures that were in place to keep people safe and this corresponded with recorded risk assessments.

There were detailed risk management plans in place which showed where restrictions were in place and why. Clear guidance was provided for staff on how to manage these situations to ensure the safety of the individual and other people who may be present. Staff told us how risks were managed, which reflected the information seen in the records. A member of staff said that the management ensured that staff members read everyone's risk assessment and signed each assessment to confirm that they had read it. We found staff had a positive attitude to risk taking, which allowed people to take risks safely. For example, people were supported to go swimming regularly and to engage in other activities and outings. However, it was not always clear that the person or those who acted on their behalf had been included when risk assessments were updated to ensure people's views had been taken into account.

Staff had a good understanding and knowledge of safeguarding. Staff knew people well and were able to describe the individual changes in people's mood or behaviour and other signs which may indicate possible abuse or neglect. They understood the procedure to follow to pass on any concerns and felt these would be dealt with appropriately by senior staff. Staff were clear they would have no hesitation in reporting any concerns and were aware of whistleblowing procedures and how to use them. Staff told us they had received safeguarding training for adults, which the training matrix confirmed.

There were sufficient staff on duty to keep people safe. There were between four and six staff on duty each day for nine people and extra staff were on duty at times when people were engaged in activities or required intensive support. There were two waking members of staff on duty each night. A staffing rota for a four week period showed that staffing was organised to take account of experience and skill mix to ensure people's needs were met. The acting manager said the staffing levels were monitored and

Good

Is the service safe?

reviewed regularly to ensure people received the support they needed. Staff we spoke with told us the staffing levels enabled them to support people safely, though not to always engage in as many activities as they would like to. Some people's needs were complex and required at least one to one and sometimes two to one support when they engaged in activities. The manager told us that staffing ratios had increased recently due to recruitment and that they were planning to improve people's access to fulfilling pastimes.

We looked at the recruitment records for three recently employed members of staff, which showed safe recruitment practices were followed. We found that application forms had been used and potential staff had been interviewed with set questions from a panel for consistency. Recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) were in place and two references were obtained for each member of staff before they began work. This minimised the risk of employing people who were not suitable to work with vulnerable people.

The registered manager told us that staff all had up to date medicines handling training. We checked the training records of three members of staff which confirmed this. Staff were also assessed through regular observations of medicine handling. There was a medicines policy and a procedure on medicine handling in place to protect people. The acting manager showed us how staff carried out a stock check each time medicines were administered. The system was robust, with two members of staff having responsibility for ensuring each medicine was safely administered. Audits were carried out weekly to ensure that the records were correct. Any shortfalls were discussed in handovers and on a one to one basis with staff to improve practice.

We found the premises were well maintained. People and staff told us any maintenance works were dealt with quickly and effectively. We saw safety records and maintenance certificates were up-to-date.

The registered manager told us that staff had received training in infection control, staff confirmed this and were able to explain what effective infection control practice was. They referred to the use of aprons, gloves and the importance of hand washing when giving personal care to people. We saw records of training in infection control which were all up to date. Clear timescales were recorded for when this needed to be updated. We visited the laundry room and saw that clothes were handled in a way which reduced the risk of the spread of infection, though the storage area was cluttered with personal items. We saw that the home was clean throughout and that sanitising wash was available at sinks with paper towels which reduced the risk of cross infection.

Good

Is the service effective?

Our findings

People who were able to communicate with us did not make comments about this key question. We made observations of care for those people who we could not communicate with which are detailed in this section.

Staff told us they received the training and support they required to carry out their roles. They said they received regular supervisions and had until recently received regular appraisals. This was confirmed in records. The manager told us that the way appraisals were to be offered in the future was under review. Staff were knowledgeable about the needs of the people they supported and knew how these needs should be met.

Staff said their training was comprehensive and confirmed they received regular updates. The organisation had its own training and development team and we saw there was an induction, training and development programme planned for the year. Staff told us their training had been very informative. They had an offsite induction to the organisation, which included all mandatory areas of care. Staff then completed the care certificate within twelve weeks. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It provides care workers with introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Following completion of the Care Certificate staff completed mandatory training. Staff said this allowed them to get to know people's needs well and meant they felt prepared and confident when they first worked unsupervised. The training matrix showed the training staff had completed and identified when updates were required. Staff had received core training in subjects such as first aid, infection control, fire safety, food hygiene, medication, moving and handling and learning disabilities. We also saw training had been provided to meet the specific needs of the people who used the service, such as courses in mental health, autism and managing behaviour that challenges. .

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests. All nine people who lived at the home had been referred for assessment under DoLS and there were eight DoLS in place to protect people. Several decisions were recorded in care plans which had been taken by a multidisciplinary team in the person's Best Interest when people lacked the capacity to make certain decisions. For example, decisions had been taken in relation to medical examinations and other procedures.

Care staff were clear on the process for DoLS and mental capacity assessments, as well as best interests decision making and the implications of lasting power of attorney powers. The manager told us that staff had received MCA and DoLS training and records confirmed this. The registered manager understood the implications of the Supreme Court ruling, which had clarified the concept of deprivation of liberty for people in a care home setting. This meant that people were protected regarding their mental capacity.

We observed that staff routinely asked for people's consent before giving assistance and that they waited for a response. When people declined, staff were respectful and returned to try again later if necessary. Care plans emphasised the importance of presenting choices to people in a way which supported them to decide, for example, by avoiding open ended questions, limiting choices to reduce people's confusion and by choosing the time of day a person was best able to make a decision.

People's needs and preferences in relation to eating and drinking had been taken into consideration and were written into care plans. For example, comments were recorded such as "I like a big breakfast, and sometimes only a small lunch." "I prefer blended food. Please present this blended together and not separately as I do not like different textures." Care plans included advice from Speech and Language Therapists (SALT) and from other specialists such as diabetes nurses. Details on requirements relating to fortified foods and thickened fluids were also written into plans. People who required their fluid intake to be monitored had marked cups which contained a set number of millilitres, so that staff could easily calculate how much fluid had been consumed. Nutritional and fluid charts were in place where necessary so that staff could monitor people's intake. This information was communicated to specialists so that plans could be adapted to meet people's needs. People's specialist needs in relation to pre-diabetes,

Good

Is the service effective?

diabetes or weight management were written into care plans. The home had received a level 5 in food hygiene from the environmental health authority, where 5 is the safest rating.

We observed a lunch time meal experience. People were offered a meal and if they pushed it away staff tried them with an alternative. We noted that some people settled on the second or third choice. There was a written menu for the day and the day after on a blackboard near the kitchen for people to consult and we heard staff reading out what the meal was going to be for people. There were no pictorial images of food which could have been used to enhance communication between staff and people using the service. When we discussed this with the manger they explained that those people who were able to choose their meals could do so without pictorial prompts, and those who were not able to express a choice, did not find such prompts useful.

Staff told us people were supported with accessing health care services such as GPs, dentists and opticians. This was confirmed in the care records we reviewed. The home manager told us they liaised with the GP surgery to make sure people's annual health checks were completed. People had health action plans which gave a comprehensive overview of their individual health needs and health passports, which were documents to support people to receive the correct care for their needs when they visited or were admitted to hospital. Records showed that people were supported to access other health care professionals as required. For example, we saw input from the diabetes nurse, consultant psychiatrist and the neurology department of a local hospital.

Requires improvement

Is the service caring?

Our findings

Some staff were aware of the need to uphold people's dignity and cared for them respectfully. For example, we observed one member of staff attend to a person's dignity around meal time to ensure that their face and hands were kept clean. We also observed some staff supporting people to eat their lunch in a respectful way. One person had been assisted into a secondary lounge because they were sensitive to noise. A member of staff spoke to this person in gentle encouraging tones whilst they assisted them to eat their meal.

Other people however, were not supported so well. For example, when one person's empty plate was taken away, two staff mentioned something to each other about the person and laughed. The 'Dignity Charter' displayed in the foyer of the home stated, "There is a difference between laughing with, and laughing at." Although this was not mocking, it was not inclusive either and we did not feel staff were laughing with the person. We noted that one person was eating using their hands which we considered may have been undignified for them. However, we consulted with a number of people involved in this person's care and concluded that they had been assessed to require the option of eating in this way.

We observed that care was sometimes given in a functional, rather than a caring way. For example, one person who had limited mobility was being supported to eat their meal by a member of staff who stood behind the wheelchair the person was using. We saw that the spoon containing food appeared out of nowhere for this person. The manager later agreed that the person could have been supported successfully from a seated position to one side of them where staff could have spoken with the person and given eye contact. This meant that this person was not supported in as caring or compassionate way as they could have been.

However, we did observe other staff interacting in a kind manner with people, asking them about their day and interacting with them kindly and thoughtfully. Staff skill in offering a caring approach did vary however, with some other interactions being a little lacking in warmth and focus on the person.

The home had a dignity charter, and staff were able to speak with us about what this meant in practice. One member of staff told us that they had signed up to be a dignity champion.

Staff spoke about the importance of working with people in a respectful manner and that they strove to do this at all times.

People who had difficulty communicating were enabled to give their views through staff spending time with them and listening. Some people used a loud speaker telephone so that they could hear relatives and friends. Staff told us that in limited cases pictorial prompts did assist, but that they often had to rely upon observing people's reactions, body language and facial expressions to decide what people felt.

The home's visitors policy stated that visitors were always made welcome into the home. The manager told us that people's families and friends were welcome at all times and were also invited to specific events. There were no visitors during the day of inspection, but the relatives and friends of people we spoke with after the inspection confirmed that they could visit at any time.

Because of the size of the service the manager told us in the Provider Information Return that the main lounge could become quite noisy at times. There were a number of quieter areas in the home which people could use if they preferred to be alone or with a smaller group. We saw people using these rooms and they appeared to be enjoying this.

Staff understood people's life histories well, and they had been afforded time to read these in care files. Staff also spoke about having gathered information from families so that they were in a position to offer caring support.

We observed that when people appeared to be in pain that staff responded to this quickly and in a caring manner. One person was feeling unwell and we noticed the manager talking with this person kindly and rubbing their back, which they appeared to find comforting.

The manager told us that the interview process for new staff included questions which were designed to bring out staff's kindness and compassion and that staff were recruited with this in mind. "The people we care for are vulnerable, we need to know that staff have an instinct for kindness, and when we see this we are much more likely to recruit them."

Requires improvement

Is the service caring?

We recommend that the registered person consults best practice guidance on ensuring people are treated with dignity and respect at all times.

Requires improvement

Is the service responsive?

Our findings

From our observations and discussions with relatives, people were not always sufficiently consulted or involved in their care. We were not able to communicate with a number of people to discover their views and the responses of those we did speak with did not relate to this key question. However, relatives told us that the quality of responsiveness varied. One relative told us that they visited Isabella Court at weekends but found it difficult to ascertain what their relative had been doing during the week. They said they had to "quiz" staff for information, as there were a number of new employees, whilst other staff had little knowledge of what had been happening as they didn't work during the week. They also mentioned that their relative liked to chat. As other people in the house were not able to communicate well their relative needed more verbal interaction with the staff. They told us "Staff don't always have time to chat to [them] as much as I would like."

Each person had an activity planner. These were not fully developed. People were not always supported to choose what they wanted to do, and they had not been fully consulted over their preferences. Our discussions with staff showed they thought this was an area which could be developed. They felt the shortfall was due to difficulties with recruitment which were now improving.

People were not given sufficient opportunity to engage in fulfilling and meaningful activities. Some people's planners only contained two or three activities a week. There were some days with nothing scheduled for a number of people and we did not see or hear evidence that this was sufficiently compensated for by unplanned activity. The home had a sensory room, but this was not very inviting and was in need of updating. People did use this room, but we observed that one person was left alone in it for a long time with no company. At other times a person was positioned in a chair so that they could not watch what was happening or take part. One person had written into their care plan that they should go out every day when the weather allowed, because they enjoyed the change of scenery and benefitted from the fresh air. However, staff told us that the person did not in fact go out because their wheelchair was no longer comfortable and they were waiting for a replacement. There was nothing written into the care plan to reflect this or what other measures were in place to ensure the person received stimulation and interest.

However, despite these shortfalls records about people care needs were detailed. We looked at four people's care records. Each file had a section which recorded who and what was important to people, how they wanted to be supported and what people admired about them. Care plans focused on people's strengths and provided information about the care and support people required from staff to have their care needs met. Each plan contained information about what people's dreams, wishes and life goals were and personal histories were recorded to support staff to understand people's lives before they came to live at the home. The manager was developing a 'Life at Isabella Court' scrap book for each person, where staff would write about things people had done and include photographs to show relatives and friends and to provide a focus for conversations with people. These were not yet completed.

Staff told us that people were consulted about their care and that they used guidance on how to interpret body language, facial expressions, tone of voice and gestures. Some people had developed specific signs for key messages they wished to convey and these were written into plans. Staff told us they used a range of communication methods to ensure people understood what choices were available and so that staff understood what people were communicating to them. Staff gave detailed examples of people's individual style of communication so that they could be sure for example when people were happy or sad, comfortable or uncomfortable.

Plans recorded discussions with people around holiday destinations including suggestions from staff, family and friends. Care plans contained information about keeping in touch with significant people and about important dates, such as birthdays. Daily records showed how support was given in accordance with the care plans. Monthly reviews monitored people's progress towards achieving their goals. The social care professional we spoke with said they thought the home was good at providing individualised care and that when people's needs changed the service was quick to make adjustments.

Requires improvement

Is the service responsive?

Those who enjoyed swimming had a weekly visit to the local pool, some people attended Brookleigh, a day centre specialising in care and activities for people with a learning disability, some people received aromatherapy. Staff told us that they planned trips for the people that lived at Isabella Court. They said that they had recently been on a steam railway trip and to the railway museum at York. When asked about how people decided about whether they wanted to go on a particular trip, a staff member said, "You pick the people who will get the most out of a certain activity." They told us that one person had been to see a pop group they loved in concert. The member of staff also told us that they had discussed one person's planned outings within the staff team, which had resulted in an outing to a new sensory centre in the next county. Staff also said that they had organised a brass band to visit the home at Christmas time in response to one person's love of brass bands.

Care plans included details of the ways in which the staff supported people to stay in touch with those they cared about, through loud speaker telephones. We observed that staff were engaging people with Halloween decorations, and that people were enjoying helping with getting these ready for display. The manager had written in the PIR that they planned to introduce a more person centred activities plan to enhance people's experience of living at the home.

People who needed equipment, such as aids to mobility and moving and handling, had this in place. The manager told us about piloting the use of tablets to promote people's communication but they had found that none of the service users living at the home at the present time could benefit from these. Likewise a Makaton application had not been successful, however, they told us that they were open to trying new equipment for the benefit of people who lived at the home.

The service had a complaint policy and procedure. Staff told us they understood that people were vulnerable because they were not always able to express their concerns clearly. However, they told us they were vigilant and would notice if people's behaviour changed or if they appeared unhappy. The manager told us they dealt with relatives and friends concerns in an open way and we saw that concerns had been recorded with actions in place. Staff told us that learning from concerns which had been raised was discussed in team meetings.

We recommend that the registered provider consults best practice guidance on consulting with people to provide meaningful and fulfilling activities for each individual person's needs and interests.

Requires improvement

Is the service well-led?

Our findings

We observed that the manager was communicative with the people who lived at the service and that the manager appeared to have a good rapport with staff.

There was no registered manager for the service. The post was being advertised at the time of the inspection but no appointment had been made. The home was managed by an acting manager.

The provider has a panel of service users who give their opinions on the service that they receive. Representatives from all Wilf Ward Family Trust organisations are invited to participate. The manager told us that one person from Isabella Court attended these meetings and was supported to give their views. The service did not hold meetings for the people who lived at them home as this did not support people to give their views in the most effective way. The manager said, "we use more of a key worker role, using staff to advocate for each individual service user." This meant the service had worked with people to promote their involvement in their care.

However, the relatives we spoke with did not feel they were sufficiently consulted about people's care. For example, one person told us that they had not been informed of the recent changes to the management of Isabella Court and they felt that the current management was not sufficiently involved in the day to day care of the people at the service to understand their needs well. They were not invited to any meetings other than the annual review organised by the local authority and they felt they could be better involved. They told us that newsletters which were informative and helpful had stopped recently. However, the area manager told us that the newsletter had been stopped by the wider Wilf Ward Family Trust and a replacement 'spotlight ' newsletter was under review which would feature information for everyone involved in the home. Another person told us that they were happy with the management and that the manager knew their relative, "Inside out. If I have any problems I just say and it is sorted."

Staff told us that they discussed each person's care daily and passed on any information between shifts. Staff told us that the lines of communication from the providers to them were clear and they felt consulted and encouraged to give their views back to the acting manager about how to improve care. This meant that staff views were sought and acted upon for people's benefit.

Staff told us that they understood the scope and limit of their role and when to refer to another person for advice and support to ensure people received appropriate care.

The manager worked well in partnership with health and social care professionals to ensure people had the benefit of specialist advice and support. Daily notes and monthly updates contained information about how advice was to be incorporated into care practice. Health and social care professionals told us that they were consulted and that the manager worked well with them.

The manager had submitted notifications to CQC as required.

There were systems and procedures in place to monitor and assess the quality of the service. For example we saw records of audits of water temperatures, environmental risks, portable appliance testing, and hoist servicing. Care plans were regularly reviewed and there were regular checks on infection control practices and medicine handling. Required actions were recorded and there were plans for improvements in place.

We recommend that the service consults best practice guidance on involving those people who are significant in the lives of people who live at the service to promote good quality care.