William Morris (Camphill) Community Limited

William Morris House

Inspection report

William Morris House
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Ratings

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

Overall summary

William Morris House is a specialist residential college that forms part of the Camphill Community. The service is registered to provide accommodation and personal care for up to 35 young people with a learning disability or autistic spectrum disorder during term time. The Care Quality Commission (CQC) regulates and inspects the accommodation and personal care. The educational provision at the college is regulated and inspected by the Office for Standards in Education (OFSTED).

At the time of our inspection eight people were using the service. Five people using the service lived in one house (Hiram) three people in another (Merton). Additional accommodation was being used for activities and staff training. The provider had plans in place to increase the numbers of people using the service.

This inspection was unannounced and took place on 4 and 5 November 2015.

There was no registered manager at the service at the time of our inspection. The manager of the service had

Summary of findings

applied to the Care Quality Commission to become the 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 2008 and associated Regulations about how the service is run.

We found a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service people received was not always effective. The service did not comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People's capacity to make choices and decisions had not been assessed and any restrictions upon people's liberty had not been identified.

People were safe. The registered manager and staff understood their role and responsibilities to keep people safe from harm. People were supported to take risks, promote their independence and follow their interests. Risks were assessed and plans put in place to keep people safe. There was enough staff to safely provide care and support to people. Checks were carried out on staff before they started work with people to assess their suitability. Medicines were well managed and people received their medicines as prescribed.

Staff received regular supervision and the training needed to meet people's needs. Arrangements were made for people to see their GP and other healthcare professionals when they needed to do so. The physical environment was personalised and met people's needs.

People received a service that was caring. They were cared for and supported by staff who knew them well. Staff treated people with dignity and respect. People's views were actively sought and they were involved in making decisions about their care and support. Information was provided in ways that were easy to understand. People were supported to maintain relationships with family and friends.

People received person centred care and support. They were offered a range of activities both at the service and in the local community. People were encouraged to make their views known and the service responded by making changes. Relatives said communication between the managers, staff and them was not always good.

The service was well led. The manager, senior staff and trustees provided good leadership and management. The vision and culture of the service was clearly communicated to and understood by staff. The management team demonstrated good leadership and management, particularly with respect to developing the vision and values of the service. However, relatives felt changes had not been communicated clearly and had been implemented too quickly. The quality of service people received was monitored on a regular basis and where shortfalls were identified they were acted upon.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 were safe from harm because staff were aware of their responsibilities and able to report any concerns. The provider had ensured arrangements to keep people safe were put in place.

Risk assessments were in place to keep people safe. These were designed to support people to undertake activities of their choosing.

There were enough suitably qualified and experienced staff. Staff recruitment procedures ensured only suitable were employed.

Medicines were well managed and people received their medicines as prescribed.

Good

Is the service effective?
The service was not always effective.

The service did not always comply with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The provider had not assessed people's capacity to consent to care and support arrangements. Consequently, they had not submitted applications to the appropriate authorities for any deprivation of people's liberty to be authorised.

People were cared for by staff who received regular and effective supervision and training.

People were supported to make choices regarding food and drink. People's fluid and nutritonal intake was monitored.

People's healthcare needs were met and staff worked with health and social care professionals to access relevant services.

Requires improvement

Is the service caring?
The service was caring.

Staff provided the care and support people needed and treated people with dignity and respect.

People's views were actively sought and they were involved in making decisions about their care and support.

Good

Is the service responsive?
The service was responsive.

People received a service that was designed around their individual needs.

Good

Summary of findings

People participated in a range of activities within the local community and in their home.

The service encouraged feedback from people using the service and others and made changes as a result.

Relatives were not always happy with the communication between the managers, staff and them.

Is the service well-led?

Good

The service was well led.

The manager and other senior staff were well respected.

The trustees and senior management team worked closely together on the long term strategy for William Morris House. This had resulted in changes to the vision and values of the service.

The vision and values had been clearly and effectively communicated to staff. However, relatives felt the changes had not been communicated clearly and had been implemented too quickly.

There was a person centred culture and a commitment to providing high quality care and support.

Quality monitoring systems were in place and used to further improve the service provided.

William Morris House

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.

This inspection took place on 4 and 5 November 2015 and was unannounced. The inspection team consisted of two adult social care inspectors. The last full inspection of the service was on 19 January 2014. At that time we found no breaches of legal requirements and had no concerns regarding the service provided.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We did not ask the provider to complete a Provider Information Record (PIR) before this inspection. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

We contacted three health and social care professionals, including a community nurse, social worker and commissioner. We asked them for some feedback about the service. We were provided with a range of feedback to assist with our inspection.

Some people were able to talk with us about the service they received. We spoke with five people. We spent time with people in each house. We spoke with nine staff, including the manager, the strategic director, other senior staff, three care staff, one agency staff member and one volunteer. William Morris House is a part of the Camphill Community and is a charitable organisation managed by a voluntary management board of trustees. We were able to talk with the current chairperson of the board of William Morris House. We also spoke with relatives of three people using the service by telephone and exchanged correspondence with a relative of one further person.

We looked at the care records of five people using the service, four staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints, mental capacity and deprivation of liberty, recruitment, accidents and incidents and equality and diversity.

Good

Is the service safe?

Our findings

Some people who used the service were able to tell us they felt safe. One person said, "I feel safe here with the staff". Others spoke positively about their lives and the staff supporting them. We observed people in both houses and saw they reacted positively to staff and seemed relaxed and contented. Relatives said they felt people were safe.

People were kept safe by staff who knew about the different types of abuse to look for and what action to take when abuse was suspected. Staff were able to describe the action they would take if they thought people were at risk of abuse, or being abused. They were also able to give us examples of the sort of things that may give rise to a concern of abuse. There was a safeguarding procedure for staff to follow with contact information for the local authority safeguarding team. Easy read flowcharts of action to be taken if abuse was suspected, witnessed or alleged were on display in each house. Staff we spoke with told us they had completed training in keeping people safe. Staff knew about 'whistle blowing' to alert management to poor practice.

The provider had appropriately raised safeguarding alerts in the 12 months before our inspection. On each of these occasions the provider had taken the appropriate action. This included sharing information with the local authority and the Care Quality Commission (CQC). For example, the manager had arranged for additional agency staff with specific training to assist in caring for one person during a difficult time for them. They had kept the CQC and other professionals informed of arrangements and progress in keeping people safe.

There were comprehensive risk assessments in place. These covered areas of daily living and activities the person took part in, encouraging them to be as independent as possible. For example, risk assessments were in place to keep people safe from harm when carrying out domestic activities such as cooking and for people to use community leisure facilities safely. Risk assessments contained clear guidance for staff and detailed the staff training and skills required to safely support the person. Assessments were regularly reviewed and were based upon individual activities people wanted to do.

Accident and incident records were completed and kept. These identified preventative measures to be taken to reduce the risk of reoccurrence. The provider also documented 'near misses'. The registered manager explained these were occasions where no harm had come to anyone but due to the circumstances it may have done. They said, "This is a way to identify and remove risks to people before anything happens".

Relevant checks were carried out before staff started work. These checks included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check an applicant's police record for any convictions that may prevent them from working with vulnerable people. References were obtained from previous employers. The service made use of volunteers. Where volunteers were recruited who were non UK residents, it was evident from their files that the relevant immigration checks were undertaken prior to employment. Recruitment procedures were understood and followed by the manager. We saw in staff personnel files that a robust recruitment process was used, with the provider assessing the values of potential employees. The registered manager told us that people using the service were involved in recruiting and selecting staff.

People were supported by sufficient numbers of staff to meet their needs. Staff were allocated to work in individual houses. Staff rotas identified senior staff and an on call person who could be contacted at any time of the day or night. Night time staffing had recently been altered at Hiram House. This was a response to people's changing needs and ensured people were safe at night. The service had a stable staff team and made use of agency staff to ensure staffing levels were maintained. People said they were able to receive care and support from staff when they needed it. Staff said there were enough staff to safely provide care and support to people. During our visit we saw there was enough staff to safely provide care and support to people.

There were clear policies and procedures for the safe handling and administration of medicines. These were followed by staff. Medicines were securely stored and records of administration were kept. Staff had received training in administering medicines. Following this training the registered manager assessed the ability of staff and signed them off as competent to safely administer medicines.

Staff had access to equipment they needed to prevent and control infection. This included protective gloves and

Good

Is the service safe?

aprons. The provider had an infection prevention and control policy. Staff had received training in infection control. Cleaning materials were kept in a locked room to ensure the safety of people. The accommodation was clean, well maintained and odour free.

Requires improvement

Is the service effective?

Our findings

People using the service told us about the service they received. They told us their needs were met. One person said, "I do all sorts of things, I'm going to start playing football for a team". Relatives said they felt people's needs were met. Staff we spoke with told us people's needs were met.

The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack capacity to make some decisions. People's capacity to make choices and decisions had not been assessed. As a result the service was not applying DoLS appropriately. These safeguards protect the rights of adults using services by ensuring that if there were restrictions on their freedom and liberty, they were assessed by professionals who were trained to decide whether the restriction was needed. The manager and other senior staff had a good understanding of MCA and DoLS and stated they were aware of these shortfalls and had plans to address them.

This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a programme of staff supervision in place. Supervision meetings are one to one meetings, a staff member has with their supervisor. The manager carried out supervisions with senior support workers. Senior support workers with care and support staff. Staff members told us they received regular supervision. Staff records showed that supervision were held regularly. Supervision records contained details of conversations with staff on how they could improve their performance in providing care and support. Staff said they found their individual supervision meetings helpful.

People were cared for by staff who had received training to meet people's needs. We viewed the training records for staff which confirmed staff received training on a range of subjects. Training completed by staff included, first aid, infection control, fire safety, food hygiene, administration of medicines and safeguarding vulnerable adults. Staff said the training they had received had helped them to meet people's individual needs. However, staff said they would benefit from further training on the Mental Capacity Act and on working with people with specific mental health conditions. They said the manager was aware of this and would be arranging this training.

Newly appointed staff completed induction training. An induction checklist ensured staff had completed the necessary training to care for people safely. The manager told us new staff shadowed experienced staff as part of their induction training. Staff confirmed they had received an effective induction.

People chose what they wanted to eat. Menus were planned with the involvement of people using the service. The menus were varied and included a range of choices throughout the week. People were encouraged to participate in the preparation of food. Participation was planned and people said they enjoyed doing this. One person said, "I like cooking". People told us they enjoyed the food. Staff said care was taken to ensure food was wholesome, well-balanced and nutritious. At lunchtime on both days of our inspection, we saw that people interacted well with each other and staff and enjoyed the food and social engagement. People's dietary and fluid intake was monitored and recorded.

People's care records showed relevant health and social care professionals were involved with people's care. Plans were in place to meet people's needs in these areas and were regularly reviewed. There were detailed communication records in place and records of hospital appointments. People had health plans in place that described how they could maintain a healthy lifestyle.

The physical environment in both houses was of a high standard and met people's needs. Communal areas were homely and people's own rooms were personalised. People who showed us their rooms were proud of them. When necessary repairs were identified these were quickly acted upon. Each house had clear notices and signs, to assist people to find their way around. The provider had plans in place to further develop the facilities available to people. These included a plan to convert one of the attics into a games room.

Good

Is the service caring?

Our findings

People told us they liked the staff and thought they were caring. We saw that people were treated in a caring and respectful way. Relatives told us staff were caring. One relative said, "We have no concerns over the staff, they're very caring". Staff were friendly, kind and discreet when providing care and support to people. People responded positively to staff, often with smiles, which showed they felt comfortable with them. We saw a number of positive interactions and saw how these contributed towards people's wellbeing. For example, one person was playing card games with a staff member whilst lunch was being prepared. It was evident from the observation that they had built a good relationship with each other.

Staff spoke to people in a calm and sensitive manner and used appropriate body language and gestures. People's care records included a communication plan which described how people's communication needs were met. A variety of communication aids were used to assist people with limited verbal communication. Staff were able to explain how people expressed their views.

People were cared for by staff who knew them well. Staff were able to tell us about people's interests and individual preferences. For example, we were told that one person liked to go for a run in the grounds after their lunch. This person did indeed go for a run after their lunch and told us they enjoyed doing this.

People's care records included an assessment of their needs in relation to equality and diversity. We saw the provider had planned to meet people's cultural and religious needs. For example, specific dietary requirements were met. Staff we spoke with understood their role in ensuring people's equality and diversity needs were met. Staff had received training on equality and diversity.

People were supported to maintain relationships with family and friends. People's care records contained contact details and arrangements. People spoke with us about their families. Staff said they felt it important to help people to keep in touch with their families.

Promoting people's independence was a theme running through people's care records. Guidance was included for staff on how to work alongside people providing coaching for people to carry out activities themselves. Staff told us they saw this as a key part of their role. One said, "Preparing people for more independent living is crucial". Another said, "It's great when we work alongside people, teaching them to do things for themselves".

Throughout or inspection we were struck by the relaxed and homely atmosphere in both houses. People and staff seemed to enjoy each other's company. People were engaged in conversation with each other and staff and there was a sense of fun.

Good

Is the service responsive?

Our findings

People told us the service responded to their individual needs. One person said, "I like it here, staff help me do what I want". Relatives said the service responded to people's needs. A relative said, "They arranged for (Person's name) to volunteer at the canal trust and a member of staff supports him there".

People's care records were person centred. They included information on people's life histories interests and preferences. Staff said this information helped them to provide care and support in the way people wanted. Staff we spoke with were knowledgeable about people's life histories and their likes and dislikes. People and their families had been involved in developing and agreeing their plans for how they were cared for and supported. Staff confirmed any changes to people's care was discussed regularly at team meetings to ensure they were responding to people's care and support needs.

Changes to people's individual needs were identified and plans put in place to meet their needs. For example, one person was identified of being at risk of removing their seat belt whilst in a car. It had been agreed with the involvement of the person and their parents that in order to minimise this risk a specialist seatbelt was required. Before this arrived, it had been agreed that a staff member would sit on the buckle side of the person to ensure they did not undo the seat belt.

Each house had an activities programme in place. Activities were varied and included activities at the service and trips out. The provider had a minibus to enable people to access their local community and go on trips. People told us they enjoyed the activities. Staff said there were plenty of activities and sufficient staff and transportation. Relatives said activities were arranged based upon people's interests.

The manager, senior manager and staff were all aware of the potential for people using the service to become isolated as a consequence of living at William Morris House. The manager told us they reduced this risk through developing links with the local community, making use of volunteers and supporting people to participate in events and activities in the local area.

Regular meetings were held with people to seek their views regarding their care and support. They said they enjoyed these meetings and felt their views were listened to and acted upon. Records of these meetings were kept. These showed people's views were sought on areas such as activities, menu choices and planned changes to the service.

People told us they were able to raise any concerns they had with staff or the manager. One person said, "I say if I'm not happy". The provider had a policy on comments and complaints. The policy detailed how complaints were responded to, including an investigation and providing a response to the complainants. An easy read version of this policy was on display in both houses. A record of complaints was kept at the service. The provider had received three complaints in the previous 12 months. Two of these related to communication between the service and parents, one concerned a person undertaking a specific activity. Each had been investigated and feedback provided to the complaint regarding the outcome of the investigation.

Relatives gave mixed feedback regarding the communication with the manager and staff. One relative said communication was good. Three relatives told us communication between managers, staff and them was not good. They said they wanted this to improve. Relatives of two people said they had previously received a regular email update from the provider but that when key staff had left this had stopped. One said, "Communication is not very good. The previous staff used to send a weekly email update but we don't get that now". Another said, "We have asked for the email update to be re-instated but it hasn't been". We talked with the registered manager about this. They said this email was stopped as they believed it did not protect people's confidentiality. They felt additional communication had been put in place to compensate for the withdrawal of this. We saw in the notes of a staff meeting held in October 2015, the manager had discussed with staff the importance of improving communication with families. The manager told us that regular parent forums were held and families were invited to special events. They said, "Communication is key and we want to improve it".

Staff told us that people generally got on well with each other but staff needed to support and maintain this. Strategies were in place to guide staff on how each person should be supported to minimise the risks to others.

Good

Is the service responsive?

As William Morris House is a specialist college, people stay at the service during term-times for the duration of their course. People are often moving from school, the parental home or other residential placements. This means the provider must ensure transition between services is well-planned. People spoke to us and staff about arrangements for the end of term and plans for the future.

Sometimes this was a concern to people and a cause of anxiety for them. People's care records documented the work done by staff to ease these anxieties. There were also details of how the provider had communicated with other service providers to manage and ease transitions between services.

Good

Is the service well-led?

Our findings

People told us they liked the manager and senior staff and were able to talk to them when they wanted. Staff spoke positively about the management and felt the service was well led. Relatives said the manager was efficient and always rang them back when requested. Relatives expressed some concern that the manager and strategic director where both on temporary contracts and were unsure how this would affect the service.

Throughout our inspection we saw a person centred culture and a commitment to providing high quality care and support. Staff of all levels understood the values and culture of the service and were able to explain them. Senior staff provided us with information requested promptly and relevant staff were made available to answer any questions we had. The relationship between senior staff and trustees was positive and supportive and each spoke of the effective strategic management of the service.

Services provided by the Camphill Community have traditionally held to specific values outlined within their aims and objectives. The manager and senior staff told us how they had engaged in discussions with trustees, staff, people using the service and their families regarding the vision, values and culture of William Morris House. They said their intention in doing this was to ensure the best elements of the Camphill tradition was retained, whilst providing person centred care and support in a way that met the needs of young people today. The service had moved away from a staffing structure of house parents and co-workers living alongside people to a structure of entirely salaried staff working rostered shifts. Relatives felt this had resulted in a number of staff people knew well leaving the service. They felt this change had been implemented too quickly. The registered manager said the speed of this change had been led by the resignation of house parents. The service was working on retaining the principle of people spending time together communally on traditional activities such as arts and crafts, whilst increasing opportunities for people to use up to date IT equipment.

Senior managers and trustees had also identified the risk of isolation from the local community. To minimise this senior managers had developed links with the parish council and other groups. Plans were also in place to develop social enterprises which would provide work based activities for people and increase contact with the local community and general public.

The manager and senior staff said these measures and continued improvement planning had put them in a position where they now felt they could seek to increase the numbers of people using the service.

The provider operated an on call system for staff to access advice and support if the manager was not present. Staff confirmed they were able to contact a senior person when needed. Experienced care staff were responsible for the service when the manager or other senior staff were not present.

All accidents, incidents and any complaints received or safeguarding alerts made were followed up to ensure appropriate action had been taken. The manager analysed these to identify any changes required as a result and any emerging trends.

The manager and senior staff knew when notification forms had to be submitted to CQC. These notifications inform CQC of events happening in the service. CQC had received appropriately notifications made by the service.

The policies and procedures we looked at were regularly reviewed. Staff we spoke to knew how to access these policies and procedures. This meant that guidance for staff was up to date and easy for them to use.

Systems were in place to check on the standards within the service. This consisted of a schedule of monthly audits carried out in each house by senior staff. Audits completed by the manager included medicines management, health and safety, financial audits and care records. These audits were carried out as scheduled and corrective action had been taken when identified.

Health and safety management was seen as a priority by senior staff. Action had been taken to minimise identified health and safety risks for people using the service, staff and others.

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 11 HSCA (RA) Regulations 2014 Need for consent People's capacity to make choices and decisions and consent to their care and treatment, had not been assessed and any restrictions upon people's liberty had not been identified. Regulation 11 (1)