Livability

58 Whichers Gate

Inspection report

58 Whichers Gate Road
Rowlands Castle
Hampshire
PO9 6BB

Tel: 02392413519

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 6 April 2016 and was unannounced. 58 Whichers Gate provides care and accommodation for up to three people. At the time of the inspection there were three people living at the home. The home specialises in the care of people living with learning disabilities.

There was a registered manager in place. 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. However, the registered manager was not available at the time of the inspection. Livability has employed an interim manager who has been in place since 22 February 2016.

At the last inspection on 25 September 2013 the service was not meeting all the requirements of the regulations that were inspected at that time. The areas where actions were required were: the safety and maintenance of the property and the lack of an effective system to monitor the service. At this inspection we found that action had been taken and the previous requirements had been met.

People who lived at the home told us they felt safe and secure with staff to support them. People told us staff supported them to manage their finances. We looked at two people's care records and saw that they detailed their preferences, interests, likes and dislikes.

We observed positive staff interaction with people during our inspection visit. We found staffing levels and the skill mix of staff were sufficient to meet the needs of people and keep them safe.

Pre-employment checks that were required had been completed prior to staff commencing work.

People received their medicines in a safe manner. We found staff responsible for administering medicines had received formal medicine training to ensure they were confident and competent to give medicines to people. However, there were inadequate arrangements for the storage of the medicines. The interim manager had found errors in the records for medicines and was taking action regarding staff training and awareness.

People were asked for their consent before support was provided. Staff were aware of their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported by sufficient numbers of staff who had the knowledge, skills and experience to carry out their role. People told us that there were always staff available to help them when needed.

People had access to a range of health care professionals to help maintain their health. A varied and nutritious diet was provided to people. This took into account their dietary needs and preferences, so that

their health was promoted and choices respected.

People told us they could speak with staff if they had any worries or concerns and felt confident they would be listened to.

People participated in a range of daily activities both in and outside of the home which were meaningful and promoted their independence.

There were systems in place to monitor and improve the quality of the service provided.

We found one 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people were assessed and reviewed and staff understood how to keep people safe.

People were protected from abuse and avoidable harm in a manner that protected and promoted their right to independence.

Arrangements were in place to ensure that medicines were managed safely. However, medicines were not kept securely.

There was a robust recruitment process in place.

Is the service effective?

Good

The service was effective.

Staff received training and support for their roles and were competent in meeting people's needs.

Staff we spoke with had a good understanding of the Mental Capacity Act 2005 and how to ensure the rights of people to make decisions were respected.

Is the service caring?

Good

The service was caring.

We saw that members of staff were respectful and understood the importance of promoting people's privacy and dignity.

People who used the service told us they received the care and support in a kind and caring manner.

Is the service responsive?

Good

The service was responsive.

People's care plans were reviewed to enable members of staff to provide care and support that was responsive to people's needs.

People who used the service were given the opportunity to take part in activities organised both inside and outside of the home.

Is the service well-led?

Good

The service was well led.

We were told by people that staff were approachable and supportive and they enjoyed living at the home.

Feedback was sought from people who used the service.

There were systems in place for assessing and monitoring the quality of the service provided.

58 Whichers Gate

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 6 April 2016 and was unannounced. One inspector undertook the inspection.

Before the inspection we reviewed information we had about the service, including previous inspection reports, improvement plans and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law. The registered provider gave us additional information on the day of the inspection.

We spoke with and observed care and support given to all of the people who lived at the home. We spoke with the interim manager and the area manager. There were five support staff employed to work at the home, of whom we spoke with two.

We looked at the care plans and associated records for two people. We reviewed other records, including the provider's policies and procedures, emergency plans, audits, staff training, staff appraisal and supervision records, and recruitment records for two members of staff.

Requires Improvement

Is the service safe?

Our findings

We spoke with all the people who used the service. They told us that they felt safe in the home and that the staff at the service were nice. One person said "Lovely to meet you, I am happy here."

Risks had been assessed and there were care plans in place to say how these would be managed. For example there was a care plan in place that described the person's mobility and the support they needed. There were risk assessments in place and these were updated on a regular basis. For example, there was a risk assessment in place for the leisure activity that one person participated in to protect their health and wellbeing.

Staff told us they had undergone safeguarding training, and this was confirmed by records. Staff were able to describe the purpose of safeguarding and the signs which might indicate a person had been abused. Staff were clear about their responsibility to report any concerns they might have about people's safety.

People kept their monies in their room in a locked box. This was checked to ensure there was a correct balance. Before one person went out they checked their money with a member of staff and discussed how much they would need to buy their friend a present for their birthday and for lunch.
Accidents and incidents were reported and included measures to reduce risks for people. For example, where one person was identified as at risk of falling, changes were made to the person's care plan to reduce this risk from occurring.

All the people we spoke with told us they felt there were enough staff on duty to keep them safe. One person told us, "There is always someone here". Staff told us they felt there were enough staff on duty to meet people's needs through the day and night time.

We looked at two recruitment files for staff and saw appropriate steps had been taken to ensure staff were suitable to work with people. All necessary checks, such as Disclosure and Barring Service Checks (the DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services), work references and fitness to work had been undertaken. Staff confirmed the service had taken up references and that they had not started work until their DBS had come back. This meant safe recruitment practices were followed.

People told us that they received their medicines when they needed them. There were procedures for the safe management and administration of people's medicines. Staff had received medicine training in safe administration. The interim manager showed us the supervision agenda they had been completing with staff, which included a reminder on how to administer medicines safely as errors had been found. We found two comments on medicine records for the week before the inspection which detailed errors in medicines given and we asked the interim manager to look into these. They sent us an email about the action they had taken which was 1) to talk with the staff concerned and 2) to have them undertake medicines competency training again..

People's medicines were not stored securely. Medicines were stored in a filing cabinet which could be locked however it was not secured to the wall and did not meet the NICE (National Institute for Health and Care Excellence) guidance for the safe storage of medicines. The filing cabinet was also not appropriate because of temperature, moisture and hygiene controls as outlined in the Royal Pharmaceutical Society guidelines.

A failure to safely store and manage medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service effective?

Our findings

People received care from staff who were appropriately trained. People told us they felt well supported by staff. This was confirmed in the training information we saw. The interim manager was aware that some areas had needed to be updated and staff told us they had completed areas of training since the interim manager had started work at the service. We saw that staff had attended various courses which included: safeguarding, first aid, health and safety, medicines management, equality and diversity, the Mental Capacity Act 2005 and learning disability.

We saw staff sought people's consent before they provided care and support. Throughout the inspection we observed staff involving people to make decisions about their care and respecting their decisions. For example, people were given choices whether they wished to speak to the inspector and where they would like this to take place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of this inspection nobody was being restricted under the DoLS. Staff spoken with were knowledgeable about the MCA and DoLS and how it worked to ensure any restrictions were lawful and in people's best interests.

People who we spoke with told us they enjoyed the food at the home. People were supported to maintain their independence and would plan, prepare and cook their own food. One person told us that staff knew what food they enjoyed and helped them to prepare this when they asked for assistance. People told us that staff supported them to go out to eat. Staff spoke of how people were given the choice of cooking in the home or going out for a meal if they wished. People were independent in making their own drinks and we saw that people had access to the kitchen to make drinks when they wanted to.

Staff told us they monitored people's weight monthly to ensure they maintained a healthy weight. Staff spoke of healthy eating, while respecting the person's choice of food. At the time of our inspection staff had no concerns about people's food or fluid intake.

People we spoke with told us they had access to healthcare professionals when they needed to and that visits were arranged when they requested them. People told us that they saw a doctor when they needed to. One person said, "They call the doctor when I've needed them". They also told us that they were supported to hospital appointments when this was required. We saw in care records that staff ensured people maintained their appointments and worked with external healthcare professionals to ensure the person

received the care and treatment in a timely way.

The home was free from trip hazards and was readily accessible to people living in the home.

Good

Is the service caring?

Our findings

We saw a notice in the dining area which was discreet but could be seen. It said "Our residents do not live in our workplace, we work in their home."

This philosophy was seen and heard between staff and people who lived at 58 Whichers Gate. Two people had lived together for some considerable time and the third person had moved in last year. We saw they were happy to spend time together or in their rooms. One person had an office in the home as their bedroom was not large enough to have the desk and computer. People shared activities such as knitting or worked on things together such as knitting squares for a blanket and then one person sewed them together as they were better at sewing.

Staff asked people for permission to use the facilities as they maintained the philosophy they were 'visiting', people would go into the kitchen whenever they wanted to and make drinks or snacks, lunches for example. People used the washing machine and dryer with support if needed. People's privacy was respected and care plans stated what people liked, for example "I like staff to knock on my door or ask my permission if I am not in there."

People were treated with care, compassion and kindness. People commented on the caring approach the staff at the service provided. One person said, "The staff are great." Another said, "I love them", whilst smiling and indicating the staff.

We perceived a 'family house feeling' throughout the day of our inspection, which permeated through all our observations and discussions with the people who lived at the home and staff members.

Staff worked together to try to make sure 58 Whichers Gate felt like a home to people living there. People said it was their home and they felt that the staff were caring. Staff explained that they would accompany people to appointments if they wanted them to, to ensure they had support and fully understood any discussions relating to their care and treatment.

People were involved in decisions relating to their lives. For example one person had a syllabus for a local college; they asked staff what they thought they could do. A member of staff sat with them and discussed the various courses and encouraged them to reach their own decision by asking open questions about their interests. Although staff told us they knew what people liked to do, they ensured the person explored every option in case they wanted to do something new.

Good

Is the service responsive?

Our findings

One person requested staff to check their money each shift as they had become anxious over the amount of money they had. Staff ensured that two members of staff checked the monies each day with the person.

People we spoke with told us that the staff were responsive to their needs and that if they ever needed help there was always a member of staff available.
Staff explained how they acted in response to a person's needs as they changed. For example one person became anxious when they had saw news items and sometimes associated them with their family.

People were supported in their independence. People told staff if the phone was ringing and opened the front door to visitors. People made drinks for themselves, other people and for staff. People were also involved in the cleaning and tidying of their bedrooms and completing the laundry and keeping the home tidy.

People were supported to live an active life and to follow their hobbies and interests. One person told us how they had many hobbies and interests and staff supported them to pursue this. They told us they went to college and they liked drawing and sewing. They showed us their sewing and proudly showed their art which decorated the lounge.

People were encouraged and supported to develop and maintain relationships with people who mattered to them. One person had access to a personal computer.
The service had not received any complaints and so we were unable to assess how well the service would deal with complaints if they arose. People and relatives we spoke with told us that they had no complaints and had not had any cause to raise a complaint. We did see a policy and procedure on how a complaint would be dealt with.

People told us they felt staff understood them and provided appropriate support to them. People told us that staff asked them regularly what they would like as part of their social care needs.

We found that people's care was reviewed on a monthly basis or when their needs changed. One person told us that staff were responsive to their emotional needs and provided them with reassurance when they needed it. There was a small staff team who worked at the home which helps the service to be responsive because of established relationships.

Staff were aware of people's health and social care needs. People we spoke with told us that staff always respected their decisions about their care. We spoke with staff about some people's care needs. All staff we spoke with knew about the person's health and social care needs and what support the person required. Staff told us that they would speak with the person to ensure they were providing care to them the way in which they preferred. Staff told us that people's most recent information was in people care records and this was easy to follow. The information we saw corroborated this.

Good

Is the service well-led?

Our findings

Prior to our inspection we examined the information we held about this location, such as notifications, safeguarding referrals and serious injuries. We had received information under the whistleblowing procedure. However, we could not confirm or refute the whistle blowing concern at the time of the inspection. The staff we spoke with at the inspection told us they mostly felt supported by their colleagues. All the staff we spoke with told us they enjoyed their role. One member of staff said, "I haven't had any problems, but I know if I did I would just talk it through with the senior staff". People who we spoke with told us they found the staff approachable and responsive to them. One person we spoke with said, "Yes, I like [name]."

The interim manager explained that as the home only accommodated a maximum of three people, this enabled them to give very person centred care and support and they knew people very well. For example, staff understood the importance of routine and promoting choice and independence and how this had a positive effect on the people's wellbeing. The staff explained that there were no formal meetings with people who lived in the home to obtain their views, due to the size of the home but that they regularly discussed life at the home with people.

No recent accidents had occurred at the service. The interim manager explained that when they did these were recorded and actions were taken to reduce these from reoccurring.

There were checks in place to continually assess and monitor the performance of the service. They looked at areas such as environment, care records, staffing, training, incidents and accidents. This identified areas where action was needed to ensure shortfalls were being met. For example, the interim manager found staff were not as clear as they could have been on the Mental Capacity Act and had included this in the supervision agenda and team meetings that they had arranged with staff.

The interim manager shared an email she had sent to the seniors of the services she was managing. This included reminders to do health and safety checks, medicine ordering, medicine competencies to be renewed for all staff, and an exercise for the next team meeting.

The interim manager understood their role and promptly sent notifications to the Care Quality Commission (CQC) when required. We saw guidance for staff regarding the expectations required of them in relation to notifiable incidents.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 2(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a failure to safely store and manage medicines. Medicines were kept in a filing cabinet and were not stored in a locked cupboard attached to a wall. .