Care and Support Sunderland Limited

Woodland View

Inspection report

Sea View
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Sunderland
Tyne and Wear
SR2 0GW

Tel: 01915214497

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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

The inspection was carried out on 2 February 2016 and was announced. We last inspected the service on 24 September 2014 and found the registered provider met the regulations we inspected against.

Woodland View is a six bedroomed purpose-built bungalow providing personal care for adults with learning disabilities. The home does not provide nursing care. At the time of our inspection six people were using the service.

The home did not have a registered manager. A new manager had been appointed to manage the service. They were in the process of registering with 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.

Family members were happy with their relative's care. One family member said, "I think [my relative] is very well cared for." They went on to say, "I am very pleased with where he is. I always say I have been very lucky." They told us their relative was treated with respect by kind and caring staff who knew their needs well. One family member said, "They know [my relative] very well."

Staff we spoke with demonstrated a good understanding of safeguarding and whistle blowing, including how to report concerns. One staff member said, "If I had any concerns I wouldn't hesitate [to raise them]."

We found a small number of gaps in signatures on medicines administration records. Although these had been identified during the regular medicines audit there was no record of the action taken in response to the gaps. Trained and competent staff administered people's medicines and medicines were stored safely and securely. Staff had detailed guidance to help them administer 'when required' medicines safely.

The registered provider ensured there were enough appropriately recruited and skilled staff on duty to meet people's needs. One staff member said, "Safe numbers [of staff] are five, we try to have six on shift. There is enough and enough experienced staff."

Plans were in place to make sure people continued to receive care in an emergency situation. Each person had personal emergency evacuation plan (PEEP). Regular health and safety checks were carried out to keep the building safe for people to live in. For example, checks of fire safety, fire-fighting equipment, electrical safety, gas safety, water systems and specialist equipment. The current servicing certificates for specialist beds were not available to view.

The service was very clean and well decorated. People's rooms had been decorated and furnished to their individual taste, including personal belongings such as pictures and photos. The building was purpose-built

for people using wheelchairs to move around safely and adapted for the use of specialist moving and assisting equipment. Staff supported people to transfer safely from their wheelchair into a comfortable chair.

Staff confirmed they were well supported. One staff member commented, "Great, [manager] has been good. It is nice to come to work and feel at ease. I am extremely well supported."

The registered provider followed the requirements of the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS). DoLS authorisations were in place for all six people using the service because they needed 24 hour supervision and support . We saw examples of MCA assessments and best interest decisions in people's care records. Staff supported people with their communication needs to help them make as many of their own decisions as possible.

Staff knew how to support people sensitively with behaviours that challenged. Strategies staff used included keeping calm, talking calmly, modelling relaxed body language, having quiet time and a cup of tea.

People were supported to meet their nutritional needs. Some people had specialist input from health professionals to ensure their nutritional needs were met safely. We observed over the lunch time that staff followed people's care plans exactly. People received the support they needed to eat their meal in a calm and relaxed atmosphere. One staff member said, "We have no concerns [about nutrition], we have plans in place."

People had access to the health care they needed, including regular input from a range of health professionals, such as GPs, community nursing and physiotherapists. Each person had a hospital passport to help share important information about them should they be admitted to hospital. Care plans and risk assessment were in place to guide staff about how to support people's specific health conditions.

Staff had access to detailed information about the people they cared for. This included the person's life history, their medical diagnosis, their interests, preferences and their hopes and dreams for the future.

People's needs had been assessed and personalised care plans had been developed. These contained details about people's care preferences, such as their favourite toiletries and meals. Care plans included specific prompts for staff to follow to promote people's choice and step by step written and pictorial guidance to promote safe and consistent care. Care plans were reviewed regularly.

People, along with family members, were involved in regular reviews of their care. These considered the person's health over the preceding three months, family contact and a review of activities the person had taken part in. The review also included a discussion about people's goals, hopes and ambitions for the future.

People had the opportunity to be involved in a range of activities, such as swimming, football, discos, holidays, theatre and shopping. One staff member said, "It is a vibrant service." Another staff member said, "We always try to do something with them."

We received positive feedback about the manager. One staff member said, "The staff feel comfortable approaching [manager]. She is a really nice lady." The home had a good atmosphere. One staff member described the atmosphere as "good, calm at times."

Family members were consulted about the quality of their relative's care. All three family members providing

feedback during the most recent consultation gave the service an 'excellent' rating.

The registered provider had a quality assurance programme in place. This included monthly monitoring checks by the manager and service coordinator, as well as other audits. Action plans had been developed where there were areas for improvement. The most recent action plan was to complete all staff appraisals and medicines competencies by the end of April.

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 safe. Medicines administration records (MARs) contained a small number of gaps. Medicines audits did not record what action had been taken to investigate the gaps.

Family members said their relatives were safe. Staff we spoke with demonstrated a good understanding of safeguarding and whistle blowing, including how to report concerns.

There were enough skilled staff on duty to meet people's needs. Recruitment checks had been carried out before new staff started working at the service.

Plans were in place to make sure people continued to receive care in an emergency situation. Regular health and safety checks were carried to keep the building safe. The current servicing certificates for specialist beds were not available to view.

The service was very clean and well decorated with people's rooms decorated to their individual taste. The building was purpose built and suitable for the needs of people using the service.

Is the service effective?

Good

The service was effective. Staff were well supported and received the training they needed.

The registered provider followed the requirements of the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS). Staff supported people with their communication needs to help them make choices and decisions.

Staff knew how to support people sensitively with behaviours that challenged.

People were supported to meet their nutritional needs, including their specialist eating and drinking requirements. Staff followed people's care plans which been developed with input from health professionals.

People had access to the health care they needed, including support with specific medical conditions.

Is the service caring?

Good

The service was caring. Family members gave consistently positive feedback about people's care.

People were treated with respect. Staff were caring and knew their needs well.

Information was made available in a range of formats, such as easy read and pictorial.

Is the service responsive?

Good

The service was responsive. Staff members responded to people's needs quickly when required.

Staff had access to detailed information about people's life histories, their medical diagnoses, their interests, preferences and hopes and dreams for the future. People's needs had been assessed and personalised care plans had been developed.

Care plans were reviewed regularly. People and family members were also involved in quarterly reviews of their care.

People had the opportunity to be involved in a range of activities, such as swimming, football, discos, holidays, theatre and shopping.

Is the service well-led?

Good

The service was well led. The home did not have a registered manager. Staff told us the manager was approachable.

Family members were consulted about the quality of their relative's care. Positive feedback had been received during the most recent consultation.

The registered provider had a quality assurance programme in place. Action plans had been developed where there were areas for improvement.

Woodland View

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 2 February 2016 and was announced. The provider was given 24 hours' notice because the location was a small care home; we needed to be sure that someone would be in.

The inspection was carried by one adult social care inspector.

We reviewed information we held about the home, including the statutory notifications we had received from the provider. Statutory notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also contacted the local authority commissioners for the service and the clinical commission group (CCG).

We spoke with six family members as the people who used the service were unable to tell us their views. We also spoke with the manager not yet registered, the service co-coordinator, two support workers and an apprentice. We looked at the care records for two people who used the service, medicines records for three people and recruitment records for five staff.

Requires Improvement

Is the service safe?

Our findings

Family members and staff felt the service was safe. One family member told us, "Very safe, I have no worries about [my relative]." Another family member said, "Very safe, it's the best thing that ever happened." A third family member said, "They are there for [my relative] all of the time. I find it really safe. Everything is in order." One staff member said, "I would say they are safe."

Medicines administration records (MARs) did not always accurately account for all of the medicines given to people. We found a small number of gaps in some MARs. This was because staff had not signed or entered a non-administration code to confirm whether medicines had been given or not. Although these gaps in records had been identified during the monthly medicines audits, there was no record of what action had been taken to investigate the gaps. Other medicines records were accurate, such as records for the receipt and disposal of medicines. There were also accurate records for the management of medicines liable to misuse (controlled drugs). We saw there were open bottles of liquid medicines in the medicines cabinet. Although these medicines were in date, there was no record of when they had been opened. Staff at the home told us they did not routinely record the date liquid medicines were opened. This meant the registered provider did not have a system in place to ensure liquid medicines had not passed their expiry date and were safe to administer.

Trained and competent staff administered people's medicines. Staff competency was assessed every six months, consisting of four observations. This helped ensure staff members' skills and knowledge were kept up to date. Medicines were stored safely and securely in locked cabinets or a lockable fridge. Fridge and room temperature checks were carried out daily to ensure the environment was appropriate to store medicines safely. Some people had been prescribed 'when required' medicines to help manage specific health conditions or situations. Staff had access to detailed guidance to help administer these medicines safely. Staff were easily able to tell us the various triggers to look out for relating to some of these conditions, including when the use of medicines would be appropriate.

Staff we spoke with demonstrated a good understanding of safeguarding, including how to report concerns. They were readily able to tell us about various types of abuse and potential warning signs to look out for. One staff member said, "If I see something, I will report it straightaway." There had been no safeguarding concerns raised about the home.

Staff knew about the registered provider's whistle blowing procedure. None of the staff we spoke with had used the procedure but they all felt confident to raise concerns to keep people safe. One staff member said, "If I had any concerns I wouldn't hesitate." They went on to say concerns would be "dealt with effectively." Another staff member said, "I have never seen anything to warrant it [using the whistle blowing procedure]. I would raise concerns, the people have to come first."

The registered provider ensured there were enough staff on duty to meet people's needs. One family member told us, "There is always plenty of staff. Nearly seems to be one to one." Another family member commented, "As soon as [my relative] asks for something, they are there." One staff member said, "Safe

numbers [of staff] are five, we try to have six on shift. There is enough and enough experienced staff." Another staff member said, "Staffing levels are good. [Manager] tries to keep six. There are usually enough staff." We observed throughout our inspection that people had regular one to one time with staff members. We also saw staff responded quickly to people's needs. For example, ensuring people were occupied with an activity or ensuring they had enough to eat and drink.

Effective recruitment and selection procedures were followed to check new staff were suitable to work with vulnerable adults. We viewed recruitment records for five recently recruited staff. These confirmed the registered provider had requested and received references, including one from the most recent employer. Disclosure and barring service (DBS) checks had been carried out before confirming staff appointments. DBS checks were carried out to confirm whether prospective new staff had a criminal record or were barred from working with vulnerable people.

The registered provider had plans in place to make sure people continued to receive care in an emergency situation. We viewed the business continuity plan, which provided details of the procedures to follow in an emergency, such as the identification of alternative accommodation should Woodland View become unusable.

Personal emergency evacuation plans (PEEPs) had been written for each person. These included information about the person's support needs should they need to be evacuated from the building in an emergency. The plan contained photos of equipment the person used, fire doors and fire-fighting equipment to make the plan easier to follow. Evacuation of the building was practiced during regular fire drills.

The registered provider had a system for reporting incidents and accidents. This involved reporting all incidents to the local authority which monitored these centrally. There had been no recent incidents or accidents logged for the home.

The registered provider carried out regular health and safety checks to keep the building safe for people to live in. For example, checks of fire safety, fire-fighting equipment, electrical safety, gas safety and water systems. These were all up to date at the time of our inspection. A fire risk assessment had been completed recently. The fire service had inspected the home and had not found any areas of concern. Most of the specialist equipment used by people, such as moving and assisting equipment had been serviced annually by the relevant contractor. The current certificates for the specialist beds used at the service were not available to view. The manager told us the beds had been checked and they would locate the certificates. They went on to tell us if they could not be found the beds would be serviced again.

The service was very clean and well decorated. The people using the service had complex physical needs. The building was purpose built with lots of space for wheelchairs to move around safely and had been adapted for the use of specialist moving and assisting equipment. For example, overhead hoist tracking to allow people to move safely between rooms. We observed staff supported people during transfers from their wheelchair into a comfortable chair. This was done safely with two professional and polite staff members. Staff reassured the person by explaining in a calm voice what they doing throughout the process.

Good

Is the service effective?

Our findings

People were cared for by skilled and trained staff. One family member said, "Definitely, they know what they are doing. When they get new staff they pass it [knowledge] on." Another family member told us, "They know what to do. The younger ones are getting trained well." A third family member said, "They have been well trained."

Staff were well supported to carry out their caring role. One staff member commented, "Great, [manager] has been good. It is nice to come to work and feel at ease. I am extremely well supported." Another staff member said they were "really supported". They said, "If I have got issues I can go to [manager] or [service co-ordinator]. I always find I can go to them if needed. We get the help and support we need."

The registered provider ensured staff received the training they needed. Records confirmed training was up to date for all staff. This included mandatory training such as moving and assisting and specialist training such as epilepsy awareness.

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. Applications for DoLS authorisation were in place for all six people using the service. These had been agreed following a MCA assessment and best interest decision. We saw other examples of MCA assessments and best interest decisions in people's care records, such as for consent to people's care and managing people's finances.

Staff we spoke with demonstrated a good understanding of MCA, including their role in supporting people with communication to help them make as many of their own decisions as possible. Staff said they knew about people's care preferences as these were recorded in their care plans. People had 'communication dictionaries' to help staff understand what people were communicating in certain situations. For example, how people would tell staff yes and no or communicate they were sad or happy. For example, for one person this was by accepting or pushing away what they were being offered. Another person used noises and facial gestures to communicate their needs. Staff described how they supported people with their communication by using simple questions and showing people objects to choose from.

Staff knew how to support people sensitively with behaviours that challenged. Staff described the individual

strategies they used when people were feeling anxious or agitated. For example, keeping calm, talking calmly, modelling relaxed body language, quiet time and a cup of tea. Physical restraint was not used at the home.

People were supported to meet their nutritional needs. Due to their complex needs some people required specialist input from health professionals, such as specialist nurses, dietitians and speech and language therapists. We saw people had been assessed and the advice and guidance from professional incorporated into their care plans. This included guidance for assisted feeding, special diets and nutritional supplements people needed. For example, one person's care plan stated they needed to adopt a particular position when eating and for staff to follow a specified routine including using certain cutlery. We observed over the lunch time and saw staff followed this person's care plan exactly. One staff member said, "We have no concerns [about nutrition], we have plans in place."

We observed over the lunch time to help us understand people's experience. We found tables were set ready for people when they came into the dining room. Background music was playing to promote a calm and relaxing atmosphere. Staff chatted with people whilst they waited for their meal to arrive. There was friendly banter between one staff member and a person. The person responded back to the staff member and was laughing and joking with staff. People's meals and drinks were provided in line with their care plan. For example, some people had pureed meals, thickened drinks and specialist crockery. People were asked courteously if they would like a 'protector' to help keep their clothes clean. Five out of six people required one to one assisted feeding which they received uninterrupted from a member of staff who was focused on the task. Staff never rushed people and allowed them as much time as they needed to finish their meal. They gave friendly encouragement to prompt people to eat and finish their meal.

People had access to the health care they needed. There was regular input from a range of health professionals, such as GPs, community nursing and physiotherapists. One family member said, "They would let me know if [my relative] was poorly." Some people using the service had specific health conditions. We found in all cases there was a specific care plan and risk assessment in place to guide staff about how to support people with these conditions. Each person had a hospital passport to help share important information about the person should they be admitted to hospital. This was in the form of a traffic light system using red, amber and green to denote the importance of the information contained in the passport. For example, red were things professionals must know about the person, such as medicines, allergies and the person's capacity to consent to care.

Good

Is the service caring?

Our findings

Family members gave consistently good feedback about people's care. One family member said, "I think [my relative] is very well cared for." They went on to say, "I am very pleased with where he is. I always say I have been very lucky." Another family member commented, "Very well cared for." A third family member commented, "Brilliant, absolutely brilliant. [My relative] is really well cared for. It is a care home which is truly caring." A fourth family member said, "It is a lovely home. I am very grateful to them."

People were cared for by staff who knew their needs well. One family member said, "They know [my relative] very well." Some members of the team had worked with the people using the service for a lot of years. These staff members demonstrated they had an in-depth knowledge which they shared with newer members of staff. For example, understanding how a person expresses likes and dislikes through using body language. People and staff regularly spent time together. For example, we observed one person taking part in one to one time with a staff member doing some weaving. The person was engaged with the task and the staff member.

People were treated with dignity and respect. One family member commented, "They are very thoughtful. When they feed [my relative] they talk to him." Another family member said, "They are great with [my relative]." A third family member said people were cared for by "good, caring staff". They said, "They [staff] are very patient. I have never heard them shout." A fourth family member told us, "The staff are fantastic with [my relative], I am over the moon." Staff understood the importance of providing care in a respectful and dignified way. They gave us practical examples of how they provided care to achieve this aim. One staff member described how they would keep bedroom doors shut when providing personal care and kept people covered up. They went on to tell us they would talk to the person all of the time telling them what they were doing.

People were supported to have some control over their day to day choices. We saw people's rooms had been decorated and furnished to their individual taste, with personal belongings such as pictures and photos. Staff told us they aimed to promote people's independence. One staff member said, "I place the spoon for [person] to feed them self. I promote [person] to eat independently and dress them self." Another staff member said they prompted people to help when they were getting dressed. Staff described how people had progressed since moving into the service. They told us about one person who was quiet and withdrawn when they first moved in. They said now they were more open and were happy.

Most of the information we saw was available in easy read and pictorial formats. This included people's support plans, meeting minutes and procedures, such as the complaints procedure. People had access to information about advocacy services, although no-one currently had input from an independent advocate. However, for most people family members were actively involved in decisions about their care.

Family members told us their relatives had made real progress since moving into Woodland View. One family member commented, "[My relative] has improved a million fold." Another family member commented that their relative now "had a life". The building had also been adapted to meet people's

physical and emotional wellbeing. People had regular use of a sensory room and sound beam room (this is a specialist device which translates people's body movements into music and sound) to help meet their sensory needs. They had regular access to these facilities as part of their individual activity timetable.

Good

Is the service responsive?

Our findings

Staff members were attentive and regularly checked that people were alright or whether they needed anything. For example, staff checked whether people needed a drink, which were brought to the person quickly if they wanted one. Staff supervised people with hot drinks to check they were safe and didn't burn themselves.

Staff had access to information to help them better understand the needs of the people they cared for. People had 'pen profiles' which provided details of the person's life history, their medical diagnosis and other information relevant to them, such as their interests, preferences and their hopes and dreams for the future. Care records also contained a section called 'important information about me' with details of their GP, care manager, next of kin, communication, and a summary of each person's needs. This meant information was available and easily accessible if someone needed to quickly find out information about a person.

People's needs had been assessed to help ensure they received the care they needed to keep them safe and promote their wellbeing. The assessment considered what people needed in place to keep them safe and what would make their life better. For people using the service this included support from staff to understand their communication styles, support their mobility and nutritional needs and exploring new activities and interests.

Care plans were individual to each person using the service. They were written in such a way as to be all about each person and what was important to them. Care plans included details about people's preferences, such as their preferred shampoo, body wash and moisturiser. They also gave specific prompts for staff to follow to promote choice. For example, one person's care plan specifically prompted staff to ask the person what he wanted to wear that day. Care plans also included step by step written and visual guidance for staff to follow to ensure people received safe, consistent care. For example, photos were used to show staff the person's agreed routine for getting dressed. Care plans were reviewed every two to three months to keep them up to date.

People's care was reviewed every three months. The review records were in an easy read and pictorial format for ease of understanding. The review involved a consideration of people's health over the quarter, such as visits from health professionals, as well as family contact and a review of activities the person had taken part in. The review also included a discussion about people's goals, hopes and ambitions for the future. For example, these included to have continued support, going shopping, outings, theatre trips and to have a safe and secure environment to live in.

People had the opportunity to be involved in a range of activities, such as swimming, football, discos, holidays, theatre and shopping. One family member commented, "[My relative] does loads of things." Another family member said, "There are plenty of activities, [my relative] is always doing something." Personalised support plans and risk assessments had been developed for each activity to enable people to take part safely. Care plans had a section about things people liked to do during the day and night, with a

weekly timetable including meals and activities. Staff told us they felt people were appropriately engaged and occupied. One staff member said, "It is a vibrant service." Another staff member said, "We always try to do something with them." Activities for the day were displayed on a white board so that everyone knew what was happening. Activities planned for the day of our inspection included crafts, pamper sessions, foot massages, relaxing with music, ball play, the sensory room and sound beam.

'Customer meetings' were held to pass on information to people using the service. The minutes were written in an easy read format with photos and pictures to help people to understand them. We viewed the minutes from a recent meeting which had been used to share information about new staff and forthcoming activities.

Family members knew how to raise concerns. None of the family members we spoke with had made complaints. One family member said, "I have no complaints at all." The manager told us there had been no complaints received about the service. They had recently received a compliment from a visiting health professional. They commented, "Service very settled now." There had been no complaints made about the service.

Good

Is the service well-led?

Our findings

The home did not have a registered manager. The current manager had applied with the Care Quality Commission to become the registered manager for the service. This application is currently being considered by the Commission. The registered provider had submitted the required statutory notifications when required.

Family members and staff described the manager as approachable. One family member told us, "She is very nice. I could approach her no problem at all." Another family member commented, "[The manager] is always polite, she is nice. [The manager] will let me know if anything changes." One staff member said the manager was "great, so calm." They also said, "The staff feel comfortable approaching [the manager]. She is a really nice lady."

Family members told us they felt welcomed when they visited the home. One family member said, "I just go whenever. I call in for a cup of coffee. I get on well with all the staff. I enjoy the visits." Another family member told us, "They say drop in anytime."

Staff said there was a good atmosphere in the home. One staff member described the atmosphere as "good, calm at times". Another staff member said, "It is a happy atmosphere. All staff try to get on together. The service users come first. Their needs are always put first." A third staff member said, "A professional atmosphere is always maintained from coming in to work and going home."

Family members were consulted about the quality of their relative's care. They were asked to rate the service in terms of their overall level of satisfaction with people's care, the service and communication. Family member were also asked to rate staff members across a range of areas, such as politeness, understanding people's needs, approachability and skills. We viewed the feedback from the 'customer survey' for 2015. We saw three out of six family members had replied and had given the service an 'excellent' rating.

The registered provider had a quality assurance programme in place. This included monthly monitoring by the manager and service co-ordinator. These checks followed a similar format and included a check of health and safety, people using the service, staff and finances. The check on people using the service looked at safeguarding, complaints and the quality of care records. Following these checks action plan were developed if there were any areas for improvement. For example, following the most recent monitoring the action plan was to complete all staff appraisals and medicines competencies by the end of April 2016. We viewed the previous action plan which identified an action to convert staff files into a new format the registered provider had introduced. We saw this action had been completed by the target date. Other audits had been carried regularly, such as monthly medicines audits and infection control audits.