

Norwood

Tikvah Woodpeckers

Inspection report

Ravenswood Village
Nine Mile Ride
Crowthorne
Berkshire
RG45 6BQ

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
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 was an unannounced inspection which took place on 14 November 2017.

Tikvah Woodpeckers is a care home without nursing which is registered to provide a service for up to eight people with learning disabilities and associated physical disabilities. Some people had other associated difficulties such as being on the autistic spectrum. There were seven people living in the service on the day of the visit. All accommodation is provided within two ground floor buildings which are located near to each other.

At the last inspection in August 2015 the service was rated Good. At this inspection we found the service remained Good.

Why the service is rated Good:

There is a registered manager running the service. 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.

The service remained safe. People's safety was contributed to by staff who had been trained in safeguarding vulnerable adults and health and safety policies and procedures. Staff understood how to protect people and who to alert if they had any concerns. General risks and risks to individuals were identified and appropriate action was taken to reduce them.

There were enough staff on duty at all times to meet people's diverse, individual needs safely. The service had a stable staff team. However, if they did recruit new staff they had systems in place to ensure, that as far as possible, staff recruited were safe and suitable to work with people. People were given their medicines safely, at the right times and in the right amounts by trained and competent staff.

The service remained effective. Staff were well-trained and able to meet people's health and well-being needs. They were able to respond effectively to people's current and changing needs. The service sought advice from and worked with health and other professionals to ensure they met people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practise.

The service continued to be caring and responsive. The committed, attentive and knowledgeable staff team provided care with kindness and respect. Individualised care planning ensured people's equality and diversity was respected. People were provided with a wide variety of activities, according to their needs, abilities, health and preferences.

The registered manager was highly thought of and respected. The quality of care the service provided continued to be assessed, reviewed and improved, as necessary.

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 remains good.

Good ●

Is the service effective?

The service continues to be effective.

Good ●

Is the service caring?

The service remains caring.

Good ●

Is the service responsive?

The service continues to be responsive.

Good ●

Is the service well-led?

The service remains well-led.

Good ●

Tikvah Woodpeckers

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 was unannounced and took place on 14 November 2017. It was completed by one inspector.

The provider sent us a provider information return (PIR). This document provided key information about the service, what the service does well and improvements they plan to make in advance of the inspection visit.

We looked at all the information we have collected about the service. This included the previous inspection report and notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law.

We looked at paperwork for three people who live in the service. This included support plans, daily notes and other documentation, such as medication records. In addition we looked at records related to the running of the service. These included a sample of health and safety, quality assurance, staff and training records.

During our inspection we observed care and support in communal areas of the home. We interacted with two people who live in the home. People had limited verbal communication but were able to express their views by facial expression and body language. We spoke with four staff members. We arranged for all staff employed at the service to be given the opportunity to provide information via email about the quality of the care provided and the support they received from management and the provider. We received three responses. We requested information from other professionals and received two positive responses.

Is the service safe?

Our findings

The service continued to provide safe care and support to people.

People were protected from the risks of abuse. Staff continued to receive training in safeguarding adults and were able to explain what action they would take if they had any safeguarding concerns. There had been one safeguarding referral since the last inspection in August 2015. This had been appropriately dealt with and the relevant authorities had been involved.

People were protected from risks associated with their health and care provision. Staff assessed such risks and care plans included measures to reduce or prevent potential risks to individuals. For example, risks associated with falling, use of a specialist bath and epilepsy. During our observations we saw staff were aware of the risk reduction measures in place and were carrying out activities in a way that protected people from harm. People had an individual emergency and evacuation plan, tailored to their particular needs and behaviours. One commissioner advised us, "The service is safe with skilled staff to meet client's needs and support plans are in place."

Staff received training in responding to behaviours that challenge. The training provided used positive behaviour support approaches and plans. The focus of the training was on de-escalation to actively reduce risk and the need for restraint. Techniques to help people should they become anxious were documented in their care plans. We saw staff were quick to recognise and deal with any signs of anxiety people showed at an early stage. People were relaxed and comfortable to interact with staff and ask or indicate that they wanted help or social contact.

People, staff and visitors to the service continued to be kept as safe from harm as possible. Staff were regularly trained in and followed the service's health and safety policies and procedures. Health and safety and maintenance checks were completed at the required intervals. For example, weekly hot water temperature checks, fire safety checks and fire equipment checks. The staff monitored general environmental risks, such as maintenance needs and fridge and freezer temperatures as part of their daily work.

People continued to be given their medicines safely by staff who were appropriately trained to administer medicines and whose competency to do so was tested regularly. One commissioner advised us, "The home has a system to ensure residents medication was administered safely and timely." No medicine administration errors had been reported in the previous 12 months. We noted from the staff training record that there was an error in the required frequency of classroom based medicines training. The record stated that this should be undertaken annually but we were told that this should be bi-annually with e. Learning bi-annually between. The organisation was aware of the discrepancy and was working to rectify the issue.

The service continued to provide enough staff to meet people's needs and keep them safe. There were, generally, a minimum of four staff during the day and one waking night staff in each building. The provider organisation had robust recruitment processes in place to ensure staff employed were of good character.

People could be confident that staff were checked for suitability before being allowed to work with them. Additional staff were provided to cover any special events or emergencies such as illness or special activities. Any shortfalls of staff were covered by staff working extra hours and bank staff, as necessary. The service sometimes used agency staff but made sure they always used workers who knew and were known to the people using the service.

People were protected from the risk of infection. The premises were clean and tidy. Staff had been trained in infection control and we saw they put their training into practise when working with people who used the service. Systems were in place to ensure details of any accidents or incidents were recorded and reported to the registered manager. The registered manager looked into any accidents or incidents and took steps to prevent a recurrence if possible. Investigations and actions taken were recorded and lessons learnt were shared.

Is the service effective?

Our findings

The service continued to provide effective care and support to people.

A local authority commissioner sent us information which included, "Family visit regularly and speak highly of the service, especially in relation to the care received by their family member." The service remained effective because people received care from staff who were supported to develop the skills, knowledge and understanding needed to carry out their roles. Staff felt they received the training they needed to enable them to meet people's needs, choices and preferences. A professional told us, "I have always found the service to be positive, nurturing and very flexible in their approach. My client has benefited immensely since their move and has become a valued member of the community."

A mandatory set of training topics and specific training was provided and regularly up-dated to support staff to meet people's individual diverse needs. A comprehensive induction process which met the requirements of the nationally recognised care certificate framework was used as the induction tool. The training considered mandatory included, fire awareness, manual handling, medicines and food hygiene. Most mandatory training was up to date. However, the record was not entirely accurate as training that had been undertaken had not been acknowledged or recorded by the training department. This issue was being addressed by the provider organisation. We found staff received additional training in specialist areas, such as epilepsy and autism. This meant staff could provide better care to people who used the service.

Care plans provided information to ensure staff knew how to meet people's individual identified needs. People had documentation which covered all areas of care, including healthcare and support plans. The health care plan noted all aspects of their health needs. These included a record of treatment, a medical profile and a health action plan. Referrals were made to other health and well-being professionals such as dietitians and specialist consultants, as necessary. Each care plan was based on a full assessment and demonstrated the person had been involved in drawing up their plan. This was confirmed by the feedback from professionals we received. The care plans were kept under review and amended when changes occurred or new information came to light.

Staff received formal supervision every eight weeks as a minimum to discuss their work and how they felt about it. The registered manager acknowledged that this programme had fallen short of the providers requirements but dates were now scheduled to meet the timescales. It was emphasised that support and guidance was an on going and readily available resource which was confirmed by the staff we spoke with. Staff confirmed they had regular supervision and said they felt very well supported by their manager and the seniors. They felt they could go to the registered manager at any time if they had something they wanted to discuss. We saw staff had received annual appraisals of their work every year.

People were involved in choosing menus and any specific needs or risks related to nutrition or eating and drinking were included in care plans. The service sought the advice of dietitians or speech and language therapists, as necessary and offered food in the way they were advised. Observations at the lunchtime period suggested that people enjoyed the food at the service and we were told they could always choose

something different from the menu. Staff regularly consulted with people on what type of food they preferred and ensured healthy foods were available to meet peoples' diverse needs and preferences.

People were supported with their health care needs. The service arranged for the person to receive the necessary professional input without delay. Community professionals felt the service worked well across organisations to deliver effective care, support and treatment. One commented, "Part of the review is to identify health outcomes and I must say that the home continues to address clients health needs and family members are involved as appropriate." Another commented, "The service maintains regular email correspondence regards health updates and any incidents that have occurred."

People benefitted from monitoring of the service that ensured the premises remained suitable for their needs and was well maintained. The service had adaptations to meet the needs of people. Examples included, a special bath and a range of mobility equipment. On going audits of the premises identified maintenance issues and/or re-decoration work that needed to be carried out. We noted that there were no blinds at the windows in the bathrooms. Whilst the glass used was of an obscure nature it was not thought that this would provide sufficient privacy particularly at night on its own. The registered manager undertook to investigate the use of misted glass if it was assessed that the current arrangements did not afford an acceptable level of privacy.

People's rights to make their own decisions were protected. During our inspection we saw staff asking for consent and permission from people before providing any assistance. Staff received training in the Mental Capacity Act 2005 (MCA) and were clear on how it should be reflected in their day to day work. The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 found that conditions on authorisations to deprive a person of their liberty were being met. However, as a result of a recent local authority quality audit the service had been advised to make applications in respect of all of the seven people resident in the service. The rationale for this was explained in terms of their need for on going care and supervision. The registered manager had complied with this request but was not entirely convinced of the need with at least two of the people living in the service. They were working in collaboration with the relevant authorities to establish the validity of the applications. The registered manager had a system in place to ensure that annual reviews of any DoLS applications were made to the funding authorities for the required assessments and authorisations. One community professional told us, "Best interest decisions are well documented for example in finance as my client lacks capacity in this regards."

Is the service caring?

Our findings

Tikvah Woodpeckers continued to provide a caring service.

People continued to be supported by a dedicated and caring staff team who knew them well. People indicated by smiling or by their demeanour that they liked living in the home. People were seen to be comfortable and confident in staff presence. One professional told us, "Family members expressed that they are confident with the care provided." People's wellbeing was protected and all interactions observed between staff and people staying at the service were caring, friendly and respectful. Staff listened to them and acted on what they said. Staff were knowledgeable about each person and what they liked to do.

Staff provided support to meet the diverse needs of people using the service including those related to disability, gender, ethnicity and faith. These needs were recorded in care plans and all staff we spoke with knew the needs of each person well. A professional told us, "(Name) is also supported to meet her spiritual needs and attends and contributes to synagogue events."

People were supported to make as many decisions and choices as they could. People had detailed communication plans to ensure staff understood them and they understood staff. The plans described, in detail, how people made their feelings known and how they displayed choices, emotions and state of well-being. People's identified methods of communication were used so that staff could interpret how people felt about the care they were receiving and the service. The methods of communication used were taught to all staff through the providers 'Great Interactions,' programme which consists of a two or three day training course. This was compulsory training for all care staff upon joining the organisation and was designed to ensure that the most appropriate communication tools including the use of technology were understood and used appropriately with individuals.

People were treated with the greatest respect and their privacy and dignity was promoted. Staff interacted positively with people, communicating with them at all times and involving them in all interactions and conversations. Staff used appropriate humour and 'banter' to communicate and include people. Support plans included positive information about the person and daily notes seen were written respectfully.

People's care plans focused on what they could do and how staff could help them to maintain their independence and protect their safety wherever possible. People's abilities were kept under review and any change in independence was noted and investigated, with changes made to their care plan and support as necessary. The care plans were drawn up with people, using input from their relatives, health and social care professionals and from the staff members' knowledge from working with them in the service. Information about the service was produced in user friendly formats which included photographs, pictures, symbols and simple English. This information included pictures of the staff team.

People's right to confidentiality was protected. All personal records were kept in the office and were not left in public areas of the service. The staff team understood the importance of confidentiality which was included in the provider's code of conduct.

Is the service responsive?

Our findings

The service continued to provide responsive care and support to people.

The service was responsive to people's current and changing needs. We observed the staff team recognising and responding without delay to people's body language and behaviour when they needed assistance.

The service continued to complete a full assessment of the person prior to them moving into the service. The person and other relevant people were involved in the assessment process, which included visits to the service and getting to know the staff team and people who lived there. Detailed support plans were developed from the assessment. Support plans were reviewed, formally, a minimum of annually and whenever necessary. The service responded to changing needs such as behaviour or well-being.

People's care remained totally person centred and support plans were detailed and personalised. Support plans ensured that staff were given enough information to enable them to meet specific and individualised needs. They included sections such as my favourite routines and my community connections. Information was provided, including in accessible formats, to help people understand the care available to them. The registered manager was aware of the Accessible Information Standard. From August 2016 onwards, all organisations that provide adult social care are legally required to follow the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss and in some circumstances to their carer's. The service was already accomplished in the process of documenting the communication needs of people but needs to check that this is done in a way that meets the criteria of the standard.

The service continued to provide people with a flexible activities programme which responded to their abilities, preferences, choices, moods and well-being. People had some set and some flexible activities. People went to organised day care activities a minimum of twice per week, with staff accompaniment, as necessary. People were offered outings, day trips and short holidays and were encouraged to participate in community activities of their choice. Appropriate risk assessments were in place to support the activity programme. The registered manager told us that it was imperative that people were kept busy and engaged with activities that had meaning to them. This was in order to avoid boredom or anxiety either of which could lead to behaviours which challenged the service.

The service had a robust complaints procedure which was produced in a user friendly format and displayed in relevant areas in the home. It was clear that people would need support to express a complaint or concern, which staff were aware of. No complaints had been received since the last inspection in August 2015. We saw a compliment about the service from a relative who was clearly very appreciative of the care provided. Other positive feedback had been recorded by the service.

Is the service well-led?

Our findings

The service continued to be well-led.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. All of the registration requirements were met and the registered manager ensured that notifications were sent to us when required. Notifications are events that the registered person is required by law to inform us of. Records were up to date, fully completed and kept confidential where required.

People continued to benefit from a good quality service which was well managed. The service was monitored and assessed by the manager, staff team and provider to ensure the standard of care offered was maintained and improved. There were a variety of auditing and monitoring systems in place. Regular health and safety audits were completed at appropriate frequencies. Annual service action plans had been developed by the registered manager and had been formulated from listening to people and staff and from the formal auditing processes. There were focussed improvement plans in place designed to address prevention of falls work and choking screening.

The views of people, their families and friends and the staff team were listened to and taken into account by the management team. People's views and opinions were recorded in their reviews, at regular key worker meetings and at resident meetings. Staff meetings were held regularly and minutes were kept. One professional told us, "I find the management open and accessible for example, in the clients review, staff contributed freely in the presence of their manager and family members appeared comfortable in the meeting providing valuable contribution."

The service continued to ensure people's records were detailed, up-to-date and reflective of their individual needs. They informed staff how to meet people's needs according to their preferences, choices and best interests. Records relating to other aspects of the running of the home such as audit records and health and safety maintenance records were accurate and up-to-date. The management team understood when statutory notifications had to be sent to the Care Quality Commission and they were sent in the correct timescales.