Exalon Care Limited

Willow View

Inspection report

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Date of inspection visit:
05 January 2017

Date of publication:
04 April 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 5 January 2017 and we gave the registered manager short notice of our visit. This service was dormant for a short period of time and is registered to provide a service for up to two people with learning disabilities. One person was living at the service at the time of our inspection.

A registered manager was in post. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

Our time at the service was limited as the person was not able to tolerate unfamiliar visitors. We reviewed records and spoke to staff. We saw staff engaged well with the person and they were knowledgeable about the triggers and the actions they must take to maintain a calm environment with low sensory stimulation.

Some risks were assessed and risk assessments developed. Where risk assessments were in place they lacked detail on how to minimise the level of risk. Risk assessments were not in place for some behaviours and for travelling within the community. Fire risk assessment and evacuation procedures were in place. However, the recommendations as a result of the fire risk assessments made were not actioned. The registered manager had agreed to take action on one recommendation. We acknowledge there were difficulties in undertaking remedial action when the person was present. However, the potential risk to people and staff increased as remedial action remained outstanding. This meant the staff were not provided with the actions they must take to ensure the safety of people.

Where care plans were in place they lacked detail on the person's preferences. While social worker's care plans were out of date, the areas of need identified were not used to assess the person's current need. Strategies on managing challenging behaviour were in place but they were not reviewed following incidents. These strategies were inconsistent with positive behaviour management (PBM) plans and with the analysis of antecedents, behaviours and consequences (ABC) charts. This meant staff were not provided with updated guidance on consistently meeting people's current needs and to manage behaviours exhibited.

Quality assurance systems were not fully effective. Areas identified for improvement were not consistent with the inspection findings. Internal audits were in place and there were routine visits from the provider to ensure standards were maintained, people's rights were promoted and their welfare needs met.

The member of staff we spoke with said they had attended the safeguarding of vulnerable adults from abuse training. This member of staff was aware of the types of abuse and the expectation placed on them to report alleged abuse. Members of staff were aware of the importance of developing trusting relationships with people. They knew people's likes and dislikes and promoted their rights.

Members of staff were supported to develop their skills and deliver the roles and responsibilities of employment. New staff received an induction to prepare them for the role they were to perform. Staff attended mandatory training set by the provider and other specific training to ensure they were able to meet people's changing needs. One to one meetings were taking place to ensure staff had an opportunity to discuss performance and their personal development.

The person living at the service had one to one support from staff at all times and two to one in the community. The rotas were in picture format and confirmed the staffing levels. Members of staff said the team worked well together and the registered manager was approachable.

Recruitment procedures ensured the staff employed were suitable to work with vulnerable adults. The completed application forms in place included an employment history, the names of referees and declarations of previous conviction where applicable. Checks were conducted before new staff started work to establish their suitability and included references from the previous employer and a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

The safe handling of medicine systems were in place. Profiles gave staff information about the medicines to be administered which included guidance on the person's preferences on how their medicines were to be administered. Medication Administration Records (MAR) were signed to indicate the medicines administered.

People were subject to continuous supervision and authorisation was granted for care and treatment at the service. Staff were aware of the principles of the Mental Capacity Act (MCA) and best interest decisions taken for people unable to make specific decisions. The member of staff we asked described the day to day decisions the person living at the service made.

People were supported to maintain a healthy lifestyle. Staff assisted the person to develop menus and they were supported to purchase daily food provisions to prepare meals. Whilst we were at the service we saw the person living at the service having snacks between meals.

You can see what action we told the provider to take at the back of the full version of the 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.

Staff knew the actions needed to minimise risks identified. Risk assessments were in place for risks identified. However, risk assessments were not developed for all areas of risk. Incident reports lacked detail on the strategies followed for challenging behaviour incidents.

One member of staff was on duty at all times. Two staff supported the person to access the community.

Staff knew the procedures they must follow if there were any allegations of abuse.

Systems of medicine management in place were safe.

Is the service effective?

Good

The service was no always effective.

People were assisted by staff to make day to day decisions. People's capacity to make specific decisions was not assessed for all specific decisions such as visitors. Positive behaviour strategies were not reviewed following challenging incidents. This meant strategies were not up to date and did not give staff the guidance needed to manage challenging incidents.

People's dietary requirements were catered for. People were supported to develop menus and to prepare meals.

Members of staff attended mandatory training set by the provider

Is the service caring?

Good

The service was caring.

People benefitted from a person centred culture and the staff were committed to providing a service which put people at the centre of their care and treatment.

People were supported by a staff team who were able to build trusting

Is the service responsive?

Requires Improvement

The service was not fully responsive.

All areas of need were not assessed and to develop care plans on meeting their identified needs. Where care plans were in place they lacked detail on how staff were to meet the identified needs of the person.

People participated in activities.

Is the service well-led?

Good

The service was not always well led.

Quality assurance systems to monitor and assess the quality of service were in place but not all areas identified within the inspection were assessed by the provider for improving.

Members of staff worked well together to provide a person centred approach to meeting people's needs. They said they were valued and supported by the registered manager.

Willow 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 5 January 2017 and we gave the registered manager short notice of the visit as the person living at the service was not able to accept visits from unfamiliar visitors. We provided the person with a social story giving them some information on the nature of our visit.

This inspection was undertaken by one inspector. Before the inspection, we reviewed information we hold about the service including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke to the person living at the service and one member of staff on duty. We spoke to a member of staff, the deputy and the registered manager. We also looked at records about the management of the service

Requires Improvement

Is the service safe?

Our findings

When we asked the person living at the service if they felt safe we were given a "thumbs up." The members of staff we spoke with confirmed they had access to safeguarding of vulnerable adults from abuse procedures. They told us the procedure was followed for reporting allegations of abuse. This member of staff was able to tell us about the types of abuse and the expectation that they report all allegations of abuse.

Risk assessments were completed to identify areas of potential risk to the person. Risk assessments were in place for moving and handling and for the potential of the person developing malnutrition and pressure ulcers. Risk assessments established the person had no mobility needs and was at low risk of developing malnutrition or pressure sores. Risk assessments for unacceptable behaviours were devised following an incident. However, risk assessments were not in place on the actions staff need to take when people come in contacted with animals they fear.

The comprehensive care plan provided by the social worker stated the person at times exhibited unacceptable behaviours. We saw an entry recorded regarding an incident which occurred the previous day to the inspection. Following from the incident a risk assessment was developed. The registered manager told us a referral was made for specialist support to update the positive behaviour management plan. However the risk assessment provided lacked detail on the indicators and the expected staff response to the behaviours.

We spoke with the registered manager and deputy and we were told there was a debrief following the incident. A referral to the behaviour nurse was to be made and guidance was to be reviewed. A member of staff told us there was an expectation that staff report accident or incidents. They said there was an opportunity for staff to have a debrief with the registered manager.

Risk assessments for the environment were in place. We saw an action plan was in place on redecorating the property. The property was assessed for the potential risk of fire and recommendations were made to maintain a safe environment. However, not all the recommendations were met. The registered manage told us one had been actioned and another was to be actioned following the inspection. However one recommendation was outstanding. While we acknowledge there were difficulties with the person tolerating unfamiliar visitors, there were risks implicated to people's safety for not acting on recommendations.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Emergency procedures were on display at the service giving staff guidance on the action to be taken in the event of a power cut, gas or water leak.

The registered manager told us there was a core team working at the service. They said during the day there was a one to one at all times and two to one to support the person in the community. It was stated that two staff had transferred with the person from their previous placement. The rota was a combination of the staff

working at both services and was in picture format. A member of staff said the staffing levels were appropriate to the needs of the person living at the service.

Recruitment procedures ensured staff suitable to work with vulnerable adults were employed. There were safe recruitment and selection processes in place to protect people. We reviewed the personnel files of two staff and saw appropriate checks had been carried out before staff worked with people. This included seeking references from previous employers relating to the person's past work performance. New staff were subject to a Disclosure and Barring Service (DBS) check before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Medicine profiles gave staff instructions of administering medicines, their purpose and the side effects. The person's preferred method to have their medicines administered was part of the profile. For example, medicines were to be administered in liquid form. The profile made staff aware that a Deprivation of Liberty (DoLS) authorisation was in place to administer medicines covertly where necessary.

Good

Is the service effective?

Our findings

"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 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 whether any conditions on authorisations to deprive a person of their liberty were being met."

The person accommodated was not able to accept unfamiliar visitors to the service. Although social stories were prepared in advance of visitors this person was likely to present with challenging behaviours when unfamiliar visitors arrived at the service. MCA assessments were not developed on visitors and best interest decisions on how to manage visitors to the home.

MCA assessments were in place for the person to receive care and treatment at the service and to administer medicines covertly. The registered manager told us a DoLS applications for care and treatment were made to the supervisory body. They said medicines were administered in fluids without the person's knowledge but the staff were working towards self-administration

The member of staff we spoke with said the person was helped to make decisions. For example, helping the person to make healthy food choices when developing menus. This member of staff said they observed the person, spoke calmly and from their observation of the person they had developed an understanding of the behaviours presented. It was also stated the person disliked to be ill which at times triggered challenging behaviour and from their "long standing" knowledge of the person liked consistency. This member of staff also stated "we explore the cause of the behaviour, we ask question about the action taken, and it's usually a build-up of events. We offer refreshments." They said the person would indicate if staff support was needed to regain self-control.

The person living at the service was supported to develop menus. Meals were planned and daily shopping lists prepared for the planned meals. Daily shopping trips were organised for food shopping. When we asked the person if they liked the meals we were given a "thumbs up". We saw the person was having a snack when we arrived.

New staff attended an induction programme to prepare them for the role they were to perform. We looked at the personnel files of two staff. For one member of staff their induction covered attending mandatory training, reading care records and shadowing more experienced staff. A checklist was used to ensure new staff were made aware of important information about the service on their first day of work. For another

member of staff we saw their induction also covered their role, codes of conduct and policies and procedures. A member of staff said they were currently on their induction and had shadowed more experienced staff and had read procedures.

The registered manager told us staff had attended mandatory training set by the provider. They said mandatory training included respecting people's rights, dementia awareness and safeguarding people from abuse. Other specialist training included proactive strategies which included breakaway and proximities. The registered manager said the aim was to increase staff's skill to support people from moving away from their usual behaviour. The also stated there were opportunities for staff to undertake vocational qualifications.

Staff were supported to develop their skills and knowledge. The registered manager told us one to one sessions with staff were four to six weekly. The supervision matrix in place showed one to one sessions were booked with staff. A member of staff told us a one to one meeting with the registered manager had not taken place for some time. They said there were opportunities to have conversations with the registered manager who ensured they had the support needed to perform their role.

We saw for one member of staff during their one to one with their line manager goals were set, their role and training was discussed. The application form showed for one member of staff there were a number of short employments in their employment history. The registered manager had explored the reasons for leaving and this had become part of their personal development programme.

Good

Is the service caring?

Our findings

Our time at the service was limited. While the person had invited us into the service and gave us a "thumbs up" when we asked about meals and activities, the person became anxious soon after our arrival. The member of staff on duty was aware of the triggers of challenging behaviour and we were asked to leave within half an hour of arriving. We provided a social story before arriving about the nature of the inspection. However, this person was not able to tolerate visits from unfamiliar visitors. This was confirmed by records of challenging incidents which occurred between the 1 October 2016 and 24 October 2016 when unfamiliar people had visited the service. For example, maintenance engineers and the member of staff on duty.

We saw the property was adapted for the person's needs. There was a lounge, kitchen and bedroom which included the personal items and belongings which reflected the person's interests.

A member of staff said they had known the person for "sometime" and "felt strongly" about the quality of care the person received. It was stated the person would always greet them with a "high five" when they arrived on duty. This member of staff also said trusting relationships were built by staff as they worked with the person over a period of time. They stated "XX senses, (he) understands. He will apologise (and say they were) sorry" following challenging incidents. It was also stated the person would also convey their gratitude to staff and "XX responds to social stories and likes to be kept informed about visits and processes in advance."

The person was helped to maintain relationships with family members. A member of staff said the person had visitors from relatives and on special occasions, cards were sent to the person by their extended family members.

A member of staff described the actions taken when delivering personal care which supports the person's rights. They said staff knocked on doors and waited for an invitation to enter and used Makaton to ensure the person understood them. It was also stated where the person wanted space this was respected.

Requires Improvement

Is the service responsive?

Our findings

The one page profile gave staff important information about the person. What people admired about them, how best to support them and the things that were important were part of the profile. For example, staff were to use social stories to help the person understand events and for staff to give personal space.

The overview of needs listed the medical and emotional conditions that had an impact on the person's day to day living at the service. For example, the person's sensory processing needs included them seeking sensory stimulation which lead to them being over responsive to sensory stimulation. A sensory diet was provided for this area of need by external health care professional and was linked to the behaviour management strategy as sensory overload was a trigger to challenging behaviour.

Care plans lacked detail on how staff were to deliver care and treatment in the person's preferred manner. The information from the social workers comprehensive plan was not used to develop care plans. For example, the person had a fear of dogs and some personal care routines were disliked. The registered manager said "given the nature of the bespoke service provided, with a permanent support staff team who have considerable experience of the sole individual supported, it is preferable to develop the written plan over time rather than set in stone what may turn out to be incorrect strategies."

We saw recorded within daily reports that when the person was in the local community they had showed fear when dogs were approaching them. A member of staff providing one to one explained the actions taken whenever dogs were in proximity of the person. Another member of staff said "we observe for possible triggers such as dogs. We link arms with the second member of staff following. We cross the road if dogs are approaching. We divert them (the person)." Care plans on how staff were to support the person in the community were not in place.

Positive behaviour management plans had not been reviewed following the person's admission to the service or following challenging incidents. Members of staff had completed Antecedent, Behaviour and Consequence (ABC) charts when challenging incidents had occurred. ABC charts were used for the purpose of identifying triggers of challenging behaviour and for developing strategies on how staff were to respond to the triggers identified. The registered manager had included comments within the ABC charts on reducing the potential of an incident re-occurring. However, the behaviour care plan was not updated with the new guidance. For example, comments recorded from the registered manager gave staff instruction to check in future with the person the route to be taken on their car journeys.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations2014.

The personal care plan in place included the aspects of hygiene the person was able to manage without staff support. The action plan was for the staff to check the temperature of the water to lower the potential of the person scalding themselves. A member of staff on duty told us care plans were improving and had been updated since the person's admission to the service. They said they were kept informed of changes in

the person's care needs. For example, there were handovers when shift changes occurred and staff read the updated section of the care plan.

The person developed a daily planner and this was on display in the kitchen. For example, visits to the park. The person gave us a thumps up to indicate they had devised the activity planner for that day. The member of staff on duty said the person had become more skilled in horse-riding. They said "everything here matters, everyone matters."

The complaint procedure was sectioned into three stages which included local resolution, reviewing and external settlement of the complaint. We saw emotional cards were used by the person to convey "happiness" and "sadness". There were no concerns raised since the dormancy of this service was lifted.

Good

Is the service well-led?

Our findings

Provider visits were taking place to ensure standards of care were met. The report of the most recent visit included the discussions with people and staff. Where shortfalls were identified an action plan was developed listing the staff responsible for meeting the action plan and the target date. Developing care plans and one to one meetings with the staff were identified for improvement. Internal audits were combined with the sister home. The medicine audit showed all standards were met and health and safety audits included fire safety systems and infection control. However, not all areas identified within audits were consistent with the inspection finding. For example, the plan did not include updating positive behaviour management plans and developing risk assessments for unacceptable behaviours.

A registered manager was in post. The registered manager told us they had management responsibilities for two locations and their style of management was to maintain a presence at both locations. They said the newly introduced staff structure where two deputy managers were to be in post was to create better management presence. They said the aim was to provide leadership and consistency as the service had gone through a period of instability with changes of managers. The appointment of a second deputy was to provide more consistency, role modelling and "hands of care." They said developing effective communication was also focus and the staff were to be complimented for their care and treatment delivered to the person. Staff said the team worked well and they delivered consistency to the person. A member of staff we asked said the manager was "lovely, supportive and approachable.

The registered manager told us the values of the organisation included natural progression for the person, who was seen as an individual and not for their needs. They said the culture of the service was developing and as some staff had historical knowledge of the person and they were striving to breakdown some learnt perceptions.

Staff surveys and team meetings were the forums used to gain feedback about the service and to share information. The registered manager told us an action plan was in place on improving staff views about the service. For example, 60 percent of the staff said their views were taken into account, 100 percent felt part of the team and 73 percent were enabled to learn. At a recent team meeting the approach to be used, codes of conduct and person centred care was discussed.

The staff received positive feedback about the service provided. The staff were complimented by the relative of the person living at the service and the social worker. The social workers told staff the improvements with care and treatment were seen in the person's behaviour.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Positive behaviour management plans were not up to date or reviewed following challenging incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not developed on how to minimise all areas of risk. Incident report lacked detail on the strategy followed during challenging incidents