Bridgewood Trust Limited

Well Royd House

Inspection report

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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 we carried out on 10 August 2016.

We last inspected Well Royd House in August 2014. At that inspection we found the service was meeting all of the legal requirements in force at the time.

Well Royd House is a care home that provides accommodation and personal care for up to 12 people with learning disabilities. 12 people were living at the home at the time of inspection. Nursing care is not provided.

A manager was in post who had applied to be registered with the Care Quality Commission. 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.'

Staff said the management team were supportive and approachable. The manager monitored the quality of the service provided and introduced improvements to ensure that people received safe care that met their needs.

People told us they felt safe. Robust vetting procedures were in place when new staff were recruited. People were relaxed and appeared comfortable with the staff who supported them. Staff had received training and had an understanding of the Mental Capacity Act 2005 and Best Interest Decision Making, when people were unable to make decisions for themselves. We have made a recommendation for staff to receive other training to meet any specialist needs of people.

Staff knew the people they were supporting well. Care was provided with patience and kindness and people's privacy and dignity were respected. Care plans were in place detailing how people wished to be supported and people were involved in making decisions about their care. People were supported to maintain some control in their lives. They were given information in a format that helped them to understand if they did not read to encourage their involvement in every day decision making.

People told us they were supported to go on holiday and to be part of the local community. They were provided with opportunities to follow their interests and hobbies and they were introduced to new activities. People had food and drink to meet their needs. Some people were assisted by staff to cook their own food. Other people received meals that had been cooked by staff. People had access to health care professionals to make sure they received appropriate care and treatment. People received their medicines in a safe and timely way.

The premises were mostly well maintained but some floor coverings were showing signs of wear and tear

and we have made a recommendation about this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being. Appropriate checks were carried out before staff began work with people. People received their medicines in a safe and timely way.

People were protected from abuse and avoidable harm. Staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

Is the service effective?

Good

The service was effective.

Staff were supported to carry out their role and they received training to give them more insight into people's care and support needs.

The service was meeting the requirements of the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005.

The building was showing signs of wear and tear in some areas.

Systems were in place to ensure people received a varied diet to meet their nutritional needs. People were supported by staff to access other professionals to ensure their health needs were met.

Is the service caring?

Good

The service was caring.

Staff were kind and respectful with the people they supported.

People were helped to make choices and to be involved in daily decision making.

There was a system for people to use if they needed the support of an advocate.

Is the service responsive?

Good

The service was responsive.

People received support in the way they needed because staff had detailed guidance about how to deliver their care. Support plans were in place to meet all of people's care and support requirements.

People were provided with a range of opportunities to access the local community. They were supported to follow their hobbies and interests and were introduced to new experiences.

People told us they knew how to complain if they needed to.

Is the service well-led?

Good

The service was well-led.

A manager was in place who promoted the rights of people with a learning disability to live fulfilled lives within the community.

An ethos of involvement was encouraged amongst staff and people who used the service.

Staff and people who used the service said communication was effective.

The manager monitored the quality of the service provided and introduced improvements to ensure that people received safe care that met their needs.

Well Royd House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 10 August 2016 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during a mealtime.

During the inspection we spoke with six people who lived at Well Royd House and four support workers. We reviewed a range of records about people's care and how the home was managed. We looked at care plans for four people, the recruitment, training and induction records for five staff, three people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the registered manager had completed.

Good

Is the service safe?

Our findings

Due to some people's complex communication needs they were not able to communicate verbally with us. People appeared calm and relaxed as they were supported by staff. Other people who used the service told us they felt safe. People's comments included, "I like living here," and, "I feel safe."

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the manager. They were aware of the provider's whistle blowing procedure and knew how to report any worries they had. They told us they currently had no concerns and would have no problem raising concerns if they had any in the future. They told us, and records confirmed they had completed safeguarding training.

The provider had a system in place to investigate safeguarding concerns. Nine safeguarding incidents had been raised since the last inspection. Safeguarding alerts had been raised by the service and investigated and resolved to ensure people were protected. The manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission of notifiable incidents. They had ensured that notifiable incidents such as safeguardings, and serious incidents were reported to the appropriate authorities or independent investigations were carried out. Where a safeguarding alert had been raised and investigated and resolved internally information had been shared with other agencies.

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people using the service and their needs. There were 12 people who lived at the home and they were supported by four support workers and the manager during the day. This number reduced to a waking member of night staff and a sleep in member of staff after 8:00pm. We were told staffing levels were flexible and if people were going out at night more staff would be made available to provide support.

We checked the management of medicines. People received their medicines in a safe way. All medicines were appropriately stored and secured. Medicines which required cool storage were kept in a fridge within a locked room. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Medicines records were accurate and supported the safe administration of medicines. We checked the procedures and records for the storage, receipt, administration and disposal of medicines. All records seen were complete and up to date, with no recording omissions.

We saw there was detailed written guidance for the use of some 'when required' medicines, and when and how these should be administered to people who needed them, such as for pain relief. Specific guidance was also in place for some people to advise staff about 'when required' medicines should be used for agitation and distress to ensure a consistent approach. For example, one care record stated, 'May need to be administered if [Name] is showing signs of severe anxiety or agitation. Signs such as pacing around rapidly or jumping up and down.'

Assessments were undertaken to assess any risks to people using the service and to the staff supporting

them. These included environmental risks and any risks due to the health and support needs of the person such as moving and assisting, epilepsy and distressed behaviour. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring. At the same time they gave guidance for staff to support people to take risks to help increase their independence. Our discussions with staff confirmed that guidance had been followed.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of other checks were available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

Good

Is the service effective?

Our findings

Staff had some opportunities for training to understand people's care and support needs. Comments from staff members included, "We do training at the office," "I'm doing sign language training," and, "There are opportunities for training."

Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff for a number of days. One member of staff told us, "I had four days induction training when I started, I also looked at policies and procedures." This ensured they had the basic knowledge needed to begin work. They said initial training consisted of a mixture of work books, face to face and practical training.

The staff training records showed staff were kept up-to-date with safe working practices. The person in charge told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training about learning disabilities and the person's right to live an 'ordinary life'. Staff told us they had received training about epilepsy, autism, Mental Capacity and Deprivation of Liberty. Staff were also completing a British sign language course to assist communication with a person who was hearing impaired.

Staff told us they received regular supervision to discuss their work performance and training needs. They said they were well supported to carry out their caring role. Staff members comments included, "We have supervision every two months," "At supervision you get the opportunities to say about training of if you need support," "The manager will let me know when my supervision is due," "Supervisions do happen." And, "[Name], the manager does the supervisions." Staff said they could approach the manager at any time to discuss any issues. Staff comments included, "The manager is approachable," and, "The manager is there if you need them." They also said they received an annual appraisal to review their work performance. This was important to ensure staff were supported to deliver care safely and to an appropriate standard.

People's needs were communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and wellbeing of people. Staff comments included, "Communication is fine," "Communication could be improved," "We catch up when we've been on days off," "We have a verbal handover," and, "We use a communication book and diary as well."

We checked how the service met people's nutritional needs and found that people had food and drink to meet their needs. Four weekly menus were in place. Peoples' care records included nutrition care plans and these identified requirements such as the need for a weight reducing or modified diet. People required different levels of support. Some people received support from staff to help make their breakfast and drinks. One person made their own meals. People's records showed the individual support they required. For example, 'I enjoy most foods and will let you know when a dislike something.' A person commented, "I like to make pizza."

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive 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). The person in charge and staff were aware of the deprivation of liberty safeguards and knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The person in charge told us four applications had been authorised and three applications were being processed.

Most people's care records showed when 'best interest' decisions may need to be made. Best interest decision making is required to make sure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. For example, one health care plan stated, "Requires family and possibly an Independent Mental Capacity Advocate, IMCA." Staff knew people well and could tell us about people's levels of understanding. However, for one person who received one to one staff support to keep them safe, a mental capacity assessment and support plan were not yet in place to show why this level of support was required. The person in charge told us that part of this was already being addressed as the DoLS application had been submitted and was waiting to be processed by the local authority. They told us a support plan would be put in place immediately.

People who used the service were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'. The person in charge told us one person's relative had been officially appointed by the Court of Protection and was responsible for decisions with regard to their relative's care and welfare and finances.

People who used the service were supported by staff to have their healthcare needs met. Records showed people had access to a range of healthcare professionals. For example, in people's care records there was evidence of input from General Practitioners (GPs), opticians, dentists, physiotherapist, behavioural team, nurses and other personnel. Staff told us they would contact the person's GP if they were worried about them. Written guidance was available for staff with regard to people's support requirements. For example, one care plan stated, "[Name] has been supported to make an appointment. They require support with their chiropody appointments and will need staff to advocate for them if they are unable to explain any issues."

We looked around the premises and saw it was mostly well-maintained. We were told there was an on-going programme of refurbishment. However, the flooring in some communal areas and lavatories was showing signs of wear and tear. The person in charge told us that this would be addressed.

We recommend that the environment is better maintained in some areas of the home for the benefit and comfort of people who live there.

Good

Is the service caring?

Our findings

People spoke positively of the care provided by staff. They told us staff were kind and caring. Comments included, "Staff listen to me," "Staff are very good," and, "Staff are kind."

The home was relaxed with a positive, bustling atmosphere as people were supported with their daily living requirements. Some people were supported to go out and other people chose to stay in the house. Staff were observed to be warm, kind, caring and respectful. Staff interacted well with people, joking with them and spending time with them when they had the opportunity. People appeared comfortable with the staff who supported them. Staff asked people's permission before carrying out any tasks and explained what they were doing as they supported them. People who were able to talk to us about their experiences said they were happy with the care and support they received. During the inspection we saw staff were patient in their interactions with people and took time to listen and observe people's verbal and non-verbal communication.

Staff engaged with people in a calm and quiet way. They were enthusiastic and made time to sit and talk to them. Staff bent down as they talked to people so they were at eye level. We observed the lunch time meal in the dining room. People had a snack at lunch time as the main meal was in the evening. People were served their individual choice for lunch and one person prepared their own food. The atmosphere was lively, pleasant and unhurried with people eating their meal at their own pace and staff talking to people and providing people with assistance as necessary. We saw a staff member who assisted a person to eat explained what they were doing and reassured them as they supported them and provided words of encouragement.

People told us they were involved and kept informed of any changes within the home and staff kept them up to date with any changes in their care and support. They told us they were involved in individual meetings to discuss their care and support needs and household meetings took place to ask people for any suggestions or areas for improvement. Minutes of meetings showed areas discussed included, activities, holidays and menu suggestions.

Information was made available in a way to promote the involvement of the person. For example, by use of pictures or symbols for people who did not read or use verbal communication. We saw evidence of this with the complaints procedure and the information guide given to people when they started to use the service. A staff member commented, "We show pictures to [Name] to help them make a choice."

Not all of the people were able to fully express their views verbally. Support plans provided detailed information to inform staff how a person communicated. For example, '[Name] can experience difficulty with identifying pain. They can exhibit distress by rubbing their head,' and, '[Name] is able to understand verbal communication and can communicate well verbally with people they are familiar with.' This meant staff had information to inform them what the person was communicating to them. Two staff members commented, "If someone can't tell us verbally we will sign with them," and, "[Name] can lip read."

People were encouraged to make choices about their day to day lives. Care records detailed how people could be supported to make decisions. People told us they were able to decide for example, when to get up and go to bed, what to eat, what to wear and what they might like to do. One person told us, "I like to buy puzzle books when I go shopping." Support plans were individual and provided information about people's preferred routine if they were unable to inform staff verbally. For example, '[Name] prefers to retire to bed around 10:00pm and is usually up at 7:00am.'

Staff respected people's privacy and dignity and provided people with support and personal care in the privacy of their own room. People were able to choose their clothing and staff assisted people, where necessary, to make sure that clothing promoted people's dignity. We saw staff knocked on a person's door and waited for permission before they went into their room. Support plans included information about staff being aware of people's right to privacy. For example, 'Currently [Name] appears content with the company of others and is enjoying all communal rooms of their home. No reason why [Name] wouldn't be able to enjoy time in their own room.'

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the manager or senior staff any issues or concerns. The person in charge told us if necessary a more formal advocacy arrangement would be put in place. They told us an advocate had been used for a person who needed some medical treatment in hospital. Advocates can represent the views of people who are not able to express their wishes.

Good

Is the service responsive?

Our findings

People were supported to access the community and try out new activities as well as continue with previous interests. Some people attended a day placement full or part time. Records showed there were other activities and entertainment available for people. For example, shopping, cinema trips, concerts, gardening, football, bowling, going to discos, trips to the country and coast and meals out.

People were supported by staff to go for days out either individually or in a small group. Day trips to Blackpool were being arranged with some people. Resident meeting minutes showed that some people were keen to go on a cruise and plans were being made for the following year. Other people had enjoyed a holiday to a Butlins holiday resort.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. We were told if there was a vacancy in the home a long process took place to check that people wanted to live at the house and that they were compatible with people who already lived there. The phased induction included visits such as tea time and overnight visits and was carried out at the pace of the person.

Records showed pre-admission information had been provided by relatives and people who were to use the service. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Support plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, mobility and communication needs. Support plans provided instructions to staff to help people learn new skills and become more independent in aspects of daily living whatever their need. Examples in support plans for personal hygiene included, '[Name] is able with support to get their own toiletries and towel for use in the shower,' and for nutrition,'Food to be cut into small bite sized pieces,' 'I feel able to plan, shop and prepare a meal,' and, 'I can cook independently.'

Records were in place for some people who displayed distressed behaviours. These people had care plans to show their care and support requirements when they were distressed. Information was available that detailed what might trigger the distressed behaviour and what staff could do to best support the person.

Staff at the service responded to people's changing needs and arranged care in line with people's current needs and choices. Records showed regular meetings took place with people. Weekly meetings took place to discuss menus and activities for the following week. Regular meetings were also held to review each person's care and support needs and aspirations. We saw that staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans. This was necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

People's care records were up to date and personal to the individual. They contained information about

people's likes, dislikes and preferred routines. For example, records included, '[Name] likes de-caffeinated tea,' 'I watch Manchester United,' '[Name] enjoys watching Coronation Street,' and, '[Name] enjoys visiting charity shops.' Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service.

Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends. Some people had regular visitors and other people were supported by staff to visit their family.

People had a copy of the complaints procedure which was written in a way to help them understand if they did not read. A record of complaints was maintained and no complaints had been received since the last inspection. Resident meeting minutes showed people were asked if they had any concerns about the support they received. Staff meeting minutes also showed the complaint's procedure was discussed with staff to remind them of their responsibilities with regard to the reporting of any complaints. People said they knew how to complain and they would speak to staff if they were worried. One person commented, "I'd tell the staff."

Good

Is the service well-led?

Our findings

A manager was in place and they had applied to be registered with the Care Quality Commission in July 2016.

The atmosphere in the home was 'open' and friendly. Staff said they felt well-supported. Their comments included, "I find the manager nice. They're good," "I love working here, it's a fantastic place," and, "The manager is approachable."

The manager promoted an ethos of involvement and enablement to keep people who used the service involved in their daily lives and daily decision making. Staff were made aware of the rights of people with learning disabilities and their right to live an 'ordinary life.' Information was available to help staff provide care the way the person may want, if they could not verbally tell staff themselves. There was evidence from observation and talking to people and staff that people were encouraged to retain control in their life and be involved in daily decision making.

Staff told us they thought communication was good and they were kept informed about the running of the home. They told us they received a handover at the change of duty. This was to make them aware of any changes and urgent matters for attention with regard to the people's care and support needs. A communication diary was also used to pass on information and record any actions that needed to be taken by staff. Records showed staff meetings were held with the manager and staff every two months. Staff told us they could give their views and contribute to the running of the service. Areas of discussion included, staff performance, health and safety, safeguarding and support worker duties. Staff told us meeting minutes were made available for staff who were unable to attend meetings.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. The audits consisted of a range of weekly, monthly, quarterly and annual checks. They included infection control, the environment, health and safety, medicines and care documentation. Infection control was checked on a weekly and three monthly cycle. Other weekly audits included health and safety, security and fire safety. Audits identified actions that needed to be taken.

The annual audits were carried out to monitor the safety and quality of the service provided. Records showed regular audits were carried out by a representative from head office and the manager to check on the quality of service provision. A monthly audit was carried out by the manager which looked at accidents and incidents, care documentation, staffing levels, activities, supervisions and staff training. A report was produced which was sent to head office. A monthly peer audit was carried out by the service co-ordinator to speak to people and the staff with regard to the standards in the service. They also audited a sample of records, such as care plans and staff files. These visits were carried out to provide an external monitoring of the service. They were to check on service provision to ensure any areas of need were identified and that timely action was taken to improve the care experience for people who used the service.

The person in charge told us the registered provider monitored the quality of service provision through

information collected from comments, compliments/complaints and survey questionnaires. These were sent out annually to people who used the service and relatives. Results were analysed by head office and we were told if any action was required it would be taken if required to improve the quality of service. The survey results from the last survey were not available at the time of inspection.