Potensial Limited

Larwood House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 22 August 2018. The service was last inspected in December 2016, when it was rated 'Good'. At this inspection we found the majority of the evidence continued to support the overall rating of good and there was no significant evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. However, we have made a recommendation for improvement in 'effective' and this key question has been rated 'requires improvement'. This does not affect the overall rating which remains 'good'. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The service is a small service registered to provide care and support to people with a learning disability. It is registered to care for nine people. At the time of the inspection eight people lived there. Larwood House is a purpose built property all on one level with level access to a large outdoor space.

Larwood House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager 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.

Care plans were developed in line with current legislation and guidelines. They were person-centred and included the views and preferences of people. However, we found they were not always reviewed and up-dated in a timely manner when people's needs changed. People had a varied and nutritious diet based on their preferences and staff knew if people needed further support or monitoring if they were at nutritional risk. However, we found the records were not always consistent with what was actually taking place and guidance was not always followed. We made a recommendation regarding nutrition and hydration.

The provider took responsibility to ensure that they were operating under the principles of the Mental Capacity Act 2005 (MCA) and were not placing unlawful restrictions on people. Where required, Deprivation of Liberty Safeguards (DoLS) were in placed or had been requested, and any conditions had been met. 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 practice.

Staff understood how to keep people safe at Larwood House and there were policies in place to support this. Risk assessments were used to identify risks to people and plans put in place to reduce the likelihood or impact of such risks. Medicines were managed safely and people received their medicines as prescribed.

Staff were kind and compassionate and developed positive and friendly relationships with people. They respected people's choices and personal space and promoted their independence and dignity.

Staff knew people's preferences and encouraged people to access activities of their choosing, either within the home or in the local community. People were supported to become active citizens in their local community. People received information in a format that they understood and they were supported to participate in meetings and decisions about their care. Discussions had taken place regarding people's preferences regarding the end of their life, these were documented and easily accessible to staff, when required.

The quality assurance systems in place were effective and identified areas for improvement. The development plan was reviewed and updated each month, which ensured continuous improvements were made to the service. The provider actively sought feedback from people, staff and stakeholders, and this was used to improve the care offered to people. Staff felt included and supported by the management team.

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 remained safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Weight, diet and nutrition records were not always accurate and were not always updated in a timely manner.
Guidance from specialist advisors regarding food was not consistently followed.
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 practice.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Good

The service remained responsive.

Is the service well-led?

Good

The service remained well led.

Larwood 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 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 visit took place on 22 August 2018 at Larwood House. The inspection team consisted of two inspectors.

Before the inspection we reviewed any information we held about the service, including any information the provider had sent us. This included the provider information return (PIR). A PIR is a report that we ask the provider to complete which gives details of how they deliver their service, including numbers of staff and people using the service, and any plans for development. We also reviewed any notifications the provider had sent us. Notifications are reports the provider must send to us to tell us of any significant incidents or events that have occurred.

In order to gather information to make an assessment of the quality of the service, we looked at a variety of records and spoke to people. We spoke to five people who used the service, the registered manager and five staff. We reviewed five care records which included needs assessments, risk assessments and daily care logs. We also reviewed management records which included staff records, policies, development plans and evidence of training. Prior to the inspection we contacted health and social care practitioners who also help provide care to people who lived at Larwood House and organisations that commission services for people. We used information they provided to help formulate a judgement on the quality of service people received.

Good

Is the service safe?

Our findings

People were protected from the risk of abuse or harm. Staff understood their responsibilities to protect people from abuse or harm and there were policies in place to support this, including a whistleblowing policy. Staff told us they knew how to report any concerns they had and how to escalate them if necessary. One staff member said, "I would not hesitate to report any concerns if I felt someone was not safe; and I would take it further if nothing was done."

Risk assessments were in place. These were used to identify known risks to people and risk management plans were in place to reduce the likelihood or impact of these risks to people. For example, we saw risk assessments were in place to assess how many staff would be needed to support people on trips out. People and staff confirmed that sufficient staff accompanied people on trips, to keep them safe.

There were enough staff on duty to care for people. On the day of inspection one staff member had called in sick which meant there was not enough staff to support a planned outing in the morning, so an alternative activity was provided within the home. We saw this activity was supported by the number of staff available in the morning and meant people did not miss out on activities. The provider followed safe recruitment practice and new staff completed a suitable recruitment process. This included an interview, providing adequate references and a Disclosure and Barring Service check, which assesses their suitability to care for people. There was also a detailed induction process which new staff told us they were working through. One staff member said, "I receive lots of support and staff have been really friendly and helpful. I really like it here."

People told us they received their medicines and knew what they were for. One person said, "[Name of staff member] gives me medicine if I don't feel well or if I have a pain." We saw the medicine records and storage arrangements and were satisfied that these were all in order. We saw records that demonstrated people had their medicines reviewed when their health needs changed. Medicines were managed safely by staff who had received training, which was followed by competency assessments conducted by senior staff.

The property was clean, tidy and safe and we had no concerns regarding infection control. Staff undertook cleaning as part of their duties and encouraged people to be involved as part of their independent living plans. One person told us, "I love cleaning, my room is spotless and I love helping other people keep everywhere clean". This person showed us their room and it was clean and tidy. Staff wore gloves and aprons when handling food or supporting people with personal care. This reduced the risk of cross contamination.

The registered manager reflected on lessons learnt and ensured learning was shared with all staff and changes made to improve outcomes for people. For example, improvements were discussed at staff meetings and the registered manager gave feedback to staff following audits and observations. Improvements that had taken place included - involving people when cleaning the home, in order to improve or maintain their independence and mobility; and recording individual activities in people's one to one records, to demonstrate how this time and funding was used to improve people's daily living and

independence. Staff also signed the 'Challenge Charter'. This charter had been developed in response to poor practice within parts of the wider organisation going unchallenged; and was introduced to encourage staff to learn from each other and reflect on their care.

Requires Improvement

Is the service effective?

Our findings

Staff did not always follow guidance in respect of fluid and nutrition. Where people had difficulty eating or swallowing we saw they had been referred to specialist services for advice. However, we found this advice was not always followed. For example, one person was assessed by the speech and language therapist (SALT) as needing soft food cooked in specific ways to reduce the risk of choking. We noticed they were given sausages and chips for their lunch. When we asked staff about this they said the sausage was skinless, was cut into small pieces and the chips were soft and not crispy. They said the person was able to manage with this and they were observed by staff throughout the meal, as per SALT recommendations. This meal did not follow all the recommendations of the SALT team which were in place to reduce the risk of this person choking. As this person lacked capacity to make safe decisions about their food choices, a 'best interest decision' should be in place to document how and why staff had deviated from the recommendations from SALT. This was not in place at the time of inspection, but the registered manager said they would review this and ensure it was done immediately. We did see that SALT recommendations were followed for other people; we saw this information in people's care plans and observed their food being prepared as recommended.

As there were two different systems for recording care, one paper based and one computer based we found the records did not always match and were not always updated in a timely manner. For example, fluid and nutrition records were maintained for people who were identified as at risk of weight loss or dehydration. Staff told us one person's weight was recorded monthly as they were at risk of weight loss, but no comments had been recorded within the paper records, when they indicated a loss of 8 kg over a two week period in December 2017 and a gain of 9 kg in one week in February 2018. The registered manager told us this information was recorded in the computer records but could not explain why there had been no comments made on the paper records which would identify any concerns and direct staff to further guidance.

A staff member told us it was difficult to get accurate weight measurements for this person due to their health condition and presentation. However, they understood the different records and knew when this person needed further support or monitoring. They explained this person's food was now liquidised and fortified with cream and supplements. When we checked the food records for this person we found they did not include how they had been supplemented which would make it difficult for different staff to provide the same combination of supplements to this person's food. This could lead to inconsistent weight loss or gain, with no obvious reason and create difficulties for staff to support this person to maintain a healthy weight.

We recommend that the provider seek advice and guidance from a reputable source in regard to ensuring and maintaining hydration and suitable dietary needs.

Despite this, we found staff understood people's current needs and were able to tell us if any changes had been made recently to how people were cared for. The registered manager said they were working towards a computer based system which would eliminate any discrepancies and all relevant staff had password protected access to these records.

Care was planned using current legislation and recommended guidance. For example, care plans followed person centred care principles. This meant people and their families were involved in developing personalised care plans around the particular needs, views and preferences of individuals. Staff considered individual capacity when they supported people to make decisions and where appropriate, mental capacity assessments were completed to assess if 'best interest decisions' needed to be made by staff.

Staff received training to support them in their role of caring for people with complex needs. We saw the training records which identified when training had been completed and when it was due. Records demonstrated staff had completed training on specific aspects of care which met the provider's expectations. One staff member told us how they used Makaton (a form of sign language) to help them communicate with people who had limited vocabulary. We saw staff safely manoeuvring one person using a hoist and assisting others to walk around. This demonstrated that staff were competent in moving and handling techniques.

The provider had an induction process in place for new staff as part of the development of their caring role. This was aligned to the Care Certificate which is a set of care standards and introductory skills that non-regulated health and social care workers should consistently adhere to. This showed the provider recognised the need to ensure staff had the necessary training and skills to meet people's needs.

Staff told us they were supported in their roles by managers and we saw records that confirmed that supervision took place and aspects of care were discussed in staff meetings. This demonstrated that staff were able to access support and guidance to fulfil their role and meet their responsibilities to care for people effectively.

People received a varied and nutritious diet. There was a rolling four week menu that included options at each meal and was flexible to accommodate people's changing preferences each day. For example, people were asked what they wanted for lunch and three people said 'sausages', which was not on the menu that day. This was prepared by staff with some assistance from people who were able; this demonstrated the flexibility of staff to meet the dietary preferences of people.

Larwood House was a small service with a small staff team. There were effective communication and handover arrangements in place across the organisation, to update staff on each shift and make them aware of any changes in people's care needs. Staff demonstrated there was effective cross organisational care in place and they understood people's care needs. For example, two staff assisted a person to transfer from a chair to their bed, using a hoist as documented in the care plan. We also saw staff from two different shifts provided the same response to one person's request for information. This demonstrated consistency of care.

People were supported to attend community healthcare services for example, opticians, dentist and chiropodist. This was documented in people's care plans and in the diary, which ensured enough staff were available to accompany people to appointments.

The building was purpose built and all on one level with easy access around the building and to the large outdoor space. Rooms were furnished with furniture appropriate to people's individual needs including high-low rise beds and airflow mattresses, where required. One person who now spent more time in bed had patio doors installed in their room to allow them a better view of the garden and fresh air when it was warmer. There was an easy access wet room and bathroom for people who needed assistance with bathing, and ensuite shower rooms for those who were more independent.

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 provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found DoLS were in place for people who required some form of restrictive care to keep them safe; and where they had expired, applications had been made to renew them. There were currently no conditions on the DoLS in place. This showed that the provider took responsibility to ensure that they were operating under the principles of the MCA and were not placing unlawful restrictions on people.

Good

Is the service caring?

Our findings

People were cared for by staff who were kind and compassionate. People told us they enjoyed living at Larwood House. One person said, "I love it here" and another said, "The staff are nice to me". We saw positive and respectful interactions between staff and people, we saw them chatting and laughing together and people were clearly comfortable in the company of staff and each other. Staff told us they enjoyed working at Larwood House and said there was a good staff team. One staff member said, "Everyone gets on together, staff support each other, as well as people who live here"; another staff member said, "I love working here".

Staff actively sought people's views and these were considered when planning activities and people's care. On the day of inspection, people were asked what they wanted for lunch and even though they requested something that was not on the menu that day, this was provided and enjoyed by everyone. People were asked where they wanted to eat and some people chose not to eat in the dining room and were accommodated in the small lounge or their bedroom, as they preferred. Where people needed assistance to eat this was provided, otherwise people were left to eat independently, with staff observing from a discrete distance.

Staff followed the principles of the Accessible Information Standard (AIS). This was introduced to make sure that people with a disability or sensory loss are given information in a way they can understand. Some people at Larwood House were not able to communicate verbally and found it difficult to join in meetings. The provider took steps to ensure people received information in a format they could understand and enabled them to contribute to discussions and decisions made about their care. Staff took time to speak with people individually before each meeting, using their preferred method of communication, for example picture cards and sign language; to capture people's preferences and points of view. This information was recorded and reported at the 'resident meetings' to ensure that decisions considered everyone's point of view, where possible. This demonstrated that staff treated people equally and were inclusive.

Staff promoted people's dignity. We heard staff used people's preferred names, and respected their personal space and wishes. We saw staff knock on people's doors before entering and giving people space to spend time on their own, if this is what they wanted. People were free to move around the home and spend time as they wished in two lounges, their bedroom, dining room and a large outdoor space with patio and garden furniture. One person went to their room for a rest after lunch and another sat outside in the garden enjoying the sunshine. Staff observed at a discrete distance, maintained the person's personal space and respected their choice to be alone.

People were encouraged to be independent and participate in daily living activities, suited to their ability. For example, where people were able, they cleaned their own rooms and communal areas, made drinks for people and assisted with food preparation, helped create shopping lists and accompanied staff on shopping trips. People were also encouraged to identify their own goals and participated in activities that helped them achieve this. For example, one person had recently completed a 'sponsored walk' for charity and another had participated in a local concert. People were encouraged to join external groups in the local

community. This enabled them to develop their identity, independence and citizenship and understand their contribution to the wider community.

Good

Is the service responsive?

Our findings

Staff understood people's personal preferences and considered these when planning daily activities. For example, one person liked to remain in bed in the morning so activities were planned for them in the afternoon, when they were more alert. Another person preferred bathing to showering, this was documented in their care plan and staff told us this was known to staff, who ensured this happened. Feedback from external practitioners that we received before the inspection was that staff were very responsive to people's individual and changing needs. For example, we were told staff had supported a new person to settle quickly when they transferred from another service. Their care coordinator had identified an improvement in this person's motivation and wellbeing. Another practitioner told us how staff had supported a person to improve their motivation and mobility. This person was now walking daily, when they had been unable to walk previously.

Staff promoted people's rights and adapted support to make sure everyone had a voice and was treated equally. One staff member told us "We treat people as individuals, they have rights and their own opinions, and it's important that they contribute to discussions about things that affect them." Where people were unable to communicate verbally with staff, we saw staff responded to different sounds or body language and were able to explain to us what the person wanted. For example, they recognised when one person needed assistance with personal care and when another was hungry. We saw staff used touch to calm a person who was distressed and diversionary activities to distract a person who was becoming anxious. We saw information on one person's wall which was written in symbols, they told us this was to remind them to ring a relative each week. Staff understood how to communicate with people and made sure their views were included in decisions and care planning.

We saw staff chatting with people and offering choices of drinks or activities that met their documented preferences. People told us how they had chosen the furnishings and decoration of their own rooms and were involved in discussions about decorating communal areas. One person showed us their room, which was decorated in their favourite colour and full of personal mementos and photographs. There were lots of photographs around the walls of the home, which showed people happy and smiling whilst taking part in activities, for example, shopping, gardening, crafts or spending time with family. Care was personalised and adapted to people's changing needs.

There was a complaints policy in place and people knew how to make a complaint. Complaints were recorded and analysed as per their own complaints policy. There was a pictorial version of the policy within the resident's handbook and people told us they knew how to make a complaint. When we asked one person what they would do if they were unhappy about their care they said, "Tell [name of staff member]." We saw complaints had been discussed in residents meetings and people's comments had been recorded. When one person had been asked who they would contact if they had a complaint, one person had replied "My social worker or CQC". A staff member explained they had invited a member of the local safeguarding team to a meeting and they had discussed with people how to keep themselves safe and who to tell if they were not happy with their care or felt unsafe. This demonstrated that staff respected people's right to complain and provided information to people in a way that they could understand.

Care plans identified people's increasing needs and identified if a person was on an end of life (EOL) care plan. Where people's needs were becoming more complex, the EOL plan had been completed, documenting people's known preferences including 'Do not attempt cardiopulmonary resuscitation (DNACPR) or Allow Natural Death (AND). Other people's plans had been partially completed as appropriate to their understanding and plans were in place to involve significant others in completing these.

Good

Is the service well-led?

Our findings

There was a registered manager in place. The registered manager told us of their vision for the service and showed us the development plan. This was reviewed by the management team each month, with new actions added as they were agreed. Staff told us they felt involved in the service and were included in decision making about changes. We saw a group of people and staff chatting with the registered manager about plans for decorating the communal areas and developing the garden to grow vegetables. People and staffs views were actively sought and included in the conversation.

The management and auditing systems in place were used effectively to identify where improvements were needed. For example, in the monitoring and updating of staff DBS checks; making sure all new staff inductions were completed and signed-off by a senior worker and recording how staff supported people during the funded 1:1 hours, which were in place to ensure people had access to activities that promoted their independence and citizenship. These actions were fed into the on-going development plan and progress was reviewed each month by the management team. The service was also inspected by contract managers and commissioners. We saw the action plan following the last contract management review, it demonstrated that the registered manager had responded positively and productively to feedback, and had completed any actions identified.

The registered manager understood their responsibilities and sent in notifications as required under the terms of their registration with CQC. The rating for the last inspection was prominently displayed within the entrance hallway to the home and was visible to all who visited the service. There were clear lines of management and accountability within the service. Staff told us they were encouraged to develop and learn new skills, if they wished to develop their role or career in the health and social care sector. Records were stored securely in locked cabinets or password protected computer files.

The views of people and staff were captured locally at resident and staff meetings. Staff received local feedback through one-to-one supervisions and staff meetings. We were told 'Head Office' coordinated annual satisfaction surveys and sent them out to people, relatives, staff and stakeholders. We saw that visitors to the service were also invited to complete a satisfaction survey and any complements were shared with staff and comments added to the on-going action plan for improvements. Surveys were collated at 'head office' and results shared with staff at regional events or through the line management process.

Good practice and learning was identified and shared with regional teams. One example of how good practice had been shared across the wider organisation was the introduction of the 'Challenge Charter' which staff at Larwood House had adopted. This encouraged staff to appropriately challenge each other if they identified areas for improvement. This initiative was promoted as a positive challenge in order to improve outcomes for people and not to blame staff. Staff told us they thought it was a positive step and were happy to adopt it in their service.

We received positive feedback from external services and practitioners that demonstrated the productive relationships between staff at Larwood House and other services involved in caring for people. For example,

a social worker told us that staff worked with them to plan a smooth transfer for a person moving to Larwood House. They also commented on the positive communication they had with staff. Another social worker commented on how staff had taken time to understand one person's needs and preferences; and supported them to take part in activities of their choosing and increase their mobility. Staff told us how they sought guidance from specialist services and this was documented in people's care records.