The Bevern Trust

Bevern View

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Bevern View on the 23 March 2017 and the inspection was unannounced. Bevern View provides care and support for people living with profound physical and learning disabilities and complex communication needs. The service is registered to accommodate up to 11 people, nine full time residential care places for both male and female clients, with two places available for short term respite care. At the time of the inspection there were nine people living at the service and two people receiving respite care.

The service had 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not able to communicate with us using speech, we therefore spent time observing how staff and people interacted and gained feedback from people's relatives. One relative told us, "It is brilliant here. I'm really happy and there is nothing that I can think of that can be improved." Another relative told us, "(Person) loves it here. Staff are very competent and the manager is very approachable."

People received their medicines on time and in a safe manner. However, prescribed fluid thickener had been left in easy reach of people which posed a risk. People's privacy and dignity was not consistently upheld or protected. Where CCTV was used at night, consideration had not been evidenced on how the provider planned to uphold and respect people's dignity and right to privacy. Staff were heard talking about people's care needs in front of other people and often referred to people using terms which did not uphold and respect their dignity.

The provider was not consistently working within the principles of the Mental Capacity Act 2005. Mental capacity assessments were not in place to demonstrate whether people could consent or not consent to the use of restrictive practice. Accurate, complete and contemporaneous records had not been maintained.

Statutory notifications had not been routinely submitted to CQC by the provider. A notification is information about important events which the provider is required to tell us about by law. The registered manager acknowledged this shortfall and submitted the notification during the inspection. However, we have made a recommendation for improvement.

The management team were dedicated to the on-going improvements of Bevern View. A quality assurance framework was in place, but the positive improvements were still in the process of being embedded and implemented.

Systems were in place to monitor the quality of the service provided and regular checks were undertaken on all aspects of running the service. The registered manager had a range of tools that supported them to ensure the quality of the service being provided. Despite this system in place, the provider and registered

manager had failed to recognise that policies and procedures had not been updated to reflect current legislation and guidance. We have made a recommendation about internal review of policies and procedures.

Staff and relatives felt staffing numbers were sufficient. One relative told us, "Oh yes, there is definitely enough staff." Staffing levels were based on the needs of people and systems were in place to assess staffing numbers.

Incident and accidents were consistently recorded. However, they were not subject to a formal audit to monitor for any emerging trends, themes or patterns. We have made a recommendation about the internal review and monitoring of incidents and accidents.

Risks to people were identified and managed appropriately and people had personal emergency evacuation plans in place in the event of an emergency. Positive relationships had been developed between people as well as between people and staff. There was a friendly, caring, warm and relaxed atmosphere within the home and people were encouraged to maintain relationships with family and friends.

Relatives spoke highly of the caring nature of staff and felt staff were confident and competent. People received care and support that was responsive to their needs. Care plans provided detailed information about people so staff knew exactly how they wished to be supported. People participated in a wide and varied range of activities. Regular outings were organised and people were encouraged to pursue their interests and hobbies.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers 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

Bevern View was not consistently safe.

The management of medicines required improvement. Prescribed fluid thickener had been left in easy reach of people.

Risks to individuals were safely managed. There were enough staff deployed. Staff were subject to rigorous pre-employment checks to ensure they were suitable to work at the service.

Staff had received adult safeguarding training and following any safeguarding concerns and enquiries, improvements had been made to ensure people remained safe.

Is the service effective?

Requires Improvement

Bevern View was not consistently effective.

The requirements of the Mental Capacity Act 2005 were not always followed and decision specific mental capacity assessments were not consistently in place.

Staff received training that was appropriate to their role and responsibilities.

Staff had a good understanding of people's complex support and health needs

Is the service caring?

Requires Improvement

Bevern View was not consistently caring.

People's privacy and dignity was not always respected and upheld.

Staff knew the care and support needs of people well and took an interest in people and their families supported them to provide individual personal care.

Attention was given to ensuring that people's bedrooms as far as possible reflected their choices and tastes.

Is the service responsive?

Good

Bevern View was responsive.

Care plans provided detailed and comprehensive information to staff about people's care needs, their likes, dislikes and preferences.

There was a range of activities that people engaged in. People were encouraged to pursue their own hobbies and interests.

Is the service well-led?

Requires Improvement

Bevern View was not consistently well-led.

Accurate, complete and contemporaneous records had not been maintained. Further work was required to embed and sustain positive changes.

Staff and relatives spoke highly of the registered manager and their leadership style. Staff were encouraged to feedback on the running of the service.

Bevern 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.

The inspection took place on the 23 March 2017 and was unannounced. The inspection was carried out by two inspectors.

On this occasion, we had not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we checked the information that we held about the home and the provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we spent time with people who lived at the service. We spent time in the lounge, dining room and activities room. We took time to observe how people and staff interacted. People were unable to use structured language to communicate verbally with us, so we took time to observe how people and staff interacted at lunch time and during activities. We spoke with four visiting relatives, the chef, registered manager, the activities coordinator, the operations manager and four care staff. We contacted two members of staff and five people's relatives via telephone after the inspection to obtain their views. Their feedback has been included within the body of the report.

We reviewed three staff files, six care plans and associated risk assessments, four weekly staff rotas, medication records, policies and procedures, health and safety files, compliments and complaints recording, incident and accident records, quality monitoring documentation and meeting minutes. We also looked at the menu and weekly activity plans.

Bevern View was last inspected on the 12 March 2015 when it was rated as 'Good.'

Requires Improvement

Is the service safe?

Our findings

Due to communication needs, people were verbally unable to tell us if they felt safe living at Bevern View. Observations of care demonstrated that people were comfortable in the presence of staff. People's behaviour also showed us they felt safe. For example, the interactions and communication with all of the staff were open and warm. People freely approached staff and responded to staff with smiles. Relatives confirmed they felt their loved ones were safe in the hands of staff at Bevern View. One relative told us, "(Person) wouldn't be here if I didn't feel they were safe." Despite relatives praise, we found areas of care which were not consistently safe.

During the inspection we found that a prescribed fluid thickener, which is used to thicken drinks to help people who have difficulty swallowing, was left in open reach of people. It had been left on the kitchen counter (the kitchen was within the communal dining room). Prescribed thickeners should be kept locked away to prevent accidental ingestion of the powder. A patient safety alert had been cascaded by NHS England in February 2015 which warned care providers to the dangers of ingesting thickener. Staff told us how the thickener was usually stored within a kitchen cupboard; however, we found this practice had not been followed in principles.

Failure to provide safe care and treatment of people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed to the way medicines were monitored and managed. Each month, the service would receive a delivery of medicines from the pharmacy ready for the next month's cycle. Two members of staff would check and sign in these medicines. Some medicines would be stored in the service's medication cupboard, whilst others would be stored on the medicines trolley. When checking the medication in and storing in the medication cupboard, staff would record the quantity of stock, but not the date when the quantity was checked in and stored within the cupboard. The quantity of stock was not checked again until four weeks later when the new cycle of medicines was received. This meant the provider was not maintaining a clear audit trail of how much stock they had in from one month until the next. For example, if any medication went missing or was stolen from the storage cupboard, the provider would be unable to demonstrate when the medication went missing as they were not completing periodic checks. We have therefore identified this as an area of practice that needs improvement.

We recommend that the provider seeks guidance from a reputable source on the oversight and monitoring of their medicines.

Medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely. The date liquid medicines were opened was recorded and the temperature of the medicines fridge was checked on a daily basis. Where people had been prescribed medicines to be taken when required (PRN) clear guidance was available to staff about how and when these should be administered. Senior staff had completed training in the safe handling of medicines and when administering medicines, staff followed good practice. They wore a red tabard which indicated they were supporting

people with their medicines and not to be disturbed. Each person had an individual Medication Administration Record (MAR chart) which recorded when medicines had been administered and at what time. However, where medicines had been carried forward from one month to the next, the quantity had not consistently been recorded. A staff member told us, "Yes that is an oversight and the quantity being brought forward should be recorded." We brought these concerns to the attention of the registered manager, who recognised our concerns and also advised that at the end of each day, staff stock count people's individual medicines which are stored on the medicine trolley. This ensured that accurate stock levels were being monitored and monitored on the medicines trolley. The provider had appointed a full time clinical advisor who was working in partnership with the service and staff to ensure the management of medicines was consistently safe and robust.

Staff had received adult safeguarding training and described the different types of abuse and what action they would take if they suspected abuse had taken place. One staff member told us, "It's our responsibility to keep people safe and secure and not to be abused in any way. We make sure people's human rights are observed. I would report any concerns to the shift leader or the manager, and if I wasn't listened to I would go to ESCC safeguarding adults." Where safeguarding concerns had been raised, the registered manager told us how they worked in partnership with the local authority and implemented positive changes. For example, following one safeguarding concern, the provider had implemented a new percutaneous endoscopic gastrostomy (PEG) feeding form. Where concerns had arisen regarding the provision of respite care, the provider had implemented a new job role called the 'respite relationship supervisor.' The purpose of that role was to work in partnership with respite residents and their relatives ensuring their needs are managed and they received the highest quality care and opportunity during their respite stay. One relative told us, "We've had some ups and downs, but things are improving and things are on the right track. If it wasn't for the new respite relationship supervisor, I don't think we'd still be coming here." Another relative told us, "Communication has definitely improved since the implementation of the new respite relationship supervisor. I would say things are on the up now."

The provider had effective systems in place for the safe recruitment of staff. Records demonstrated that recruitment checks were in place to ensure staff were suitable to work at the service. Prior to their employment starting there were security checks completed and employment history was gained. Disclosure and Barring Service (DBS) checks were carried out for all the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with adults at risk.

Systems were in place to determine staffing levels. Although a formal dependency tool was not in place, the provider informed us that staffing levels were tailored to the individual needs of people they supported, including people who received respite care. The provider used the care funding calculator which acted as a tool which determined the amount of hours of care needed to meet a person's needs. Staffing levels consisted of eight care workers during the day and two care workers at night. A staff rota was in situ but this was not consistently easily to read or decipher. For example, on Friday 24 March, the rota reflected only four care workers were on shift and providing support. After the inspection, the provider sent us further evidence demonstrating that eight staff members were on duty and this was reflected on shift planners and a staff whiteboard. Staff felt staffing levels were sufficient and one member of staff told us, "I have no concerns with staffing levels." However, relatives experiences of staffing levels varied and we received mixed opinions. Some relatives felt staffing levels were sufficient and had no concerns, whereas other raised concerns. One relative told us, "It can take them a long time to answer the front door which makes me wonder where they are." Another relative raised concerns over staffing levels at the weekends. We brought these concerns to the attention of the registered manager to act upon.

Regular health and safety checks ensured people's safety was maintained. Checks included infection control

and cleaning checks, gas and electrical servicing, hoists and specialist bath servicing and portable appliance testing. All staff had received fire safety training and people had personal emergency evacuation plans. They contained information to ensure staff and emergency services were aware of people's individual needs and the assistance required in the event of an emergency evacuation. The risks associated with scalding and burning had been mitigated and risk assessed. Hot water temperatures were checked every morning. High water temperatures (particularly temperatures over 44°C) can create a scalding risk to adults at risk who use care services. People's risk of scalding had been individually assessed and included within their personal care risk assessment. Staff members confirmed people received 1:1 care when having a bath or shower and the water temperature would always be tested in the morning to ensure the risk of scalding was minimised.

Guidance produced by the epilepsy society advises that epilepsy is more common in people living with a learning disability. Where people had a diagnosis of epilepsy, clear guidance and risk assessments were in place. Relatives confirmed they felt confident that their loved one was well looked after during a seizure. One relative told us, "I was visiting one weekend and (person) had a seizure. I was amazed at how the staff member handled it. They explained everything they were doing whilst I was standing watching. They were ever so competent." Guidance included on when medical care should be sought. For example, the risk assessment for one person identified that emergency medicines should be administered in their seizure lasted longer than five minutes. Epileptic seizure monitoring charts were in place along with seizure reports which included a description of the seizure, duration of the seizure and recovery following the seizure. This demonstrated that the overall management of epilepsy and seizures was safe.

Potential risks to people in their everyday lives were assessed and managed to protect them from the risk of harm. For example, where people required the assistance of two staff members to move and transfer along with a mobility aid (hoist), risk assessments considered the equipment required, handling constraints and other factors which may prevent a safe transfer. Good moving and handling practice was observed throughout the inspection. We observed two staff members hoisting one person from their adapted chair to a mat on the floor. The staff ensured that one care worker was leading the task and they explained each step of the move to the person before they carried out any actions. Staff also provided care and support to people living with a swallowing difficulty and heightened risk of choking. Nutritional risk assessments were in place which provided guidance to staff on how to mitigate the risk of choking, such as providing a soft diet, ensuring the person was sitting upright and one to one support with eating and drinking.

Requires Improvement

Is the service effective?

Our findings

People's relatives told us they believed people received effective care and their individual needs were met. One relative told us, "I feel that the staff are very skilled, knowledgeable and competent." Another relative told us. "Staff are very good at knowing (person's) needs and communicate effectively with him." Despite relatives praise, we found areas of care which were not consistently effective.

People's rights were not always upheld and respected as the provider was not consistently adhering to the principles of the Mental Capacity Act 2005. 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 application procedures for this in care homes 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. Training records demonstrated that most staff had received MCA training and some staff were due to receive training in the next couple of weeks. Staff told us how they gained consent from people and their understanding of the Act. One staff member told us, "You need to be able to answer five questions to decide whether a person has capacity to make a decision for themselves. It's if someone can make a decision, so if (person) got out of the door he couldn't make a decision to keep himself safe."

However, the provider was not following the principles of the MCA 2005 Code of Practice. For people who lived at the service on a permanent basis, appropriate applications had been made which referenced the use of restrictive practice. Although, the use of restrictive practice had been identified in the DoLS applications, the provider had failed to consistently undertake mental capacity assessment to determine that people lacked capacity to consent to the restrictions imposed on them and whether care could be provided in a least restrictive manner. Where mental capacity assessments had been completed, they had been undertaken in 2014 and covered the decision, 'support to keep the person safe.' These mental capacity assessments covered a range of decisions within one assessment. Under the MCA code of practice, a single mental capacity assessment should be in place for each time specific question. The provider had not failed the principles of the MCA code of practice. For people who stayed at the service on a respite basis, deprivation of liberty safeguards would not be applicable. However, the provider had failed to demonstrate how they were working within the principles of the Act. For example, one person who received respite care required the use of bed rails, wrist cuffs and lap belts. Consideration had not been given as to whether this individual could consent to these restrictions or whether these restrictions were in place in their best interest. The registered manager told us, "We've identified that this is an area of practice we need to focus on."

Bevern View deployed the use of CCTV (surveillance) inside five people's bedrooms and within the two bedrooms that were dedicated for the use of respite care. The purpose of this CCTV was to monitor seizure

activity at night so staff could provide assistance in a timely manner. The legal framework requires that any use of surveillance in care homes must be lawful, fair and proportionate and used for purposes that support the delivery of safe, effective, compassionate and high-quality care. Information was available within the entrance hall of the service informing people of the use of CCTV. The registered manager told us, "The footage is a live stream that displays on a laptop which is password protected. Although the footage is live, we don't keep records of footage." The use of CCTV had been included within people's DoLS applications, however, for people receiving respite care the provider had failed to consistently consider and review people's mental capacity and whether the use of CCTV was in their best interest or whether there was other options to monitor seizure activity, such as the use of technology sensors.

A readily accessible policy on the use of the MCA and DoLS was also not in place for staff to access and follow.

Failure to work within the principles of the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and contravenes Article 5 of the Human Rights Act 1998.

Despite the above concerns, staff recognised the importance of gaining consent from people. Staff empowered people to make daily choices and used pictorial aids, objects of reference and Makaton to communicate with people to empower them to make decisions over what they wished to eat, wear and do that day.

Some people required total support in regard to their mobility. The premises and equipment was laid out appropriately to meet people's needs. People had specialist beds and mattresses to prevent the risk of skin pressure areas. There were tracking hoists in place to aid the transfer of people, for example from their bed to sitting chair or bath.

Relatives and staff spoke highly about the food provided. One staff member told us, "The food is excellent. It's well balanced and a good variety." One visiting relative told us, "The food is better now. It used to be quite bland: lots of noodles and rice, but it's lovely now. We're here for meals and if he didn't like it you'd wear it. He needs a high calorie diet. They weigh him a lot and he's got a good weight on him now."

People required careful support around their nutritional and hydration needs. There was clear individual guidance about how to support people safely and effectively with eating and drinking. For example, one person's nutritional care plan identified that they needed to eat their evening meal by 17.00pm as otherwise they will be too tired and not eat. Guidance was available on how to promote people's independence and involvement with eating and drinking. One person's eating and drinking care plan noted, 'I may participate in eating by putting my hand up to the spoon while I am being supported.' Some people needed specialist support with complex healthcare needs, including PEG feeding. This was required when people could not maintain adequate nutrition with oral intake. Guidance and information was readily available on the person's PEG regime which included advice on when staff should administer water flushes and at what time should an individual PEG regime commence. A visiting relative told us about how their loved one was unable to eat orally, but still enjoyed being involved in lunchtime and spending time with people at the dining room table. We observed this in practice. Adapted cutlery and plate guards had been sourced and were in place to promote people's independence with eating and drinking. A large number of people required one to one support with eating and drinking at lunchtime. Staff sat down next to people and supported people at their own pace.

People's health needs were assessed and met. People received support from healthcare professionals when

required, these included GPs, learning disability nurses, speech and language therapists (SALT) and physiotherapists. Staff knew people well, were able to recognise any changes in their behaviour or demeanour and ensured they received appropriate support in response to noted changes. Staff members told us how they supported people to access regular healthcare appointments and a visiting relative confirmed their loved one was supported to access regular healthcare appointments. A number of people were living with complex healthcare needs that required nursing intervention. The registered manager told us, "A clinical advisor visits the service and provides oversight and support on meeting people's nursing care needs and any advice, staff follow."

Guidance produced by Skills for Care documented that, 'effective supervision is key to delivering positive outcomes for all people who use social care. All organisations therefore need to make a positive, unambiguous commitment to a strong supervision culture.' The provider's supervision policy noted that staff would receive supervision every two months. However, we found that staff had gone in excess of six months and on occasions over a year without supervision. The registered manager told us, "We have identified this and have actively been trying to hold supervisions with all staff members to ensure they have received a recent supervision." The staff supervision matrix reflected that improvements were being made, but these improvements required time to embed and be sustained.

All staff completed training that the provider considered mandatory. It included such areas as safeguarding, moving and handling, fire safety, basic first aid, food hygiene and infection control. Training was also provided to equip staff with the relevant skills and knowledge. For example, staff completed training in epilepsy and care of medicines. Staff were also supported to pursue professional qualifications and obtain diploma's in health and social care. A member of the management team told us, "Over half of our staff are undertaking further training such as an NVQ." Staff spoke highly of the training provided and that it provided them with the skills necessary to provide effective care. One staff member told us, "Training is excellent as it's all face to face. We've recently had a different company and they're very good. I did first aid a few weeks ago and it was theory as well as practice and for the first time I feel if I encounter issues on shift I know what to do."

Requires Improvement

Is the service caring?

Our findings

We observed staff engaged in positive caring relationships with people and saw examples of genuine warmth between people and staff. A visiting relative told us, "All the staff are very nice." Another relative told us, "I would say its brilliant here, the staff are ever so kind." A third relative told us, "Staff are caring: they wouldn't fit in here if they weren't. One staff wanted to take (person) to a show and they made it happen." However, despite relative's positive praise, we observed areas of care which were not consistently caring.

The provider's policy statement on 'values on privacy and dignity' noted that 'Bevern View believes that every resident at Bevern View has the right to live in an environment where staff promote the values of Privacy, Dignity, Choice, Fulfilment, Rights, Independence and Security.' We found this statement was not consistently embedded into practice. During the inspection, we observed on occasions, staff talking about people's personal care needs in front of other people. For example, during lunch time, one staff member commented loudly to another staff member in front of five people, 'can you two change (person).' This comment did not uphold that individual's dignity. Another member of staff was sitting at a dining room table with other staff and people. They commented to one person at the table which was overheard by Inspectors, 'got to eat your dinner, you've got to be changed at 13.30pm.' Later on during the inspection, we heard one member of staff talk loudly to another member of staff across a room, '(person) has started their menstrual cycle so you know.' Again this interaction was in front of people and did not uphold that individual's dignity.

Many of the people living at the service had lived there for many years and were now adults within their 30s and 40s. However, we observed staff refer to people in terms which did not uphold their dignity and could be seen as Infantilisation. For example, we heard staff refer to people using terms such as, 'are you a happy boy?' 'Oh you are such a good boy and yummy yummy, yes good girl.' Guidance produced by Skills for Care advises that 'infantilisation of adults with profound learning disabilities may prevents them from being allowed to take risks in their lives and to experience what other people want to, or can, experience. This paternalistic attitude gives people even less control over their lives and reinforces their dependency on others.' We brought these concerns to the attention of the registered manager to take action.

The service deployed the use of CCTV at night to monitor people's seizure activity. This was in place for five people and those who received respite care. The CCTV was in place at night time, however, we found that the care planning process had failed to evidence how the provider had considered people's dignity at night time. For example, how the use of CCTV was balanced against people's right to privacy at night time. The registered manager acknowledged that the care planning process could clearly demonstrate how people's right to privacy at night time was protected.

The above evidence demonstrates that people were not always treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At other times staff interacted with people in a caring and compassionate way. One relative told us, "Staff are just so lovely." Staff gave people time and spoke with them face to face to facilitate effective

communication. They knelt down when they talked with people, so that they were at the same eye level. They used touch to communicate genuine affection, concern and care for the individual. Some staff showed that they knew people well and demonstrated compassion and respect in terms of understanding what was important for an individual in delivering person centred support and care. One staff member told us, "I find Bevan View a very kind, caring and nurturing place for residents and staff." Another staff member told us, "Caring relationships is all about reading people's care plan. One resident likes staff to knock on various objects or to pretend they are really hurt and they think it's hilarious. Another resident likes it when we rub their back and have snuggles on the sofa, they will give us lots of cuddles."

People were able to maintain relationships with those who mattered to them. Visiting was not restricted and guests were welcome at any time. People could see their visitors in the communal areas or in their own room. A visiting relative told us, "We can visit whenever we wish. Staff are ever so friendly and always make us feel welcome."

The atmosphere in the service was calm and staff spent time interacting with people. One staff member asked a person, "Would you like me to paint your nails?' Staff recognised what was importance to people and supported people to maintain their personal identity. People were encouraged to treat the home as their own. People's bedrooms were highly personalised to their own tastes and preferences. For example, people had chosen their own colour schemes and décor. People's likes and hobbies were reflected in the pictures and ornaments they had in their rooms. The registered manager told us, "The pictures outside of people's room are pictures of them and they really reflect their personality." A visiting relative spent time showing us their loved one's bedroom. They told us, "The room is lovely and we designed it so it's similar to their bedroom at home. The theme is important to theme and it is lovely they have all their pictures around them."

Guidance produced by the National Institute for Health and Social Care Excellence (NICE) advises that sensory stimulation for those living with a learning disability can promote quality of life. Sensory equipment was available throughout the service and in people's individual bedrooms. This included lights of various colours to help aid a sensory experience. The service also had a sensory room with various lights and a touch screen computer which people could use independently via switches. The registered manager told us, "It's a great space and we also have mats we can put on the floor, so people can have sensory time on the floor."

For people living with a learning disability, communication is vital in ensuring that people can express themselves and make sense of the world around them. People were unable to fully express their needs verbally. Staff demonstrated a good knowledge of how people communicated. One staff member told us, "People have various ways of communicating. For example, using objects of reference, Makaton, picture boards and through facial expressions." Each person had a 'This is Me care passport' which included detailed information on how they communicated. For example, one person's care passport identified that they could communicate by using their eyes and blinking. Another's person's care passport identified, 'I will take your hand and show you where I want you to go. I use facial expressions, gestures, body language and vocalisations to express myself: you need to know what they mean.' Where people used objects of reference, information was available on those objects, for example, for one person, a flannel represented a bath and an apron represented mealtimes. A visiting relative told us, "We recently attended a carol service and (person) doesn't cope well with big crowds, out of nowhere, a staff member appeared and recognised that (person) looked distressed and asked if they wanted to go somewhere with less people. I was really impressed that they recognised that and knew how (person) communicated."

Good

Is the service responsive?

Our findings

Bevern View was responsive to people's changing needs and people's preferences were taken into account so that they received personalised care. A visiting relative told us, "The service is very good at keeping me updated and communication is good. They took (person) on holiday recently, his first holiday without me, but they kept me updated the whole time. They would text me saying, just getting on the ferry now. He had a great time." Another relative told us, "I love the atmosphere at the service. People are always doing things and everyone is involved."

People's needs were assessed before they came to live at the service to ensure that their care and support needs could be met there. This assisted staff to deliver responsive care and support. Following the pre-admission assessment, individualised care plans were devised. The aims of the care plan included for the team to work consistently in their approach, to provide a safe environment and to work towards improving the quality of life for the individual. Care plans included a 'This is Me care plan' which provided an overview of the person's needs and how best to support the individual in a person centred manner.

Each person had a care plan which reflected their personal choices and preferences regarding how they wished to live their daily lives. Care plans covered areas of care such as eating and drinking, continence, mobility, social needs, communication, personal safety and social development. Care plans considered what the person could do, how they would like to be supported, what they would like to achieve and what they need help with. For example, one person's communication care plan identified that they could answer yes or no by blinking. They used a slow blink to indicate yes and a quick blink to indicate no. They needed help from staff to recognise that their blinking for no was difficult to notice. Information was also included on what staff should do, such as come down to their level and talk them through what was going on. Care plans also included recommendations from health care professionals about how to maintain their physical wellbeing. Some information had been produced using photographs to illustrate how best to support people using their specialist equipment and how to position them correctly, safely and comfortably. For example, where people used sleep systems and CPAP masks (help with maintaining oxygen levels), picture illustrations were in place to demonstrate how to safely meet people's needs using those pieces of equipment.

Information was readily available on how people preferred their morning and evening routine. For example, one person liked to have a lie in and get up around 09.00am. Care plans also included information on people's life history, hobbies, interests and information on their family circle and who was important to them. One person's 'all about me' care plan identified that they enjoyed being sung to and for staff to read to them.'

People were supported to pursue social interests and activities that were important to them. The service employed a dedicated activities coordinator whose role included mitigating the risk of social isolation and promoting people's quality of life. A weekly activity timetable was displayed in picture format in the lounge and activities included one to one time with the activity coordinator, trampolining, trips out, gardening, arts and crafts and many other activities. During the inspection, we observed a group activity. Staff introduced

themselves and used Makaton signs for good morning, what's the weather today, who is here and who is not here. The activity was making a mother's day present. Before the activity staff passed a yellow ball to each person and the person chose a song for staff to sing to them. Staff members were using intensive interaction techniques to engage people. Intensive interaction is an approach to teaching the pre-speech fundamentals of communication to children and adults who have severe learning difficulties. The person with the yellow ball was then greeted by staff singing to them 'how are you; we're happy to see you' the tune that they chose, such as frère Jacque or mama mia. One person chose staff to rap to them. The rap was based around the persons' likes such as Zombies and as the staff rapped to them they were showing clear delight and joy. People were then supported to paint a plant pot. Staff showed people the pot and asked people to choose colours by looking at different paints. People were supported with hand over hand support to paint different designs and colours on the pots. During the activity one person became distressed. When staff could not work out what was wrong they took the person for a walk and made them a drink which helped to calm them. During the afternoon, people enjoyed one to one sessions with an external entertainer who engaged people with movement and music. Relatives spoke highly of the activities provided, one relative told us, "I've just been reading through their daily notes and I don't think I could keep up with what they do. He's out and about nearly every day doing something. The other day they went to Cuckfield for a walk and do various activities within the home." Another relative told us, "They have the music man, hydro-pool, horse riding and trampoline, so he's got a social life that we as parents couldn't provide. The activities are very imaginative and sometimes we need an appointment to see him he's so busy."

The provision of activities was based on people's likes, interests and hobbies. For people living at the service on a full time basis, they were engaged with activities that were meaningful and promoted their wellbeing. For people who received respite care, it was not always clear how they were supported to engage with activities that were meaningful. People could engage in the group activities that were planned and the general activity timetable was documented in people's care plans. However, the general activity timetable did not actually record what the group activities were in the evening. Therefore, for people who arrived at Bevern View for respite in the late afternoon, the activity timetable was not consistently clear on what group activities were taking placing. The activity coordinator told us, "There's no individual timetable for people on respite in the later hours, and this is something we need to work on." The activity coordinator and registered manager were responsive to our concerns and agreed this was an area to focus on.

A hydrotherapy pool was on site and people were supported to have one to one sessions in the pool. The registered manager told us, "We've been ever so lucky to get this pool on site as they are a very limited resource. A physiotherapist visits throughout the week and staff are also trained as lifeguards. There is an overheard hoist, so people can easily access the pool and there is a range of light settings and people can listen to music in the pool. Relatives with relevant training also use the pool to spend time with their loved one." One relative told us, "The hydrotherapy pool is a real added bonus and I'm really keen for them to use it as much as possible."

The use of technology was integrated and used to promote interaction and engagement between staff and people. For example, during the inspection, one person was being supported to use an Ipad to look at videos and photographs of their family. Another person was sitting with staff using an Ipad to find Disney songs and dance along to the music. The provider was also in the process of implementing eye glaze technology (way of accessing the computer or communication aid using a mouse that you control with your eyes). The activity coordinator told us, "We are in the early stages, but we have sent one member of staff off for specialised training, but we will be personalising it for people."

Support was in place for people to access the local community. On the day of the inspection, staff supported people to access the local transport college. One member of staff told us, "It is a really good idea; people get

together with other people from local care homes and go out to various places that have a link with transport. For example, they might go to Lewes to get the train or go to a local bus centre to look at buses. But there is always the theme of transport." A relative told us how their loved one really enjoyed transport college and spending time on various forms of transport. The registered manager told us, "We have some people who absolutely love trains, so transport college is a great way of promoting their passion."

There were arrangements to listen to and respond to any complaints. The service had received seven complaints in the last 12 months. We saw these were responded to in line with the provider's policy. Feedback was also given to the complainant. A copy of the complaints policy was displayed in the entrance hall of the service. Relatives confirmed they felt able to approach the registered manager. During the inspection, we identified that the service did not have a copy of their complaints policy displayed in an easy read format. We brought this to the attention of the registered manager who agreed it could be helpful to a copy of the policy in picture format. The registered manager agreed they would take action to address this.

Requires Improvement

Is the service well-led?

Our findings

Staff and relatives spoke highly of the registered manager. One relative told us, "He's ever so approachable. Any concerns, he deals with them straight away." Whilst all feedback about the management was very positive we found the leadership of the service was not effective in all areas.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. These include events such as safeguarding and deprivation of liberty safeguards. The registered manager had not consistently notified us of all safeguarding concerns and deprivation of liberty authorisations. The registered manager acknowledged these had been an oversight and consequently submitted the notifications during the inspection.

We recommend that the provider reviews their monitoring and oversight of statutory notifications.

Each person had a range of documentation in place, these included, bowel movement charts, daily recording sheets, night time checks, mask recording forms and continence charts. Despite, a range of monitoring charts in place, we found the oversight of these charts was not robust. For example, one person's daily record sheets re-directed staff to complete their bowel movement chart. However, we were unable to locate one in their daily record folder. We brought this to the attention of the registered manager who felt staff may have moved it or if they received support from staff, such as through the use of medicines, bowel movement charts may not be in place." It was therefore unclear if bowel movement charts should be completed to ensure effective oversight. One person had a bowel movement chart dated 13 March 2017 yet this had not been completed. Due to the care and support needs of people, a number of people received supported to meet their continence needs. One person's daily notes folder included a continence chart; however, this had not been completed to evidence when they received support to meet their continence needs. We found this was a consistent theme across the service. Where people were required to wear a CPAP mask (help with maintaining oxygen levels), a mask recording form was available to reflect the date and time of when they wore the mark, how long they had the mask on for and how they were when wearing the mask. However, we found this recording form had not been completed. Omissions were also identified with recording, for example, one person's seizure chart had not been dated, therefore we were unable to ascertain when the person had experienced those seizures and at what time. People were subject to half hourly night time checks, however, documentation reflected that one member of staff checked on 11 people at exactly the same time. Therefore, documentation was not accurate and failed to reflect the time people were actually checked on.

For people living at the service on a permanent basis, we found their care plans and risk assessments were robust, however, for people receiving respite care, we found their risk assessments and guidelines were not consistently robust. For example, one person had very complex care needs and required a high level of attention to meet their bowel and nutritional needs. They received nutrition via their PEG. The individual's medicine sheet contained a method for giving medicines via the PEG. Although staff had been trained there were no photographs on the method to guide staff. One part of the method stated that if the person was not in pain, after the first medicines had been administered, then staff could go ahead and give the rest of the

medicines. However, it did not describe what to do if the person was in pain. The care plan also identified a potential issue that an error reading could be displayed. However, documentation stated, 'try restarting over and over again, having checked that food is running by disconnecting and running and placing a syringe of 2mls of water through button to check it is not blocked.' There was no further guidance on what to do if this measure was not successful. Their PEG guidance also lacked detail. For example it stated, 'regularly check the connections of the giving set for signs of leakage and twisting. Ensure the feed pump is properly changed in and working.' However, there was no follow up to this to explain how it should be checked. There was also a lack of guidance on how to support the person when they were around others who were eating.

Staff clearly told us how they supported people and managed risks associated with eating and PEG regimes and the provider had appointed a full time clinical advisor to address these concerns; however, failure to maintain accurate, complete and contemporaneous records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Documentation was in place for the recording of incidents and accidents. This included the date, time, person and staff involved and details of the incident/accident. Incidents and accidents were then reviewed by the registered manager to consider the root cause and the actions required to reduce any further incidents and accidents. Although incidents and accidents were reviewed, they were not subject to a formal audit to monitor for any emerging trends, themes or patterns. We have identified this as an area of practice that needs improvement.

We recommend that the provider seeks guidance from a national source of the auditing of incidents and accidents.

The provider and registered manager were committed to the on-going improvements of Bevern View. The registered manager told us, "The recent number of safeguarding's has been a massive challenge for us. However, we are making a number of positive changes which are helping us to move forward." The provider had employed an external care consultant to undertake an audit of the service which contributed to their overarching improvement plan. The audit was undertaken in February 2017 and inspected the service against CQC's five key questions. A range of actions were identified which included the need to evidence compliance with the MCA 2005 and implementing a robust supervision programme. An overarching service improvement plan was in place which considered areas of improvements in relation to clinical governance and management governance. Actions included the need to transfer to 'Icare', an electronic system for the management of medicines. Improvements were in the process of being made, but required time to be embedded and sustained.

The registered manager and provider had a range of tools that supported them to ensure the quality of the service being provided. They undertook quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included medication and infection control. The Trustees of the organisation also completed audits which covered a range of areas. Their latest audit completed in September 2016 focused on staffing, premises and equipment, premises and equipment and fit and proper persons employed. However, despite a governance framework in place, the provider had not identified that policies and procedures had not been updated to reflect current guidance and legislation. For example, the safeguarding adult's policy had not been updated to reflect the Care Act 2014. This posed a risk that staff were not aware of their new responsibilities under the Act. Policies and procedures referenced old legislation such as the Health and Social Care Act (2008) Regulated Activities 2009 and not the new fundamental standards. Failure to update and review policies and procedures poses the risk that the service is governed by procedures that do not reflect current policy, legislation and guidance.

We recommend that the provider reviews their internal policies and procedures to ensure they reflect up to date guidance.

Bevern View was opened in 1999 and the values of the organisation were understood by staff and embedded into the running of the service. The registered manager told us, "The father of one of our residents founded the service back in 1999. They wanted a home that would meet the needs of their son and other people in the local area. Although the service has a Christian ethos, a number of people living here have different religious beliefs." The service was governed by a value statement which reflected, 'we are passionate about releasing people from the expectations others have about their disability.' Staff told us how they encouraged people to be as independent as possible whilst supporting them to pursue their own individual hobbies and interests. A visiting relative told us, "My son has been coming to Bevern View for 10 years now. He absolutely loves it. When he comes to stay for a weekend I bring him back to Bevern, he has a beaming smile on his face and I can see he wants to see what other people are doing and get involved in the activities."

Relatives spent time describing the key strength of the service which they commented as the atmosphere and the core stable team of staff that look after and support people. One relative told us, "We have recommended Bevern View to other parents and they have told us how the atmosphere of the service is like no other services. It is friendly and welcoming."

Systems were in place to involve staff and relatives in the running of the service. Parents meetings were held on a regular basis and one relative told us, "The parent's forum is a good opportunity for us to get together and raise any issues. The manager or CEO will always listen and act on those issues and concerns." The registered manager told us, "Sometimes I get invited to those meetings, sometimes I just get sent actions. They provide a forum for parents to get together and discuss how things are going." Meetings with staff were also held on a regular basis. Minute meetings reflected items such as whistle-blowing, safeguarding, medication and supervision were discussed at staff meetings. Satisfaction surveys were in the process of being drafted and sent out to professionals, staff, visitors and relatives to help drive improvement.

The provider was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a legal requirement which all providers must follow. It requires care providers to act in an open and transparent wait. Where a notifiable safety incident had occurred, the provider worked in partnership with the local authority, provided an account of the incident and taken steps to learn from the incident.

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 10 HSCA RA Regulations 2014 Dignity and respect Service users were not treated with dignity and respect. The provider had failed to ensure the privacy of the service user. Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The care and treatment of service users was not provided with the consent of the relevant person. Where the service user was 16 or over and was unable to give such consent because they lack capacity to do so. The provider had failed to act in accordance with the 2005 Act. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably practicable to mitigate any such risks. Regulation 12 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain accurate, complete and contemporaneous records in respect of each service user. Regulation 17 (2)

(c).