Care Quality Commission

Individual Care Services

Individual Care Services - 11 Wembrook Close

Inspection report

11 Wembrook Close
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Ratings

Overall rating for this service	Requires improvement
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?	Requires improvement

Overall summary

This inspection took place on 23 October 2015 and was unannounced. 11 Wembrook Close provides care and accommodation for up to four people with a diagnosis of a learning disability or autistic spectrum disorder. Three women lived at the home at the time of our visit.

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.

There were sufficient staff to meet the needs of people in a way they preferred. Staff received regular training, and new staff were provided with an induction to help them understand people's needs and how to support people effectively.

Summary of findings

Staff had received training in keeping people safe and understood their responsibility to report any observed or suspected abuse. Where risks associated with people's health and wellbeing had been identified, there were plans to manage those risks. Risk assessments ensured people could continue to enjoy their life as safely as possible and access the community.

Checks had been completed before new staff started work at the home to make sure, as far as possible, they were safe to work with the people who lived there. There were systems to ensure that medicines were stored and administered safely.

The registered manager had an understanding of the principles of the Mental Capacity Act 2005 but they had not always been put into practice. Decision specific assessments had not been completed. The registered manager had recently received advice and was in the process of completing assessments so staff were clear about what decisions people were able to make themselves and where they needed support. Where people's freedom was restricted, the provider had applied to have this authorised by the local authority. This meant they complied with the DoLS legislation.

People were encouraged to eat a varied diet that took account of their preferences and where necessary, their nutritional needs were monitored. People were supported effectively with their health needs and had access to a range of healthcare professionals.

Staff were caring and supported people to participate in activities and outings in the local community and further afield. People were supported to make decisions and choices about their everyday lives.

Each person had a care and support plan with detailed information and guidance personal to them. Care plans included information on maintaining the person's health, their daily routines and preferences. Staff had the information they needed to manage and support people who had behaviours which challenged others.

Staff told us they felt supported by the registered manager. However, when the registered manager was not present in the home, there was a lack of clear leadership.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People received care from staff who were aware of safeguarding procedures and knew what action to take if they suspected abuse. Where risks around people's health or behaviours had been identified, staff knew how to support people to keep them safe. People received their prescribed medicines from trained staff and regular checks made sure medicines were given as prescribed.

Good

Is the service effective?
The service was not consistently effective.

The provider had not assessed people's capacity and had not demonstrated decisions were made in line with legal requirements. Staff had not received training in the Mental Capacity Act 2005, but had received other essential training so they could meet people's needs safely and effectively. People were offered choices of meals and drinks that met their dietary needs. The registered manager and staff made sure people received support from other health care professionals.

Requires improvement

Is the service caring?
The service was caring.

People were treated with kindness by staff who were attentive to their needs. People were supported to make choices by staff and staff respected the choices people made. People were encouraged to maintain relationships with people who were important to them.

Good

Is the service responsive?
The service was responsive.

Care was delivered in a way that met people's individual needs and preferences. There were processes for staff to share information so they could respond to people's changing needs. People were encouraged to follow their interests and to attend activities outside the home.

Good

Is the service well-led?
The service was mostly well-led.

Staff spoke very positively about the registered manager, but there was no clear leadership when they were not in the home. Staff were able to share their views about the service and felt supported in their role.

Requires improvement

Individual Care Services - 11 Wembrook Close

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 23 October 2015 and was unannounced. The inspection was undertaken by one inspector.

As part of our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR 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. The registered manager was in the process of completing the form at the time of our visit.

We reviewed the information we held about the service. We looked at information received from external bodies and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

People had limited verbal communication so we spent time observing how they were cared for and how staff interacted with them so we could get a view of the care they received. We were able to have limited conversations with two people. We spoke with five staff and the registered manager.

We reviewed one person's care plans and daily records to see how their support was planned and delivered. We reviewed records of the checks the staff and management team made to assure themselves people received a quality service.

Good

Is the service safe?

Our findings

People who lived at 11 Wembrook Close had limited communication so we spent time observing the interactions between people and the staff supporting them. We saw people were relaxed and responded positively when approached by staff. This demonstrated people felt secure in their surroundings. One person who was able to talk with us described the staff as "nice".

Staff had undertaken training to recognise the signs of potential abuse and to know what to do when safeguarding concerns were raised. Information had been provided to staff which contained clear information about safeguarding. One member of staff told us, "If [person] was left in her bedroom and she is shouting out and we didn't go, that is a kind of abuse because you are neglecting her." We gave staff various safeguarding scenarios and asked how they would respond. Staff told us they would inform the manager and document what they had seen. One staff member explained, "I would report it to the manager or a senior member of staff. If I couldn't get them, I would go straight to the head office." Staff understood their responsibility to whistle blow if the manager did not act on the information given. They told us they would report their concerns to a senior manager, and failing that, they would contact us.

The registered manager understood their responsibilities to manage any safeguarding concerns raised by staff. They told us they would deal with the matter confidentially and went on to say, "I would have to alert my directors and there would be a thorough investigation." They told us they would also notify the social worker and the local safeguarding team. There had been no safeguarding concerns in the previous 12 months.

Staff told us they would report any poor practice they observed by other members of staff. One explained, "I would report it to the management." Another said, "I would tell them they are doing it wrong and show them the right way and report it to the manager."

Staff we spoke with told us there were enough staff to meet people's needs safely. Staff told us there were normally three care staff during the day, two care staff in the early evening and one member of care staff at night. One staff member told us they could be stretched when there were only two staff on duty and said, "Sometimes it makes things difficult because it prolongs the time it takes to do everything." Another staff member told us, "During the evening, I think two is quite adequate." However, they went on to say that staffing at the weekends was not always consistent. They explained, "At the weekend you can be overstaffed and sometimes you are on minimum staff where there are only two on each shift. It is happening this weekend. Sometimes it prevents them going out. I'm not saying they wouldn't go out all day, but one person would have to go on the late shift and one on the early shift." During our visit, we saw there were enough staff to meet people's needs and staff responded promptly when people needed support or requested assistance.

We were told if a need was identified, staffing levels would be increased. For example, we were told, "Last year we had a waking night in for a spell because [person] had a sore and we had to reposition her." There were also 'on-call' arrangements to ensure staff received extra support if there was an emergency.

The provider had a recruitment policy that ensured all the necessary checks were completed before new staff started working unsupervised for the service. This included a police check and obtaining references to ensure staff were suitable to work with the people who lived in the home.

Care plans contained relevant risk assessments. This included any health issues and risks identified to the individual or others as a result of possible behaviours that could cause upset or distress. Where a risk had been identified, plans were in place to reduce and manage the risk to keep people safe. For example, risk assessments had been completed in respect of a variety of identified needs including when people were being supported to transfer from bed to a wheelchair, skin care, nutrition and medication.

Some people could put themselves or others at risk of harm if they became anxious or upset. There was information for staff to follow to manage those behaviours to minimise anxiety or distress. Staff told us they felt confident to manage situations because, "I just follow the protocol to keep them safe." We were given consistent information by all staff members we spoke with about the behavioural guidelines they followed.

Medicines were stored safely and securely and there were checks in place to ensure they were kept in accordance with manufacturer's instructions and remained effective.

Good

Is the service safe?

Administration records showed people received their medicines as prescribed. Some people's medicines were administered on an "as required" basis. There were detailed plans for the administration of these medicines; together with records of the circumstances they had been given. For example, a person with limited communication was prescribed pain relief on an 'as required' basis. The medicine plan informed of the signs staff should look out for to help them know if the person was in pain. This ensured they were given safely and consistently.

Staff completed training before they were able to administer medicines and had regular checks to ensure they remained competent to do so. This ensured staff continued to manage medicines to the required standards. Medicines were checked twice a day to make sure they were managed safely and people received their prescribed medicines.

The provider had systems to minimise risks in the environment, such as regular safety checks. These included health and safety checks and daily checks of equipment used to transfer people around the home.

Requires improvement

Is the service effective?

Our findings

Staff received the support they required when they first started working at the home so they were aware of their roles and responsibilities. A staff handbook and job description were provided and staff shadowed other colleagues and observed senior staff. The induction process gave new staff the skills they needed to effectively meet people's needs. One relatively new member of staff told us they found the time working alongside more experienced staff useful. They said, "I saw what they (staff) did, how they did it and learnt about people's routines." The Care Certificate was introduced by the government in April 2015 to support workers to have a knowledge and skill base to provide compassionate, safe and high quality care and support. The Care Certificate had not been implemented at the home, however the registered manager told us this was planned.

Staff received regular training in all areas considered essential for meeting the needs of people in a care environment safely and effectively; for example, food hygiene, infection control and safe moving of people. Staff told us they found the training useful. One staff member said, "We do have a lot of training," and another said, "The training is really, really good here. It is updated on quite a regular basis." We asked staff if there was any other training they felt they needed. One responded, "Not for the time being with the clients we have got now." We saw staff had a good understanding of people's behaviour and how to identify and reduce the opportunities for behaviours becoming challenging. One person had recently been reviewed by their psychologist. The psychologist was going to visit the home to guide staff on how to prevent behaviours escalating. A member of staff told us they felt further training in positive behaviour management would help them respond to people who could demonstrate challenging behaviours.

Staff told us the registered manager carried out observations to check staff competency. Recent observations had been completed of staff giving people their medicines and supporting people with personal care to ensure they were putting their learning into their everyday practice.

Staff had regular supervision meetings where they could discuss their role within the home. One staff member explained, "You can speak to your manager and if there is anything you are concerned about you can speak to them on a one to one basis." Another said, "I think it is good. They ask if you have got any problems, if you want to raise something, if anything has changed or they need to tell you to improve on something."

The Mental Capacity Act 2005 (MCA) sets out the requirements that ensure where appropriate, decisions are made in people's best interests when they lack capacity to do so for themselves. Staff had not received training in the MCA, but the registered manager told us that it was planned. They explained, "In the interim I have given hand-outs about the five core principles (within the legislation) and how we are going to implement it so they are aware."

The registered manager had an understanding of the principles of the MCA but they had not always been put into practice. The registered manager told us people living at the home lacked capacity to make certain decisions for themselves. We asked the registered manager how they assessed people's capacity and were told they had not completed any mental capacity assessments. We checked one person's care plans and there were no capacity assessments completed that would tell staff what that person was able to consent to.

Staff had some understanding of the principles of the MCA. One staff member said, "The Act says you have to assume capacity exists unless it has been assessed they haven't. If they haven't got capacity you have to act in their best interests." However, we found staff had different understandings of who had capacity to make their own decisions. One member of staff told us, "They all have," whilst another member of staff told us, "I think [person] has capacity to make her own decisions." When we asked if they were the only one, they responded, "Yes." One staff member said, "They might need a bit of guidance on some things," but staff were not clear what specific decisions people needed guidance with. The registered manager told us that any complex decisions would be taken in the person's 'best interests'. They explained, "If the GP says [person] needs a procedure to take place, then there would have to be a multi-disciplinary meeting." They told us the meeting would involve all those involved in the person's care and their family. They went on to say, "If they haven't got any family, an IMCA (Independent Mental Capacity

Requires improvement

Is the service effective?

Advocate) as well. We have had an advocate out for [person].” An IMCA represents those people who do not have a family member to make key decisions in their lives such as medical treatment or financial matters.

The registered manager told us they recently received guidance from a mental capacity assessor and had started to complete cognition and orientation assessments for everyone. They assured us they would complete decision specific assessments as a priority so staff were clearer about what decisions people were able to make themselves, what decisions they needed support with and what decisions staff needed to make in their best interests.

Care staff knew they could only provide care and support to people who had given their consent. One staff member said, “You have to respect their wishes. People have the right to say no. You give them time, and go back later and try again.”

The MCA and DoLS require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. The registered manager understood their responsibility to comply with the requirements of the Act. They told us applications had been submitted to the supervisory body, but no outcomes to those applications had yet been received.

One person told us the food was “nice” and said they liked chicken ravioli. They confirmed staff cooked them chicken ravioli when they wanted it. People were supported to make choices about the food they had and were encouraged to eat a healthy balanced diet. One staff member explained, “The managers have made a menu of what people like and it is changed every week. They can have something else if they don’t want it. It is not set in stone, it is just guidance.” We looked at one person’s care plan which contained information about their likes and dislikes. We saw the meals they preferred had been included on the weekly menu displayed in the kitchen. Where people had specific nutritional needs, there was information available for staff. For example, one person had to have their food pureed and another had to have their food cut into small pieces. Staff we spoke with were aware of each person’s specific nutritional needs. Where people had concerns around their nutrition, their food and fluid intake was recorded to ensure they were eating and drinking enough to maintain their health.

Staff supported people to attend appointments with other health professionals, such as doctors, psychologists, psychiatrists, physiotherapists and dieticians. A psychologist had recently asked staff to record information about one person’s sleep patterns. Staff were completing the records as requested. Records were also maintained of any behaviour that could cause a person to become agitated. These were shared with the psychologist at regular meetings to ensure staff continued to support the person in the most appropriate way.

Good

Is the service caring?

Our findings

When we asked one person if staff were kind, they told us they were. During our visit we saw staff were aware of people and attentive to their needs. There were friendly interactions with people, and staff spoke respectfully and explained what they were doing as they supported people around their home. One staff member told us, "I look on them as family. I treat them as I treat my own family members and how I would like my family to be treated."

We asked staff whether they thought the support provided within the home was caring. Staff told us they thought it was. One staff member told us, "I would like to think we all put 100% into it." We asked what that meant, and they responded, "Coming in with a smile and making things happen." Another staff member told us people's positive reactions to staff indicated they felt cared for. They explained, "The staff like the clients and they have their relationships with them. Each time you come in they (people) are welcoming and happy to see you. You build that relationship with them." Staff we spoke with told us they enjoyed working with the people who lived in the home and we saw people reacted positively when staff approached them. The registered manager told us they thought staff were caring and went on to say, "[Person] likes staff interaction and staff are very embracing of her."

One person was given a hand massage by a member of staff. There was lots of discussion between them about television programmes they had watched the night before while this was being done. When the massage was finished, the person gave the staff member a hug to say thank you.

Staff told us they involved people as much as possible in making daily choices and decisions. This included what they would like to wear, what food and drink they wanted and what activities they would like to take part in. One person was going into town shopping. Staff asked, "Are you going to have a drink out? Do you want to take your cup?"

Although people had very complex physical needs, they were encouraged to complete daily tasks around the home if they were able. This encouraged people to maintain some independence in their every day lives and gave them a sense of involvement in the running of the home. Staff understood the importance to people of achieving as much as possible. One staff member explained, "[Person] can make their own cup of tea assisted. She will make cakes, she does the whisking. She can butter her own bread."

People were supported to maintain relationships with others who were important to them. One person had a relative in another residential home and staff supported the person to visit their family member there. Staff were also liaising with staff in the other home to arrange for the person and their relative to go on an outing together. Staff went to collect the relatives of another person so they could spend time together.

Staff treated people respectfully and explained how they supported people with personal care in a way which helped ensure their privacy and dignity was respected and protected at all times. One staff member explained they "stood outside" bathroom doors and only entered when people indicated they were ready for support. Another member of staff told us, "You have to treat everyone as an individual, with respect and dignity." We observed one member of staff say to a person, "There is a letter here for you, would you like to open it?" The registered manager told us their observations when working with staff confirmed they were respectful. They explained, "To me it is the little things that can be most significant."

People had been encouraged to make their rooms at the home their own personal space. There were ornaments and photographs of family and friends, personal furniture and their own pictures on the walls.

Good

Is the service responsive?

Our findings

People were encouraged to participate in activities outside the home. People were supported to go shopping, go out for meals in local restaurants and participate in activities in the community. For example, one person enjoyed going to a day centre three times a week. Another person enjoyed going to buy their own newspaper and having a coffee in town. They also liked to visit a local pub in the early evening and a member of staff told us they would be supporting that person to go out later that day. The registered manager explained, "[Person] getting out at night is the key to her happiness." An important aspect of another person's life was to go shopping daily. On the day of our visit they told us they were going shopping to buy a new purse and have a drink in town. We were later able to see some of their recent purchases displayed in their bedroom.

A member of staff told us they supported people to go on outings further afield. "We've been to the zoo and the chocolate factory." Two people were going bowling the week after our visit. One person had recently been to see a theatre show they had chosen for themselves out of a magazine. A staff member said, "Anywhere they want to go, we will take them." The registered manager was keen to promote this aspect of people's lives. They explained, "Once a month I would like each one of them to do a significant activity."

Each person had a care and support plan which contained a wide range of information in areas including communication, behaviour and social needs. Information in support plans guided staff as to how to deliver planned care to maintain people's health. People's daily routines and preferences were described in detail so staff were able to support people as they wanted to be supported. They also contained information about what people were able to do for themselves and where they needed prompting or complete support. The plans also identified how staff should support people emotionally, particularly if they became anxious or agitated. For example, one person could become anxious when visiting other healthcare professionals. There was information in their care plan informing staff how they needed to respond to this anxiety and what action they should take to minimise the person's concerns. This information meant staff had the necessary knowledge to ensure the person was at the centre of the care and support they received. During our visit we saw staff providing care in line with people's individual care plans.

Where people had limited communication there was information in the care plans so staff understood how to respond appropriately. For example, in one person's care plan there was a dictionary of phrases they used and what they meant.

Each person had 'daily documents' containing guidance notes about people's support needs to which staff could quickly refer. These were particularly helpful to new staff in the home. The daily documents also contained a copy of people's hospital passports. These are documents that contain important information about people's needs, abilities and preferences. They ensure hospital staff have knowledge about people so they can respond appropriately to both their physical and emotional needs.

There were systems in place for staff to share information through handovers between shifts, and team meetings. This ensured staff had the information they needed so they could respond to changes in people's physical and emotional needs.

The manager told us there had been no formal or informal complaints made about the service. There was no information displayed within the home about the home's complaints procedure, but due to people's needs, staff understood they had to be vigilant to identify if people were unhappy. Care plans contained information about how people would show they were happy or unhappy. One staff member explained, "Normally [person] is very happy. By the expressions on her face, you would know she was in pain or not happy." Staff told us they would support people to make their concerns known. One member of staff said, "I would tell her if it was something that was putting her at risk, I would have to tell the manager, I would listen to her and see if I could help."

Requires improvement

Is the service well-led?

Our findings

None of the people who lived in the home were able to tell us what they thought about the quality of the service because of their complex needs.

At the time of our visit the registered manager was managing two other care homes for Individual Care Services. The day to day management of Wembrook Close had been shared with a house leader, but they had recently moved to provide support to another of the provider's services. The registered manager said they recognised they had other managerial responsibilities, but tried to visit the service every day they worked. The registered manager told us they took one day off during the week and worked most weekends. They explained, "Weekends are just as important to me as days in the week."

However, there was no clear leadership of the service when the registered manager was not in the home. Staff spoke highly of the registered manager, but acknowledged the impact when she was not there. Comments included: "[Registered manager] is very nice and very supportive. If you have any concerns she supports you." "At weekends she always comes around to make sure you are okay" "[Registered manager] is alright, she knows what she is talking about." One staff member told us, "There has been a big change recently. [Registered manager] tries to drop in every day. Sometimes it is a for a few hours and sometimes less than an hour." They went on to explain this meant there was often no shift leadership in the home and said, "We haven't got a (home) manager and we haven't got any shift leaders. The staff pick up on things that need to be done, but we don't get the credit."

The registered manager had identified this was an issue. Changes to the higher management structure had been implemented and the registered manager had scheduled a meeting to discuss the home. They explained, "We don't have a permanent leading role at the moment and I think we need one." They went on to say, "We have a complex client group. With any client group you need a leader, but with a complex client group staff need a lot of support. The way forward is to get a leader or manager in place. But to ensure the service is safe, I think it is important a percentage of my day is over here and I am achieving that."

Staff told us they worked as a team and valued the support they received from other staff members. One staff member told us, "I think the team we have got are a credit to this house." Another said, "We work together as a team. We watch out for each other and share our roles and work together."

Staff meetings took place regularly and were an opportunity for staff to put forward suggestions for the service provision. They were also used to discuss any developments in working practice and changes in people's individual support needs.

There were informal systems in place so people who lived in the home could share their views about how the home was managed. For example, people had recently had a meeting to discuss what meals they would like to have. The home had previously sent out questionnaires to people, relatives and visitors asking for their views on the service provided. The last questionnaires had been sent out in 2013. The registered manager told us further questionnaires needed to be sent to capture people's views and ensure they were happy with the level of care provided.

There was a process for recording accidents and incidents but there had been none in the 12 months prior to our visit. There were other checks such as health and safety and medication checks to ensure the safety and quality of the service.

The registered manager understood their legal responsibility for submitting statutory notifications to the CQC, such as incidents that affected the service or people who used the service.