Lifeways Community Care Limited

Woodlands Cottage

Inspection report

Woodlands Cottage
Fernlea Drive, Scotland Gate
Choppington
Northumberland
NE62 5SR

Tel: 01670828487

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Woodlands Cottage is a residential home for up to four people with learning and physical disabilities. It is located in the village of Choppington in Northumberland.

The inspection took place on 28 January 2016 and was announced. We gave short notice as it is a small service and people often go out to day care services and take part in activities in the community. We wanted to be sure that someone was in.

The service was last inspected on 25 April 2014 and all regulations that we inspected at that time were met apart from those relating to quality assurance and governance arrangements. The service was re-inspected in November 2014 and this regulation had been met.

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

Staff had received training in the safeguarding of vulnerable adults and robust staff recruitment procedures ensured people were protected from abuse.

Checks on the safety of the building and premises were carried out, and individual risk assessments were carried out to identify risks to individuals living in the service. Care plans were in place to address these risks and staff were skilled and knowledgeable in relation to people's specific health needs or risks posed by the use of specialist safety equipment.

Systems were in place to ensure that medicines were managed safely. We saw that there were appropriate procedures in place for the receipt, storage and administration of medicines.
There were suitable numbers of staff on duty during the inspection and a number of new staff had been appointed following a period of short staffing last year.

The service was clean and there were appropriate infection control procedures in place. Bedrooms were personalised and homely.

Staff were suitably trained and had undergone safety training including in the use of specialist equipment and moving and handling. A new induction process meant that staff had received training before commencing work and they were given opportunities to shadow experienced staff before working more independently. The manager was diligent in ensuring unfamiliar staff were introduced to people using the service gradually as some people found new staff unsettling.

Appraisal and supervision systems were in place and staff supervision was happening more frequently

following a period of short staffing last year.

People had access to health care services. We saw that people had attended community based health appointments and where there were concerns about the health of people using the service, these were addressed promptly. Specialist support was sought where appropriate from speech and language therapy professionals, or occupational therapy teams. Hospital Passports were in place to support people with Learning Disabilities if they were admitted to hospital.

The service was working within the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Applications had been submitted to the local authority for assessment and authorisation where necessary. Capacity assessments had been carried out and decisions taken in the best interests of people were documented.

People were supported with eating and drinking and had individual care plans which responded to their needs, preferences and risks. We saw that staff supported people at mealtimes and followed instructions identified in care plans.

Staff were caring and respectful towards people during the inspection. They demonstrated through their interactions with people that they knew their individual needs and preferences well. Staff showed skill while supporting people and were able to balance a need to set boundaries to maintain the safety of a person, with humour and a good deal of kindness. Relatives told us they were very happy with the care provided which they said they could not fault. We saw that the privacy and dignity of people was maintained.

Person centred care plans were in place in word and pictorial format. One page profiles were in place which provided detailed information about how best to support people. People were supported to take part in a variety of activities and interests. These were designed to suit their particular interests and preferences. Activities were accessed in the community and we saw that people had access to things they enjoyed in the home such as music and a trampoline.

There had been one complaint received by the service. We saw that this had been acted upon appropriately and action had been taken to prevent a reoccurrence of the same issue.

Staff and relatives spoke highly of the registered manager's dedication, experience, knowledge and leadership skills. Satisfaction surveys had been distributed and the manager and provider carried out regular audits to monitor the quality of the service provided. Regular meetings were held with staff, and staff told us there was a good culture and atmosphere in the home, and that staff morale was good.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Safe recruitment procedures were followed which meant staff were vetted to ensure they were not barred from working with vulnerable adults

Medicines were managed effectively and staff were suitably trained in the administration of medicines.

There were sufficient numbers of staff deployed to ensure the safety of people using the service.

Is the service effective?

Good

The service was effective.

Staff induction procedures ensured people had basic training prior to starting work, and had the opportunity to shadow experienced staff.

People were well supported with eating and drinking and support was tailored to meet their specific needs and preferences.

The service was working within the principles of the Mental Capacity Act 2005 and had submitted applications to the local authority to deprive people of their liberty lawfully where needed.

People's health needs were met through accessing community based health care. People with complex health needs were supported by appropriate professionals

Is the service caring?

Good

The service was caring.

We saw that staff spoke kindly and respectfully to people.

Staff had a detailed knowledge of the subtle yet important body language of people unable to communicate verbally, which allowed them to respond to their emotional needs.

Staff ensured that people's dignity was preserved. The provider was protective of people's interests, and demonstrated this by ensuring staff were introduced to people gradually before allowing them to care for them.

Is the service responsive?

Good

The service was responsive.

People had varied interests and social preferences. We saw that these were catered for individually.

Person centred care plans were in place and contained detailed information about each person. This meant that staff knew how to care for people in the way that they preferred.

People were able to exercise choice over how they spent their time.

Is the service well-led?

Good

The service was well led.

A registered manager was in post. The manager was supported by a deputy manager. Staff told us the managers were supportive and dedicated.

The registered manager carried out regular audits and checks to ensure the service was safe and effective.

The views of people were sought where possible, and systems were in place to gather the views of relatives and other stakeholders.

Woodlands Cottage

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 28 January 2016 and was announced. We gave short notice as it is a small service and people often go out. We wanted to make sure that someone was in.

The inspection was carried out by one inspector. We spoke with people using the service, but due to communication difficulties, the information they were able to share with us was limited. We observed their care during the day and joined two people for lunch.

We spoke with local authority contracts and safeguarding officers. They told us that they were not aware of any concerns about the service, and there were no on-going safeguarding investigations.

We spoke with the one person's relatives. We also spoke with the manager, four staff and the nominated individual for the service. We looked at the recruitment records for two staff and the care plans of four people. We checked records relating to the management of the service and records of safety checks to the building and equipment. We observed the administration of medicines.

Prior to carrying out the inspection, we reviewed all the information we held about the service. We did not request a Provider Information Return (PIR) from the provider. A 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.

Good

Is the service safe?

Our findings

We spoke with the relative of one person who said, "I can't fault the care my relative receives. We are so reassured that they are there".

Staff had received training in the safeguarding of vulnerable adults, and were aware of how to recognise and report signs of abuse or neglect. One staff member told us, "We have done training, and refreshers. I would definitely know the signs of abuse and I would report anything straight away to my manager." There had been no safeguarding investigations or notifications to the Care Quality Commission (CQC) regarding any incidents of abuse. Systems and procedures were in place to be followed in the event that a safeguarding incident did occur in the future.

Individual risk assessments were in place. This was particularly important as some people had very complex physical needs, which meant staff had to be specially trained in order to deliver care safely. For example, one person had a Percutaneous Endoscopic Gastrostomy (PEG) in place. PEG is a form of specialist feeding where a tube is placed directly into the stomach and by which people receive nutrition, fluids and medicines because they are unable to take these items orally. Staff had received training to manage this safely. Specialist equipment used by people could also cause harm if used inappropriately. For example, a padded sleep system designed to maintain the posture of a person when sleeping. Staff were trained before using this equipment and told us that safe use of equipment was taken very seriously by the manager who ensured all staff received training. One staff member told us, "X [Name of manager] does everything by the book. There is no cutting corners here." Bed rail risk assessments were carried out six monthly. This demonstrated that care was managed in line with safety procedures.

Systems were in place to ensure the safety of the premises and equipment. These included checks to hoists and overhead tracking which helped to move people safely. These checks had been completed recently. We saw evidence of electrical and gas safety checks. Emergency fire evacuation plans were in place, including those for individuals using the service. Regular fire drills and checks of fire- fighting equipment had been carried out.

Audits and safety checks were recorded on an electronic system and these were detailed and up to date. They included specific information, for example, including the dates that cars belonging to people using the service had completed their MOT (road safety check) and individual records relating to people using the service such as accidents and incidents. We saw that there had been no serious incidents requiring notification to the care Quality Commission.

We observed there were suitable numbers of staff on duty on the day of the inspection to meet the needs of people using the service. A member of staff told us, "There are four of us on duty today which feels like a lot, but we can manage with less as everything is so well organised." One member of waking staff was on duty at night. Another service belonging to the organisation operated next door and the fire alarm was linked to that building. We were told that in the event of a fire at night, staff from the next door service would be alerted to assist.

We checked the recruitment files of two staff. We found that appropriate checks had been carried out such as checks by the Disclosure and Barring service (DBS). The DBS checks whether applicants have a criminal record or are barred from caring for vulnerable people. This meant that staff were suitable to work with vulnerable people. Two references were obtained for each applicant.

Medicines were managed safely. Staff had received training in the safe administration of medicines and had all completed refresher training. There were suitable procedures in place for the receipt, storage, administration and disposal of medicines. Staff described the procedures they followed, and said, "We make sure we give the correct medicine, of the correct dose, to the correct person, by the correct route, at the correct time." Staff told us and records showed they counted the medicines belonging to people at the beginning and end of every shift, and also checked the medicine administration records for each person to ensure medicines had been given and signed for. In addition, managers also carried out regular audits of medicines. The temperature of the area where medicines were stored was checked daily. This ensured that medicines were stored at the correct temperature and remained safe for use. This is important as some medicines deteriorate in effectiveness if stored incorrectly. There were no controlled drug (medicines that are liable to misuse) in use at the time of the inspection. Facilities were available to administer these medicines if required. Minor medicine errors were documented on the electronic recording system and had been acted upon appropriately.

Suitable arrangements were in place to maintain health and hygiene in the home. Infection control policies were in place based on Department of Health guidelines, and staff were aware of the procedures to follow. Staff were responsible for cleaning the home, which was clean and there were no malodours. Staff described the cleaning procedures which included the use of different coloured cloths for different cleaning tasks. We observed staff washing their hands between supporting people, before cooking meals and between administering medicines to people.

Good

Is the service effective?

Our findings

Staff were suitably trained. We saw that staff had received training in key areas such as moving and handling, safeguarding, dignity and respect, confidentiality, food hygiene, infection control, safe management of medicines and fire safety. Training was up to date; with the exception of Mental Capacity Act 2005 training for some staff which we saw was booked for the following month. Staff told us they thought they received adequate training and one staff member said, "We do a lot of training and if there is any training we want to do, the manager tries to arrange it for us."

In addition to mandatory training, staff received training relevant to their role. One member of staff told us, "We've done extra training like epilepsy training which is useful in this role." This meant that staff had been trained to support people with specific health needs.

A new system of staff induction had been introduced. This involved new staff completing basic training off site prior to commencing work in the service. They then had opportunities to shadow experienced staff and were given a detailed induction hand book. They were given timescales by which to complete further e-learning (training via the computer). A staff member told us, "It's good that new people are coming with good basic knowledge before they start, especially if they have never worked in care. They get a really comprehensive induction and they know some of the legal requirements before they start."

Appraisal and supervision systems were in place, but there were gaps in the records of supervision carried out. The manager explained that this had occurred during the period of short staffing. We saw that plans were in place to address this, and staff told us they felt well supported. They said, " We can go to the manager or deputy at any time. They are both really approachable and if we are unsure of anything we just ask. The manager is very knowledgeable and passes that on to us."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). 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. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager had submitted applications to the local authority for authorisation and was aware of the need to notify the Commission of the outcome of these applications.

Mental capacity assessments had been carried out and we saw that specific decisions taken in people's best interests had been documented. Formal arrangements were in place for the local authority to manage the finances of some people through appointeeships for example. Where people lacked capacity to consent to

care plans, it was documented that the care plan review had been held in their best interests and outcomes of the review had been recorded.

People were supported with eating and drinking. Staff cooked meals and were aware of people's special dietary needs and personal preferences. Eating and drinking screening tools were used to risk assess the way in which physical and behavioural concerns might impact upon eating and drinking safely. Food plans had been developed for staff to follow at meal times. These contained detailed information about the level of support people needed during their meal.

Choking risk assessments had been carried out. Nutritional assessment tools were in use and peoples' weights were monitored and appropriate advice sought in the event of concerns. We joined people for lunch and observed staff supporting people. We found that the level of support they received was consistent with the care plan in the place for the individual. People were supported to make choices about their meals. Picture menus were available. Staff explained that it was not always easy for people to choose from menus but that they took people food shopping with them so that they could physically see food and choose anything they fancied. Staff competency assessments were in place to check staff understanding of the needs of people with dysphagia (swallowing problems).

Health needs of people were recorded in their care plans. We saw that people had regular access to health professionals which they accessed in the community. Specialist support was available when necessary including speech and language therapy (SALT) for issues relating to swallowing, or occupational therapy (OT) for example. Hospital passports were in place, the aim of the hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital.

The premises were suitably designed for people using the service. Bedrooms were nicely personalised and specialist equipment such as assisted baths and tracking hoists were available. We found some wear and tear to the premises including damage to some paint work and a carpet which had some damage. We saw that these had been identified by the manager and repairs had been requested. Some areas of the home had been redecorated and there were plans to turn the sun room into a Snoezelen room (a multi-sensory room).

Good

Is the service caring?

Our findings

People looked well cared for and a number of compliments had been received by the service confirming this. One compliment received had thanked staff as on their last visit their relative was "beautifully dressed". They commented that they were "looked after very well and they wanted to thank staff". We spoke with a relative who said, "We can go unannounced and [name of relative] is always clean and happy as they can be."

We observed positive caring and respectful interactions with people by all staff during the inspection. We saw that staff knew people well. One staff member said, "We know what people like and we deliver care to suit each person. For example, some people hate noise, and like peace and quiet. Other people like noisy activities and loud music! Some people like hands on and pampering."

Not all people using the service were able to communicate their needs verbally. We saw that staff recognised subtle non-verbal communication and responded accordingly. Staff explained that the non-verbal signal one person was displaying was that they wanted to be tickled. Staff responded accordingly and the person smiled broadly. Another person used Makaton to communicate their needs and were gently prompted and encouraged to do so by staff. Makaton uses signs and symbols to help people to communicate.

Staff spoke kindly with people. We heard one staff member complimenting one person by saying "You look lovely in that dress." The person appeared very happy to hear this. People were supported to choose and wear clothes that were appropriate to their age and preferred style. A relative told us, "The staff are very particular, they always make sure [name of relative] hair is cut regularly and that they have nice clothes to wear. They put a great deal of effort into that."

We joined people for their meal and we saw that support was provided in a way which maximised the potential of people to do as much as possible for themselves, with some agreed boundaries at times to ensure safety. We saw that this was managed well by the staff member who supported the person sensitively, and was very caring in their response when necessary. There was a good deal of humour and the meal was sociable with staff joining people at each meal time.

Staff told us that they were conscious of the need to include people using the service. They said, "We are taught that we must never sit and chat to each other without involving people." We saw that they included people at all times during the inspection.

Staff told us that the service was caring. A new member of staff with previous care experience told us, "The care is fantastic here. I'm still picking things up, I won't be put in straight away with people until they are used to me." A number of references were made to introducing staff to people gradually, as some people were unsettled by the presence of new staff in the home. Another staff member said, "There is a family feeling here. We all get along so well, and they [people] are so well looked after." We asked staff what they enjoyed about their job. One staff member told us, "I wanted to make a difference and help people to do

things they wouldn't be able to on their own."

Privacy and dignity was maintained. When medicine was administered via the PEG of one person, this was carried out in the privacy of their bedroom. We saw that personal equipment and supplies were stored discreetly in drawers to support the privacy and dignity of people. Daily records contained detailed observations, including noting that someone had a broken fingernail. This demonstrated that levels of observation were good. Records were stored correctly to maintain confidentiality.

End of life documentation as available, and we saw that the family members of some people had been consulted about this where they lacked capacity and it was deemed appropriate. For other people the documentation was available for completion at a later date if necessary.

Good

Is the service responsive?

Our findings

Person centred care plans were in place. They were available in pictorial and written formats and were detailed and specific. Pictorial care plans are helpful for people who might have difficulties reading and understanding what is written about them. They included information relating to physical, psychological, and social needs, such as communication, eating and drinking, mental health and emotional support, getting about, personal safety, work and learning, and behaviour. Most of these were reviewed regularly but we found a small number of gaps in review dates which we fed this back to the manager who said that they would address this, and that the new care plan system would help improve record keeping. Bi annual (twice yearly) person centred reviews had been carried out; this was due to be completed in 2016 and involved a thorough review of the care plans to ensure they were person centred and up to date.

Each person living in the service was allocated two key workers. The manager arranged it so that people had at least one key worker who could drive, as three people had their own transport. Key workers were given specific roles and responsibilities including contributing to the development and review of care plans. The manager told us the provider was in the process of transferring care plans to a new format company-wide which was designed to streamline and improve the way that information was recorded. There were plans to incorporate risk assessments into the new care plans to avoid duplication. One new staff member told us, "I have read all the care plans. There is so much to take in! They help you to get to know the people really well, and it is nice to know about their background."

A one page profile was available which contained detailed information at a glance about each person. This included information such as "What is important to me" and "How best to support me". These also contained essential information such as next of kin, GP, diagnosis, and safety and equipment needs. Care plans were in place relating to specific needs including behaviour support plans or care plans relating to the management of epilepsy. The service had begun using body maps alongside care plans, for example to record where there were any concerns noted in relation to people's skin for example. Body maps contain a picture of the front and back of the body and allow staff to record precisely, where on the body there is damage to skin, injuries, or bruising for example.

People were supported to take part in a variety of activities. A member of staff told us, "There are lots of outings and activities. We go on the bus or in people's cars, we have been to football and swimming, and we are planning to go horse riding." Another staff member said, "I am taking two people to the wrestling, I'm really looking forward to taking them." Two people attended a day centre on the day of our inspection. One person went out with a member of staff and another person spent time in their bedroom relaxing and then spent time with staff. Staff described how people enjoyed spending their time, and what made them feel relaxed. They knew, for example, that upon return from the day centre one person would probably like a cup of tea and to sit and watch television, and that they might be quite tired. We saw that this was the case and the person chose to do this upon their return home. Staff had the kettle on in readiness. One person had a trampoline in the garden for use in good weather, and another person enjoyed using a keyboard.

We heard that another person had regular aromatherapy sessions and we saw that activities were tailored

to suit the needs of people and ranged between being physically more active (such as attending discos and dancing) and multi- sensory (using sensory activities including touch and smell to stimulate or relax). These included the aromatherapy, use of the spa bath, and sensory lights for example. People had been supported to go on holiday, including to a specially adapted hotel in Blackpool, and abroad.

People's individual needs and choices were met in a variety of ways. Where people were unable to communicate easily, their individual signals and non-verbal communication were used to judge how they felt about certain issues. These were recorded in the communication section of their care plans which demonstrated that people were involved as far as possible in decisions about their care.. The service had also asked the day centre staff to record whether people appeared to be enjoying the experience on a daily basis, as they could not necessarily express this verbally. This helped staff to determine whether they would choose to continue to attend. This demonstrated that staff tried a variety of ways to understand the views of people with limited communication.

There had been one complaint received by the service. This was documented including a record of the response to the complainant. Appropriate action had been taken to demonstrate lessons learned and we saw that policies and procedures had been updated to prevent re-occurrence. The complaints procedure was available to people.

Good

Is the service well-led?

Our findings

A registered manager was in post and was supported by a deputy manager. Staff spoke highly of the manager and one staff member said, "The manager is very caring and has people at the centre of all she does." Another staff member said, "[Name of manager] is the best manager I have ever had. She listens to what you want to learn and is open to our ideas about how we could improve things." A relative told us, "We are very happy with the way the service is run. I have nothing but praise for the manager and staff. We can't know what happens when we aren't there but we are as confident as we can possibly be that the care is consistently good. The manager makes sure [name of person] has all they need. We would be very upset if she ever left the service."

The nominated individual for the service visited regularly, and was present on the day of the inspection. Staff told us that senior managers visited regularly and one member of staff told us, "Even senior managers are very approachable and ask how things are going."

Staff told us there was a supportive culture in the service. One staff member said, "We have a really good team. The morale and atmosphere in the home are good. We observed that the manager was in regular contact with staff and people. She had a strong ethos of person centred care which she reinforced regularly throughout the inspection. She had worked in the home for a number of years and knew the individual people living there very well. We observed the manager dealing with an employment issue with sensitivity and in a way which showed consideration for the individual concerned, and then spoke with them confidentially.

Regular meetings were held with staff including a company-wide monthly team brief with registered managers, three monthly meetings with deputy managers, and bi-monthly house meetings. This meant that there were regular opportunities to brief staff and share information within the team.

The manager carried out a number of audits. These included essential safety checks which were recorded electronically. We saw that actions had been recorded following each audit and reviewed the following month. The manager also carried out audits of people's finances and care records. Medicine audits were also carried out. The electronic system used to record audits and reviews used a traffic light system. For example, risks or outstanding work would appear in red. The manager explained that this was linked to their calendar on the computer so that any important audits or reviews would automatically transfer into their diary. This helped to ensure that important tasks were not missed.

The provider carried out regular quality visits. One had taken place two days before our inspection and we saw that these involved sampling records, reviewing staffing, including staff attitude, and observing the general appearance and atmosphere in the home. Annual quality audits were also carried out. "How are we doing" surveys were provided to relatives and stakeholders. The manager had developed a daily handover checklist to ensure that all essential tasks were carried out during each shift. These were in addition to formal audits completed by the manager. Staff had to sign that verbal and written handovers of information between each shift had been completed, keys were handed over to the next shift, medicines had been given

and signed for, and that petty cash and "clients" monies had been counted and was correct. Staff also had to ensure that fridge and freezer temperature checks had been completed and that the diary had been checked and all daily records had been completed relating to the care of people. They were also responsible for checking incoming mail and carried out visual checks of the safety and security of the premises.

There had been no statutory notifications to the CQC since the last inspection as there had been no notifiable incidents. Statutory notifications include information that the provider is legally obliged to send to the CQC. The lack of notifications could have been due to the size of the service and the fact that people received almost one to one staff attention. We checked that the manager was aware of the information that must be notified to CQC in line with legal requirements and they confirmed that they were. They were also aware of the need to notify us of the outcome of applications to deprive people of their liberty.