La Vita Nova Limited

Foxwell Cottage

Inspection report

Hunts Hill Road
Normandy
Guildford
Surrey
GU3 2AH

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13 September 2018

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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

The inspection took place on 13 September 2018 and was unannounced. This was the first inspection of the service since registering with CQC in July 2017.

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

Foxwell Cottage accommodates up to 4 people in an adapted building. The service provides support to people with learning disabilities and autism. At the time of our visit, there were two people living at the service. The service had been providing support to people since April 2018.

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

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

People's needs were assessed before they came to live at the home but we identified one instance in which the process would have benefitted from being more robust. We made a recommendation about assessments.

People's care was planned in a person-centred way with detailed information about what people liked and how to support them documented in care plans. Risk assessments were routinely carried out and measures were introduced to keep people safe. Where incidents had occurred, action was taken to reduce the risk of a similar incident reoccurring. Staff understood how to identify and respond to abuse and had received training in safeguarding adults. There were enough staff at the home to meet people's needs and the provider had carried out checks to ensure staff were suitable for their roles.

People were supported by caring staff who took time to offer choices and involve people in their care. People were encouraged to maintain their independence and develop skills. Staff worked with people to identify activities and people had individual activity schedules. Staff had received training and support which was tailored to the needs of the people that they supported. Staff told us that they felt supported by management and had opportunities to develop themselves.

Staff supported people to access healthcare professionals and information about their medical conditions

was documented in care plans. People's medicines were managed and administered safely by trained staff. The provider had links with important stakeholders, such as health and social car professionals and the local community. The home environment was clean and there were regular checks carried out to ensure it was safe. The home environment was suitable for people with appropriate signage and security.

The registered manager worked alongside staff to support people and there were systems in place to enable effective communication between staff. Staff were involved in the running of the service and felt supported by management. Staff knew people well and there were systems in place to enable people to make choices and involve them in decisions about their home. There was a complaints policy in place and where issues had been raised, these had been responded to. The provider carried out a variety of checks and audits to monitor the quality of the care that was delivered to people.

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.

Risks to people were assessed and plans were implemented to keep people safe. Staff responded appropriately to incidents.

Staff understood their roles in safeguarding people from abuse.

People's medicines were managed and administered safely.

The home environment was clean and regular checks were undertaken to ensure its cleanliness and safety.

There were sufficient numbers of staff at the home and the provider had carried out checks to ensure staff were suitable for their roles.

Is the service effective?

Good

The service was effective.

People's needs were assessed before they came to live at the service, but we identified one instance where the assessment could have been more robust.

Staff had training and support to equip them for their roles.

People's consent had been sought in line with relevant legislation.

People were supported to prepare food that they liked.

The home environment was suitable for the needs of the people that lived there.

Is the service caring?

Good

The service was caring.

People were supported by caring staff who involved them in their care.

Staff encouraged people to maintain independence and develop skills.

People's dignity and privacy was respected by staff.

Is the service responsive?

Good

The service was responsive.

Care was planned in a personalised way and care plans were regularly reviewed.

People had individualised activities schedules that matched their interests.

People and relatives were informed of how to raise a complaint.

Provision was in place to provide sensitive and personalised end of life care.

Is the service well-led?

Good

The service was well-led.

Staff felt supported by the registered manager and systems were in place to encourage good communication.

People were involved in the running of the service.

There were a variety of checks and audits carried out to monitor the quality of care delivered.

The provider had developed links with stakeholders and the wider community.

Foxwell 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 13 September 2018 and was unannounced.

Due to the small size of the service, the inspection was carried out by one inspector.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we spoke with two people, one relative and a social worker. We spoke with the registered manager and two care staff. We looked at care plans for two people including risk assessments, records relating to health and daily notes. We checked medicines records for two people. We looked at mental capacity assessments and applications to deprive people of their liberty.

We looked at a variety of checks and audits as well as minutes of meetings of staff, people and relatives. We looked at two staff files and checked records of staff training and supervision. We carried out observations throughout the day to observe staff practice and interactions with people.

Good

Is the service safe?

Our findings

Relatives told us they felt the service was safe. One relative said, "It's a lovely building and grounds are all secure." We met with people and observed that they looked comfortable around staff and were able to move safely around the home environment.

Risk to people were assessed and where risks were identified, plans were implemented to keep them safe. Risk assessments covered areas such as behaviour, choking, epilepsy and accessing the community. One person could sometimes become anxious which meant they sometimes displayed behaviours that required a response from staff. This risk had been assessed and a plan was implemented which documented words and actions that could make the person anxious and trigger them to become anxious. There were detailed guidelines for staff on how to support the person if they were anxious, allowing them space and time to relax. Both care staff we spoke with were knowledgeable about how to support this person safely.

Where incidents had occurred, action was taken to prevent them from happening again. Staff documented any incidents at the service and recorded what happened and the actions that they took. At the time of our visit, there had only been two incidents and these showed appropriate responses from staff. For example, one person had become agitated and caused a minor injury to a staff member. In response, the person's behaviour plan was updated as this incident had identified a trigger for the person and this was added to their care plan. Incidents were documented centrally and analysed by the provider in order to identify patterns or trends.

Staff understood their roles in safeguarding people from abuse. Staff had received training in safeguarding adults and this was regularly refreshed. Staff were knowledgeable about the signs of abuse and how they would respond if they suspected that abuse had occurred. One staff member told us, "I would contact the manager first. I would then contact you guys [CQC] or the safeguarding team."

People received their medicines safely. Medicines were stored securely in a tidy and orderly manner. Staff checked the temperatures of storage areas daily to ensure medicines were stored at the manufacturers recommended temperature. Regular stock checks were undertaken and staff documented when they had done this. Medicines were administered by trained staff who had their competency checked. We saw that where errors had occurred, staff were re-trained and had their competency re-assessed.

Staff were knowledgeable about how to follow best practice with medicines. One staff member showed us how they checked medicine administration records (MARs) to ensure they administered the correct medicine. They had a good knowledge of best practice and how to complete MARs accurately. We saw that MARs were accurate and kept up to date with no gaps. The provider regularly checked MARs as a part of their audits and staff told us they flagged up if they found gaps from a previous shift so that action could be taken to address them.

People lived in a clean home environment and systems were in place to reduce the risk of the spread of infection. The home was clean and cleaning tasks were allocated to staff each day. We checked these

records and they were completed daily with staff signing to show tasks were completed. The provider also carried out a monthly infection control audit to check the cleanliness of the home. Staff had received training in infection control and were observed following best practice. Staff washed their hands before preparing food and drinks and the provider had personal protective equipment (PPE), such as gloves, available for staff to use.

The provider ensured people lived in a safe home environment. Regular checks were carried out on the safety of the home and there was equipment and systems in place to reduce the risk of fire. People were involved in regular fire drills and records were kept which detailed the support people would need in the event of an evacuation. Records showed regular checks and services were carried out on electric and gas installations and tests were conducted to check for legionella.

There were sufficient numbers of staff to safely meet people's needs. Staffing numbers were calculated based on people's needs and their routines. During the inspection, we observed people had staff with them at all times and staff engaged with people in games and activities. Where people had activities outside the home, staffing levels were planned to ensure that this could take place. Rotas showed people were supported by a consistent staff team that they had got to know well.

Checks were carried out to ensure staff were suitable for their roles. We saw evidence of recruitment checks taking place before staff came to work at the service. Staff files contained evidence of work histories, references, health declarations, proof of right to work in the UK and a check with the Disclosure & Barring Service (DBS). The DBS carries out criminal records checks and holds a list of potential staff who would not be appropriate to work in social care.

Good

Is the service effective?

Our findings

We received feedback that the process for assessing people's needs was not always robust. A relative told us, "They visited [previous placement], but they are still getting used to [person]."

The provider gathered information about people's needs before they came to live at the home, but we did receive feedback that this could be improved. Where one person had recently moved in, we saw evidence of the provider carrying out an assessment which identified the support the person required as well as their preferences. We saw evidence of input from relatives, healthcare professionals and staff from their previous placement. The registered manager had visited the person at their previous placement and met with their relatives before they moved in.

However, the person's relative told us there had been some disruption when the person first moved in and staff had lacked understanding of their needs. This caused relatives to feel they needed to visit the home daily in the weeks following the person's admission. The person's needs were complex and they had gone through a significant change in environment, which had contributed to changes in their behaviour. The person's social worker told us there had been a period of assessment which they felt had been satisfactory, but there was some room for improvement. They told us there had been good communication with the provider and they had sought information to get an understanding of the person. However, they had received feedback from the previous placement that more work could have been done with them prior to the person moving in. Staff also told us they were still getting to know this person, but had previously lacked confidence in how to support them effectively. We observed that staff interacted positively with the person and they had a good understanding of their needs when we asked about them. The assessment and care plan were detailed, with frequent updates and reviews as they got to know the person. However, the feedback on the assessment process shows that it could benefit from more information being gathered before the person moved in.

We recommend the provider seeks and follows best practice guidance from a reputable source about ensuring their assessment and transition processes are robust.

Staff had received training that equipped them for their roles. One staff member said, "We had training in behaviour and we have more training next week." Staff had received training in how to respond positively to behaviours and support people safely. The provider had arranged refresher training from a community learning disability nurse the week following our visit, due to staff supporting a person whose behaviour had recently changed. Staff had also completed training courses in autism and learning disabilities and they displayed a good understanding of how to support people with needs associated with these conditions.

All staff completed an induction before they started work and records showed they were thorough. Inductions involved staff familiarising themselves with the home environment and meeting the people they supported. Time was allocated to read people's care plans and to look at the provider's policies. The provider also arranged training in areas such as health and safety, safeguarding and medicines. The training provided followed the Care Certificate. The Care Certificate is an agreed set of training standards for staff

working in health and social care. A record was kept of these training courses to enable the provider to monitor that staff were up to date in these areas.

Staff had regular support from their line managers. Records showed staff had regular one to one supervision meetings where they discussed their work and identified training needs. The provider recorded these as a 'Job Chat' and records showed this was used to identify development goals. For example, records showed at a recent supervision meeting a staff member had developed a plan to gain experience and skills to take on a more senior role. The provider also had an appraisal process which staff followed each year to identify learning goals.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's consent was sought before staff provided care to them. People had agreed to their care plan and had signed to consent to the care they received. People also signed reviews and records contained pictures and records of the discussions held to ensure they were meaningful to people. Where people were not able to consent to aspects of their care, the MCA had been followed. One person had a mental capacity assessment carried out by a social worker which found they lacked mental capacity to consent to living at the home. The person lacked insight into risks and therefore had restrictions placed upon them to keep them safe. A best interest decision documented this and as the decision involved restrictions being placed upon the person, an application had been made to the local authority DoLS team.

People were supported to prepare food that matched their preferences and dietary needs. Information about people's favourite foods was documented and menus were prepared based on these. For example, one person's care plan recorded they liked crumpets and we saw staff prepare some for them. Another person liked sausage rolls and these were on the menu for lunch one day of the week of our visit. Staff told us they used pictures to involve people in making shopping lists and one person liked to help with some aspects of meal preparation. We observed this person helping staff to remove crockery from the table after lunch. Where people had specific dietary needs, these were catered for. For example, one person was at risk of choking and their care plan documented they required their food cut up and supervision when eating in case they ate too fast. We observed this person receiving food in line with this guidance at lunchtime.

The home environment was suited to people's needs. The home was free of clutter and people were observed moving freely around communal areas. Signage around the home used an easy read format with pictures as both people who lived there responded to pictures. People had a large garden that was secure and people were observed using it freely. The registered manager told us they did not have a lift so they always considered people's ability to use stairs when assessing people. Both people at the home could use the stairs and were observed doing so safely, using hand rails.

Good

Is the service caring?

Our findings

Relatives told us that staff were caring. One relative said, "[Staff member] is lovely, she is caring and is good with [person] at night time."

We observed caring interactions between people and staff that demonstrated kindness. In the morning, staff were observed asking a person about fire drills. The staff member placed a hand on the person's shoulder and the person smiled and looked happy in the staff member's company. Later, another person wanted to go outside and opened a door. The person's care plan documented they did not like staff in their personal space so staff kept an appropriate distance and asked the person if they would like to go out. The person decided not to but the interaction showed staff provided supervision to keep the person safe whilst allowing them space and autonomy over how they spent their time.

People were supported to maintain their independence and develop skills. Care plans recorded people's strengths and informed staff of tasks they could complete independently. One person's care plan recorded that they liked to help with domestic tasks such as emptying the dishwasher. We observed staff asking the person if they wanted to help with tasks during our visit. Both people had cleaning tasks written into their weekly schedules and staff recorded where they had supported people to clean their rooms or do laundry. A staff member said, "[Person] loves to cook, but you have to egg him on. If he cooks the meal he likes to eat it more, it gives him independence."

We also saw evidence of people being supported to develop confidence and skills. One person had been supported to improve their awareness of risks when out in the community. Their care plan documented places they liked to go and documented staff were to talk to them about risk when they went out, to help them become more independent when in the community. Another person was new to the service and staff were getting to know them. Record showed that the person could be shy and liked their own space. We saw care was being planned in a way to enable them to feel more confident approaching staff and staff told us they noticed the person approaching them more often. One staff member said, "The more [person] comes to you the more you know what he wants. He is starting to do more things for himself."

People were involved in their care. Care plans contained information for staff on how people liked to make choices. One person used one-word requests and staff were knowledgeable about these. We observed staff asking the person what they wished to do and supporting them to watch a cartoon. Another person communicated by gestures and we observed staff offering choices to the person for drinks and at lunchtime, responding to the person's gestures when they made choices. Care plans contained information about what people liked, so that staff could provide support in line with people's preferences. One staff member said, "[Person] can't always tell us what foods he likes so if we try something new and he responds well we add it to the menu."

Staff were respectful of people's privacy. Staff understood the importance of maintaining people's privacy. Staff knocked on bedroom doors before entering and people were observed as able to go and use their rooms freely. Staff told us they allowed people time in their own space each day and people chose when

they wished to have time to themselves.

The provider took equality and diversity seriously. People and relatives were asked about people's culture, religion and sexuality at assessments. This meant staff could identify any cultural needs or additional support people might need to practice their faith or express their sexuality.

Good

Is the service responsive?

Our findings

People's care was planned in a personalised way. Care plans contained details about people's preferences, routines and what was important to them. Care plans contained detailed guidance on how best to communicate with people, as well as how to support with personal care and care tasks. There was detailed guidance for staff on how to support people in a person-centred way. For example, one person had a love of music and liked to listen to music or visit places associated with music in the community. Their care plan documented that music shops were very important to the person and staff should be mindful when in the community as seeing a music shop could cause the person to feel anxious if they were not able to go in there.

Another person liked to organise their clothes and furniture, but they also had a history of causing damage to their items. Staff had planned care in a way to allow the person time to do this each day whilst ensuring items could be stored safely. We saw this person had time with their belongings and observed that the provider had made another area of the home available for storage for this person. Regular reviews took place to identify and respond to changes in people's needs. Care plans contained evidence of a monthly review being carried out as well as reviews where staff noted changes.

People were supported to take part in activities that were meaningful to them whilst suited to their needs. People had their own unique activities timetables which had been drawn up based on their interests. For example, one person liked sports and regularly attended a bowling club. They expressed to us that they enjoyed this and regular visits to a local social club and trips to the shops. People also went on regular outings and staff told us they used pictures to enable people to make choices about destinations. At the time of our visit, staff had noted a change in one person's needs that identified a new risk when going out in vehicles. This had required a referral to healthcare professionals and input from the person's social worker. We saw that this was in the process of being arranged and in the mean time staff had found ways to support the person to do activities in the local vicinity and within the grounds of the service. This showed staff could adapt to changes and identify measures to enable people to take part in activities if things changed.

People were informed of how to complain. The provider had a complaints policy and it was on display within the home in an easy read format with pictures. People and relatives attended regular reviews where they were given opportunities to request changes. Where changes were requested, we saw evidence of them being actioned by staff. For example, relatives had requested changes to one person's nutrition care plan and this had been actioned by staff.

Provision was in place to provide sensitive personalised end of life care. Care plans contained person-centred information and we saw record of a discussion about advanced wishes for one person. Information about what the person's preferences and the wishes of their relatives had been documented. Staff told us they would liaise with healthcare professionals when people may require palliative care.

Good

Is the service well-led?

Our findings

Relatives gave us positive feedback about the registered manager. One relative said, [Registered manager] has been brilliant, we call for a meeting and he will arrange it."

Staff told us that they felt supported by management. One staff member said, "They are great, I like it when managers speak to you and not at you. I am always asked how I'm doing." Staff told us that the registered manager operated an open-door policy and staff could ask them questions or request support at any time. During the day, we observed the registered manager supporting staff with tasks as well as interacting with people and helping with their care.

There were systems in place to enable good staff communication. There was a communication book which staff used to pass on important messages between shifts. The communication book had regular entries that included information about people's activities, appointments and any items people needed purchasing. The registered manager checked this regularly and also checked daily shift planners to ensure tasks were completed as planned each day.

Staff had regular meetings and records showed they were used to pass on important information about people's needs as well as staff practice. For example, a recent meeting had been used to discuss responses to incidents and people's care plans. A staff member said, "We've had a couple of meetings in the last few months. They made sure I saw the minutes when I was not able to attend."

People were involved in the running of the service. Keyworkers worked closely with people and got to know them well. Monthly keyworker meetings were used to get to know people and identify anything they wanted to change. Staff told us they used pictures to enable people to make choices about the care that they received. The registered manager also saw people regularly and directly supported them alongside staff. We saw records of communication with people's relatives and healthcare professionals to ensure their views were taken into account. At the time of our visit, there were only two people living at the service and they had only been supporting people for four months. It had not been possible to arrange a relatives' meeting within this time but the registered manager told us this was something they planned to implement. We will follow up on this at our next inspection.

There were a variety of checks and audits carried out to monitor the quality of care delivery. The registered manager carried out a variety of audits which covered all aspects of people's care. We saw audits relating to documentation, equipment, dignity, medicines, infection control and health and safety. Where improvements were identified, an action plan was drawn up and staff addressed the issue. For example, a recent health and safety audit had identified that records were not up to date regarding flushing toilets that were not in use. Regular flushing of unused water outlets reduces the risk of legionella. Following the audit, an action plan was drawn up and records were kept to show unused toilets were regularly flushed. At the time of our visit, the service had only been home to people for five months and the home environment was well kept and clean. Despite the low occupancy, we saw audits were being carried out robustly to ensure people lived in a clean and safe home environment.

There were links with the local community and stakeholders. Care records and communication records showed frequent contact with relatives, and healthcare professionals. Staff were knowledgeable about who was involved in people's care and this had been documented in care plans. The provider had regular contact with one person's day club and this had benefitted them in finding parties and sporting activities that they could take part in.