The Grange (2016) Ltd

Wheatfield Drive

Inspection report

17 Wheatfield Drive
Cranbrook
Kent
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Tel: 01580715249

Date of inspection visit:
28 August 2018
29 August 2018

Date of publication:
20 September 2018

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

This inspection was carried out on 28 and 29 August 2018 and was unannounced.

Wheatfield Drive is a 'care home'. People in care homes receive accommodation and 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. Wheatfield Drive is registered to provide accommodation and personal care for a maximum of 3 people. The home specialises in providing care to people with learning disabilities and 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. At the time of our inspection there were three people living in the service, and it is arranged over two floors.

There was a registered manager at the service. 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.

At the last inspection on 17 July 2017, we asked the provider to take action to make improvements because Deprivation of Liberty Safeguards (DoLS) applications had not been made for people who needed support if they attempted to leave the service. At this inspection we found the service had made improvements and staff were following the principles of the MCA.

People were protected from the risk of abuse. Staff were trained in how to identify and report concerns. Managers knew how to report concerns. Risks to people and the environment were assessed, and staff acted to reduce those risks identified. These risks were regularly reviewed. There were enough staff on shift to meet the needs of people, and those new to the service were recruited safely. Rotas were organised fairly. People received their medicines safely. Staff received training and had their competency checked. People were protected by the prevention and control of infection. We found the service to be clean and tidy. The registered manager took steps to ensure lessons were learned when things went wrong.

People had their care delivered in line with current legislation and best practice guidance. Training was provided to staff which was built around the needs of those using the service. People were involved in devising their own weekly menu and had choice and control over what and when they ate. Staff were trained to make sure food was handled safely. Staff followed the guidance from healthcare professionals. People had access to health care and treatment and staff supported people to understand what the treatment meant. Staff knew how to seek consent from people and were knowledgeable about the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice Best interest meetings were held when needed. Applications for Deprivation of Liberty Safeguards

were sent to the local authority when required.

People were treated with kindness, compassion and respect. Staff knew people and their needs well, and had the time to listen to people express their feelings and views. Staff knew to refer to lay advocates if a person needed further support. People were encouraged to be independent. People had their privacy and dignity respected and promoted. People's confidential information was kept private.

People were in control of how their support was provided, and support was provided in a personalised way. Each person had their own care plan which was regularly reviewed. People were supported to take part in activities of their choosing. People said they knew how to raise a complaint and would do so if they needed to. The registered provider was beginning to consider how they might support people at the end of their lives to have a dignified death by speaking to them about their preferences.

The registered manager had the skills and experience to lead the service. They had oversight of the daily culture in the service, which included the attitudes, performance and behaviour of staff. The culture was transparent and honest, and staff told us they felt valued and proud to work for the organisation. People, their families and staff were encouraged to be engaged and involved in the service. There were growing links with the local community.

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.

People were protected from the risk of abuse.

Risks to people and the environment were assessed, and staff took action to reduce those risks identified.

There were enough staff available to meet the needs of people, and those new to the service were recruited safely.

People received their medicines safely from staff who were trained to do so.

People were protected by the prevention and control of infection.

The registered manager took steps to ensure lessons were learned when things went wrong.

Is the service effective?

Good

The service had improved so that it was effective.

People had their care delivered in line with current legislation and best practice guidance.

Staff had the skills and experience to meet people's needs.

People's nutrition and hydration needs were met.

Staff followed the guidance from healthcare professionals, and people had access to health care and treatment.

People's needs were met by the design and decoration of the service.

Staff knew how to seek consent from people and were knowledgeable about the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were treated with kindness, compassion and respect.

People were supported to express their views about the support they received.

People had their privacy and dignity respected and promoted.

Is the service responsive?

Good

The service was responsive.

People were in control of how their support was provided, and support was provided in a personalised way.

People said they knew how to raise a complaint and would do so if they needed to.

The registered provider was beginning to consider how they might support people at the end of their lives to have a dignified death.

Is the service well-led?

Good

The service was well-led.

The registered manager had oversight of the daily culture in the service.

The culture was transparent and honest, and staff told us they felt valued and proud to work for the organisation.

People, their families and staff were encouraged to be engaged and involved in the service.

There were growing links with the local community.

Wheatfield Drive

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 28 and 29 August 2018 and was unannounced. The inspection was carried out by one inspector.

We used information the registered persons sent us in the Provider Information Return. 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. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about.

We spoke to three people using the service. We also spoke with two support staff, the registered manager and the chief executive.

We looked at care records for two people receiving a service. We also looked at records that related to how the service was managed including training, staff recruitment and some quality assurance records. We asked the chief executive to send us other quality assurance records after the inspection, and they sent these to us in a timely manner.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service. One person said, "I feel very safe here. With the staff being here, they protect us." Another said, "If we are making something to drink you need to be careful. We know someone is there checking."

People were protected from the risk of abuse. Staff received training which gave them the skills to identify abuse, and knew how to report any concerns they had. We saw a flowchart on display in the service which provided guidance to staff on how to report issues, and staff confirmed they were confident senior staff would follow up on concerns if needed. One staff member told us, "I've had good training. I know I can speak to my line manager, or other managers if I wanted to. We can speak to on-call if anything happened out of office hours." Staff had arranged for a visit from the local authority to speak to people about what keeping safe meant, and people told us they felt safe and were confident to speak up if they needed to. The registered manager was aware of their responsibility to report safeguarding concerns to the local authority and Care Quality Commission.

Risk to people were assessed and action was taken to reduce risks to ensure people were kept safe. Staff received training on the principles of risk assessments to help them understand how to recognise risks. Risks were identified during reviews of people's care, and information on how to mitigate against the risks was recorded so staff knew what action to take. For example, one person's records showed they might be at risk of fraud when purchasing items online. Staff were to support the person's independence by enabling them to use their own private email and banking details, but to observe them when they made purchases and check all purchases made by reconciling with their next bank statement. Another person was at risk of burning themselves when using the oven. Staff knew to make sure they supported that person when they were cooking. Each person had their own evacuation plan which provided information to staff on any support the person needed to leave the building in the event of an emergency. Staff received fire safety training and regular fire drills meant people and staff were confident they knew how to evacuate the building safely and promptly. Staff also received annual first aid and basic life support training.

The registered provider made sure the environment was safe for people to live in. We saw fire equipment such as extinguishers and smoke detectors throughout the building, and there was a heat detector in the kitchen. These were checked regularly by the registered manager during health and safety audits. The temperature of hot water was checked weekly to make sure people were safe from the risk of scalding, and a staff member from the registered provider visited the service each week to carry out maintenance checks to the fixtures and fittings to make sure they were safe for people to use. The service had its own car, and regular checks were made to ensure it was operating safely.

There were enough suitable qualified staff to meet the needs of the people using the service. Although the people living at the service had done so for many years, the registered manager reviewed their needs regularly, and used this information to make sure staffing levels were sufficient to support the people in the way they wanted to be. Most support was provided by permanent staff. Agency staff were sometimes used to cover shifts, but the registered manager told us they had consistent staff from the agency so people knew

them and the staff were aware of people's needs. One permanent member of staff told us, "People like the agency staff too. They get the same induction as we do, and they shadow staff. There are the same standards for them as there are for us."

Records showed the registered provider carried out checks to make sure those being recruited were suitable to carry out their role. These included pre-employment checks such as obtaining a full employment history, obtaining character references from previous employers and completing Disclosure and Baring Service (DBS) checks before they began working with people. DBS checks identified if applicants had a criminal record or were barred from working with people that need care and support. Each new recruit was required to carry out an induction, which included shadowing more experienced staff until they were comfortable to work alone. A newly recruited member of staff told us, "I thought the induction was excellent. We went through all the procedures and I need to complete a workbook before passing my probation period."

People received their medicines safely. They had their ability to manage their medicines assessed, and when support was needed it was detailed in the person's care plan. Information about the medicine, including what it was for and why the person needed it was recorded in an accessible format and people said they felt confident they received the correct medicine. Medicine was stored safely in a locked box within a locked cupboard and was clearly labelled with the name of the person. Staff also supported people with homely remedies such as paracetamol or ear drops to help remove ear wax, and staff followed the registered provider's policy by recording what was given, when and the reasons why. Staff also received confirmation from the person's GP about which homely remedies could be given, and this information was recorded in the person's file. The temperature of the cupboards was monitored each day to ensure the medicine was stored correctly, and guidance was provided to staff on how to keep the temperature down in the warm summer months. The local pharmacist carried out a yearly audit which reviewed how medicines were managed. When improvements were required the registered manager ensured they were actioned. In the most recent audit they suggested managers sign up to an organisation which alerts people if there are any recalls of medicines. Records showed this had been actioned. The registered manager also carried out their own audits of medicine records to make sure they were being given to people as prescribed. Staff counted medicines each day at handovers which helped to quickly identify how many errors had been made. .

People were protected by the prevention and control of infection. There was a policy in place and staff followed Department of Health guidelines which helped minimise risk from infection. Staff received training on food hygiene and infection control and had access to personal protective equipment such as gloves and aprons which were used when supporting people with intimate care. Any soiled clothing or bedding went into specific bags to ensure other material did not get contaminated, and were cleaned according to recognised guidelines. Staff said they encouraged people to wash their hands before preparing food and eating meals, and we saw a sign in the bathroom which displayed handwashing guidelines. We found the service to be well maintained with a good standard of cleanliness.

Accidents, incidents and near misses were reported by staff in line with the registered provider's policy. The registered manager told us, "I think staff are confident to speak up if there is an incident. They will complete an incident form and then I will investigate fully." Staff spoke to each other about issues and learning was shared. For example, a medicine error led to a change in the procedure for checking medicines, and this information was shared with staff in a memo, the communication book and was discussed at a team meeting.

Good

Is the service effective?

Our findings

People told us the service was effective in meeting their needs and staff were skilled in carrying out their roles. One person told us, "The staff are well trained, they're doing really well." Another said, "We get to choose what we want to eat. I can have anything I want but I need help in making it."

At our last inspection on 31 July 2017 we found that the registered provider had not followed the principles of the Mental Capacity Act (MCA) 2005. This was because Deprivation of Liberty Safeguards (DoLS) applications had not been made for people who needed support if they attempted to leave the service. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

At this inspection we found the service had made improvements and staff were following the principles of the MCA. The 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 law 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 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 in order to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records showed the registered manager had carried out mental capacity assessments on people living at the service. When there were concerns about one person not being able to manage their medicines independently, staff tried to support them to come to their own decision about accepting support. This included sharing information in a pictorial format and using language they could understand. The registered manager told us, "We make the information as understandable as we can. And we know the people well, so know what time of day is best to speak to them, for example." The registered manager had received training carried out by the local authority and had submitted all DoLS applications as necessary.

People's care and support was delivered in line with current legislation. Each person had their own individual care plan which showed how the person wanted to be supported. Records included information about the person's physical and mental health needs. The registered manager had also introduced a keyworker system, and people were able to tell us who their keyworker was and what their role was. Records showed that care planning considered any additional support that might be required to ensure people did not suffer from discrimination, such as needs around cultural or religious beliefs, and other protected characteristics under the Equality Act 2010. The Act makes it against the law to discriminate against a person because of a protected characteristic, which includes their age, disability, sexual orientation or religion.

Staff had the skills and experience to deliver effective care and support. The registered provider had developed a learning and development plan, based upon guidance from Skills for Care, which indicated core subjects staff should be familiar with. Staff were supported with a mix of classroom-based and online training, which included subjects such as challenging behaviour, supporting people with autism, person centred approaches and equality, diversity and inclusion. Training was provided to staff when a person had

a particular need. For example, one person had been diagnosed with epilepsy, and records showed staff had received training in order to keep them safe when they were having a seizure. The registered manager made sure that staff were up-to-date with refresher training on subjects such as safeguarding and infection control. People's family members and friends were also invited to attend the classroom-based training sessions if they wished to.

People were supported to eat and drink enough to maintain a balanced diet. People told us they were involved in drawing up the menu each week, and those menus we saw looked nutritious and well balanced. Meals were mostly eaten together as a household. People were encouraged to cook as part of their daily routine and had access to equipment which enabled them to prepare food independently. One person had a 'workstation', where vegetables could be clamped in place, freeing up both of their hands to chop what was needed for the meal. Another had specialist cutlery which meant they could eat without assistance. We saw people making themselves drinks throughout the day of the inspection. The registered manager said people had previously found using a kettle difficult, so they had bought a hot water dispenser which was easier to use. This meant people could prepare hot drinks independently.

Staff worked well with each other and other organisations to deliver effective care and support. We saw positive but discrete communication between staff members when discussing people's needs. At the end of each shift staff carried out a handover which made sure the incoming member of staff was aware of any issues or concerns. Staff knew to make referrals to other health and social care professionals when required. For example, one person had recently been referred to a specialist nurse when they developed a new health condition. Staff kept accurate details of people's health needs and preferences, which could be given to health staff if the person needed to attend an appointment at hospital. This included detail of the person's medicines and how they prefer to take them.

People were supported to have timely access to healthcare services. Staff made referrals to professionals when needed, and arranged for people to have regular reviews of their health and medicines. Records showed people were seen by a chiropodist every six weeks, and were supported with regular visits to their GP and optician. One person had recently been referred to a specialist to help them process their words as staff had noticed they were not always understanding what was being said to them. Another person was supported to access dental treatment. The dentist had requested a specific regime for brushing their teeth, and records showed staff were following the instructions which helped prevent further deterioration of their teeth.

People's needs were met by the design and decoration of the premises. We saw people moving freely throughout the building and garden during our inspection. The house had a homely feel to it, and one person told us, "I'm proud of where I live and how it looks." People were involved in the cleaning and decorating of the service, and they told us they were in the process of discussing ideas with their keyworkers as they were about to redecorate their bedrooms. The registered manager told us that people's ability to independently navigate the stairs and get into and out of the shower was kept under review, and they would make adaptations if necessary.

Good

Is the service caring?

Our findings

People told us they thought the staff were caring and that they were treated with respect. One person told us, "They always care about all of us." Another said, "They are our friends."

People told us and observations we made showed people were treated with kindness. We saw staff taking time to listen to people and responding to them appropriately in a compassionate way. People were happy, and relationships between people and staff were relaxed and informal. When one person was seen to be anxious about our presence in their home, staff were quick to comfort them and offered them reassurance. Staff knew how the person would behave if they felt more relaxed and were able to describe this to us. We saw the person became more at ease with us being there following the support from staff. Staff told us they enjoyed working at the service and felt close to the people they supported. One member of staff said, "They're like an extension of my family. We make sure they have their medicines, make sure they have their hair cut, have healthy food, nice clothes, a nice room. Things I'd do for myself at home, really."

People were supported to express their views and were involved in making decisions about their care and support. People were also supported and encouraged to maintain relationships with their family and friends. People could have visitors whenever they liked and some people would go to stay with family over night or for weekends. Family members were encouraged to take part in reviews of their loved one's support. If people did not have friends or family members to support them at reviews, the registered manager ensured they had access to external lay advocates if they needed to. Lay advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes. Regular resident meetings were held where people had the opportunity to discuss issues such as outings, activities or the menu.

People were supported to be as independent as they could be. People's care plans included information on what the person was able to do for themselves, and guidance for staff on how to support the person to be able to do things themselves. Staff told us they helped people make as many decisions as possible about the support they received. We saw one person go into the kitchen to make themselves a cup of tea, and they needed some support from staff. The staff member said, "She might need some help with the milk. I don't pour it in the mug myself, but I just hold the bottom of the bottle to keep it steady." One person told us they chose what they wore each morning, and they chose how they spent their day.

People's privacy was taken into consideration when they were being supported by staff. Staff described how they would make sure people had privacy, like knocking on bedroom doors and waiting for a reply before entering, or reminding people to close the bathroom door when they had a shower. One staff member told us, "We treat people how we would like to be treated ourselves. We have some private space in the house and we are all respectful with one another." Family and friends had access to private space when they visited, and health professionals were encouraged to use the dining room when having confidential conversations with people.

Staff made sure people's private information was kept safe. Computers were password protected so they

could only be accessed by authorised staff, and care records were locked away when they were not being used by staff.

Good

Is the service responsive?

Our findings

People told us that staff provided them with support that met their needs. One person told us, "We get to choose what we want to drink, what we want to eat, what we want to wear and what we want to do." Another said, "If you have any problems you can go to [registered manager] or any member of staff."

People were involved in the planning of their support. Each person had their own care plan which was drawn up taking into account the person's preferences as well as feedback from family members and health and social care professionals. Staff had access to guidelines on how to support each person to understand their care plan, such as to only use short words and phrases, and to sit down with the person in a quiet room when reading it.

The care plans considered what the person could do for themselves, what they needed support with, how staff should provide that support and when the goals should be reviewed. For example, one person's care plan identified they needed to be prompted to brush their teeth as they may forget to do so independently. When doing this, staff were to encourage them to set a timer to make sure they brushed for the recommended time, and to make sure they use mouthwash afterwards. Another person's care plan included information about how they were to be supported with their religious beliefs and their preference of being a vegetarian.

When new staff were needed, people told us they were involved in the recruitment process by having the chance to meet potential candidates before the interview process to see if they got along with them. They also had the opportunity to ask questions during the interviews and their opinions formed the basis on whether candidates were recruited. People told us it was their choice that all support was provided by female staff members.

People's care plans included information on which activities people wanted to take part in. Staff told us that the newest person had moved into the service ten years prior to the inspection, and the two other people had lived there for twenty years. People said they were close to each to each other and tended to take part in activities as a household. Activities were planned in advance in resident meetings and an activity plan was on display so people knew what was coming up. Staff had access to a car, and supported people to yoga classes, visits to the library, swimming, Zumba classes, going to the cinema and food shopping. People went on annual holidays if they wanted to. People attended a local community group where one person took part in arts and crafts, and the other had drum lessons.

The service was meeting the accessible information standard. The accessible information standard sets out a specific approach to recording and meeting the information and communication needs of people with a disability, impairment or sensory loss. Records showed staff had used pictures and videos to help people come to decisions about their support.

People told us they knew how to make a complaint and said they thought any issues they had would be taken seriously. The complaints procedure was on display in the service, which showed the photographs of

the registered manager and chief executive so people knew who to direct their complaint towards, and people confirmed they knew who they were. When complaints were made the registered manager acted to resolve them. There had been one complaint made since the last inspection and the person involved confirmed it had been dealt with to their satisfaction.

The registered provider was beginning to consider how they might support people at the end of their lives to have a dignified death. The people living at the service had done so since their twenties and staff had not wanted to cause them anxiety by speaking about their end of life wishes. More recently however, as people became aware of death, such as when a family member of one person passed away, staff used the opportunity to discuss people's own wishes with them. The chief executive told us, "It has previously been difficult to approach the subject without causing people distress. But recently we have been asking people questions in passing such as 'what flowers do you think you'd like at your funeral?' or 'what songs do you think you'd like to be played?' We have found it easier to speak in an indirect way." The registered manager told us they were also beginning discussions with local learning disability nurses involved in people's care and support.

Good

Is the service well-led?

Our findings

People and staff told us they thought the service was well-led. One person said, "We know who the manager is, and [the chief executive]. We can go to them if we need help." A staff member said, "The management are a lot more involved now. I feel supported."

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. They were aware of the culture of the service, took an active role within it and knew the people and staff well. They told us, "We aim to provide fulfilled, enriched happy lives to the people we support. Staff come in to work for them, rather than to work for the company." Staff were aware of these values. Transparency and fairness were promoted within the service. Records showed the registered manager regularly worked alongside staff, and staff said they were approachable and available if there were any issues or concerns. One member of staff told us, "I feel valued. I've done a lot of care, and it's not always been like this." Rotas were drawn up taking into consideration the needs of staff, including commitments outside work such as hospital appointments. Good practice was encouraged, and the registered manager told us one staff member had recently been promoted into a more senior position.

The chief executive told us steps were being taken to include staff opinions and ideas in the development of the service. An organisation-wide meeting had been held, during which staff were asked their opinions on, for example, how new staff should be inducted, what they thought of mentoring, and how managers engaged with staff. Records showed that feedback from staff led to changes, including to the induction programme, a review of the training provision and changes to how management communicated with staff. Staff were positive about the approach. One staff member said, "I've noticed some changes. Management seem to be a lot more worried about staff, and how happy they are. When it snowed in the winter, the people who got stuck at work were sent out 'thank you' cards. That meant a lot to us."

People and their relatives were also involved in the development of the service. A recent family and friends survey had identified some concerns about how well staff communicated changes in a person's need to their family members. This feedback resulted in the home introducing a keyworker system, which the registered manager hoped would provide a better link between people, staff and their loved ones.

There was a local reporting system in place which identified shortfalls in the service and was used to improve the service. Quality audits were carried out by the registered manager, the chief executive and an external auditor. These included, for example, reviewing if staff had completed all mandatory training, and if DoLS applications had been made when necessary. We also saw a copy of an audit carried out by the local authority, which had identified people did not have up-to-date evacuation plans in place. Records showed this had been actioned. When other areas of improvement were identified they were added to an action plan so the registered manager could keep track of actions that needed to be taken. Every two months the action plans were shared with other senior managers within the organisation. The registered manager told

us this was important as it provided to be a valuable learning opportunity for them.

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. The registered manager was aware of their responsibility to comply with our registration requirements. They were also aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. They kept up to date with changes to legislation and best practice guidance by attending meetings with other registered managers which were held by the local authority, and were encouraged to further their professional development by attending management training courses.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that those seeking information about the service can be informed of our judgements. The provider had conspicuously displayed their rating both on their website and in the service.

The registered provider worked transparently with partner organisations in the local community, such as with the local authority, GPs, learning disability nurses and other health professionals. They were also working to develop the organisation's profile within the local area, including organising a stall at the local church fayre, and advertising vacancies in local facilities.