Care Quality Commission

Community Homes of Intensive Care and Education Limited

Carisbrooke

Inspection report

341 Peppard Road
Emmer Green
Reading
Berkshire
RG4 8XG

Tel: 01189462400
Website: www.choicecaregroup.com

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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

Carisbrooke is a residential care home for up to six people with a primary diagnosis of learning disabilities and associated needs. The service is registered to provide accommodation and personal care to people, however cannot provide any nursing support. The home offers six en-suite bedrooms and three communal rooms, across two floors. A large spacious rear garden offers additional areas for people to use.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

Why the service is rated good

The service continues to keep people safe. Robust recruitment and deployment ensures that sufficient staff are employed to support people and help keep them safe. Detailed risk assessments continue to consider least restrictive options to enable people to continue engaging in activities that they enjoy.

Medicine management continued to be provided in a safe way, with audits illustrating that people received their medicines in a timely way and how they wished.

Staff continued to be supported to provide the most effective care to people. Their training was kept up to date, and they were provided appropriate supervisions and appraisals to ensure their practice was assessed.

People's needs were assessed initially upon admission, and thereafter reviewed monthly to ensure care was the most apt. People were encouraged to personalise their rooms in a style that they preferred.

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.

Staff approach remained caring. People were supported by a staff team that knew them well, and ensured they enabled them to maintain their independence. Where support was required, people's dignity and privacy was maintained. People communicated in their preferred way, with records clearly highlighting this.

The service continued to ensure person centred care was delivered by staff. Care plans were written for people, detailing how they wished to be supported. Activities, both in-house and external were responsive to people's preferences.

The service continued to be well-led. There was a clear vision and direction from the registered manager. An

open-door policy was practiced, whereby staff were able to approach the manager and discuss issues.

Good community links were created, and the service worked efficiently with other professionals. The service continued to have good governance and reflective practice, with compliance of the regulations.

Further information is in the detailed findings within the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remained Good.	**Good**
Is the service effective? The service remained Good.	**Good**
Is the service caring? The service remained Good.	**Good**
Is the service responsive? The service remained Good.	**Good**
Is the service well-led? The service remained Good.	**Good**

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Carisbrooke

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.

This inspection took place on 14 November 2018 and was unannounced. The inspection was completed by one inspector.

During the inspection process the local authority care commissioners were contacted to obtain feedback from them in relation to the service. We referred to previous inspection reports, local authority reports and notifications. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service, this is a legal requirement. As part of the inspection process we also look at the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We had received the PIR for Carisbrooke and used this to help inform our inspection plan. During the inspection we spoke with five members of staff including, one apprentice, one bank worker, one care worker, the registered manager and one senior. We interacted with three people who are supported at the service, in addition to two relatives.

Care plans, health records and additional documentation relevant to care and support were seen for three of the six people. In addition, we viewed a sample of records relating to the management of the service. For example staff records, complaints, quality assurance assessments and audits. Staff recruitment and supervision records for three of the regular staff team were looked at. As part of the inspection process we completed observations during lunchtime, as well as interacting with people during the inspection process.

Good

Is the service safe?

Our findings

The service continued to provide safe care and treatment to people. Staff remained trained and knowledgeable in safeguarding. They were able to identify the different signs of abuse and further advise what action they would take should they suspect abuse. All staff spoken with during the inspection said they would not hesitate to whistle-blow. They were able to identify the provider's whistle-blowing policy, as well as consider external agencies who could be notified if abuse was suspected.

Staff completed comprehensive risk assessments on activities and any other potential risks to people, and reviewed these on a monthly basis. These assessments focused on enabling people to maintain as active and independent a life as possible, whilst ensuring they remained safe. For example, one person enjoyed accessing the community. They particularly enjoyed cycling. The service risk assessed both the activity (cycling), and the person's recognition of risks associated with this. The person was enabled with staff assistance and presence to partake in cycling. Other examples included people going for long walks, eating out and working with staff to make themselves a hot beverage. This not only increased the person's independence but also gave them the confidence to complete some tasks independently.

The service continued to ensure sufficient suitably vetted staff were employed to support people. A robust recruitment process was in placed that ensured that staff recruited met schedule three of the regulations. Whilst there were several vacancies at Carisbrooke, this did not affect the staffing ratio. A number of bank workers were used where necessary, with staff assisting and completing additional shifts. If a shortfall remained, consistent agency staff were used to ensure they knew people well.

We observed staff administering medicines, and noted their practice was in line with provider policy. One staff administered, whilst a second staff observed and checked that the correct medicines were given. People were supported to take their medicines how they wished. For example, with juice or water. Medicines were stored safely and ordered correctly. Medicine audits took place frequently, and illustrated that medicines were managed safely. "As required" medicines had comprehensive details of when these needed to be given and why. Records showed these were only given when the guidelines were met.

The service was clean. Staff had taken the relevant measures to prevent and control the spread of infection. Colour coded cleaning products were used to prevent the spread of germs and possible infection from one room to another. The service had recently been inspected by the Food Standard Agency (FSA). The FSA is responsible for food safety and hygiene across the UK. Provisions are measured against a set of standards and scored in accordance to these. Carisbrooke was rated five out of five, the maximum score obtainable.

Trends analysis continued to be completed for all accidents and incidents. This ensured that the service learnt from reportable issues, and then took the necessary action to prevent similar occurrences. The service had very few reportable issues, therefore formulating an analysis was not always possible.

People were protected and kept safe regardless of their ethnicity, religion, sexuality, gender or disability. The service had a strong drive of inclusivity and ensured that all people and staff felt safe, in line with the

company's equality, diversity and human rights policy.

Good

Is the service effective?

Our findings

People continued to receive effective support that ensured their rights were maintained in line with the Mental Capacity Act (MCA). People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS). The service had ensured where necessary all applications were made to the local authority. Where necessary best interest decisions were made for people. These where applicable were made with relatives or health professionals, when a person was unable to make an informed decision for themselves.

People's needs were continually assessed with care documentation being updated as and when required. This helped ensure staff supporting people had the relevant information to ensure they could deliver effective care. Staff completed the care certificate training as part of their induction, and worked shadow shifts with more experienced staff prior to working alone with people. The service had a rolling training programme in place, that ensured staff received refresher training as and when required. Any additional training to further support people was sourced as required. Staff reported feeling confident that they were provided with sufficient knowledge to effectively carry out their duties. Supervisions were held frequently with annual appraisals. Staff reported these, "allow me to know how I've worked within the year, and what I need to do better."

People continued to be encouraged to eat and drink healthily. Drinks and meals were prepared and discussed with people. Where required support was sought from external professionals such as speech and language therapist or the dietitian, to help develop plans around nutrition and hydration. For example, where a person was at risk of choking, rather than automatically considering a thickened diet, the service chose to work with the health professionals and the person to enable them to eat all foods, but work on changing their eating habits. This was achieved by staff eating with people at their tables, and encouraging them to eat slower, chew more, or simply to not put too much in their mouth. Another person, who had a number of food intolerances, had all their personal information discreetly recorded in the kitchen. This was not visible to visitors, but recorded on internal kitchen unit doors, with a symbol to represent the person. This not only ensured the person ate the appropriate food to manage their nutritional needs, but worked in line with General Data Protection Regulation, and did not disclose any personal information about the person.

The service continued to maintain comprehensive records of all input people received from health professionals. This included visits to the GP, dentist and any additional professional involved in the person's care. Each person had a "hospital passport" written that was to be taken with the staff and person to any hospital visit. This contained important information about the person that medical professionals may benefit from knowing, including how the person wished to be addressed, food allergies, preferred communication, medical history and current medication. Relatives advised that the service responded well to people's changing health needs. Support was sought within a timely fashion and medical advice followed through by the staff.

People were encouraged to personalise their rooms, in a way that was reflective of their personal preference. We saw each bedroom was decorated how the person wanted, with photos or artwork that held personal value to them adorning the walls. Each bedroom was en-suite, allowing people to remain as independent as possible to use their bathrooms.

Good

Is the service caring?

Our findings

People continued to be supported by a staff team that knew them well and focused on developing a positive relationship with them. Staff were observed to speak to people kindly and in a compassionate way. Touch was used where applicable, with discreet words to redirect a person if required. Staff were trained in understanding non-verbal language, and often worked with the provider's additional resource – the behaviour specialist. Training was specifically designed at understanding each person, and how the service could best meet their needs. Staff were empowered to provide information on their knowledge of the person, coupled with the theoretical teaching of positive behavioural support. This approach enabled people to remain the focal point of the training.

If people required support with personal care, this was offered to the person at a time that they requested or when needed. Staff would redirect the person to their room, ensuring the door was closed to maintain the person's dignity. Where applicable curtains were drawn, and people covered as required. Staff tried to encourage people to remain as independent as possible with all aspects of their care, including personal care and eating. For example, we observed one person who had a number of physical disabilities that could potentially restrict their ability to eat independently. Rather than de-skilling the person, the service used utensils and crockery that would enable the person to independently eat. They used motivational strategies over lunch, gently encouraging the person to persevere with their food. This had allowed the person to maintain their dignity and independence in this area of their life.

Similarly, where a person's preference was to eat alone and not in the company of others, staff ensured the person's choice was respected. They had their own table laid out in the conservatory, and chose to eat either at the same time as others, or afterwards, dependent on their mood that day.

Monthly key worker sessions focused on the person, and enabled them to be actively involved in making decisions about their care. In addition, people's meetings were held at Carisbrooke that focused on day to day issues like meal planning, group based activities and communal room décor.

Each person's file contained a communication passport. This looked at the person's preference of communicating, and provided key phrases, pictures, expressions and words with meaning, for any new staff. This was considered a working document, that evolved with the person, as they used new communication methods and became more confident in expressing themselves.

The service continued to maintain people's confidentiality. Records were kept in secured facilities within the office. If staff needed to speak about a person, they ensured they removed themselves to a quiet place where their conversation could not be overheard.

Good

Is the service responsive?

Our findings

The service remained responsive to people's changing needs. Care plans continued to provide comprehensive information and insight into how people wished to be supported and cared for. Information obtained from initial assessments, visits prior to moving to the service, family and professionals was used to inform the care plans. These were written in the first person focusing on person centred care. In one example we noted the registered manager had arranged 12 visits to the person as part of their transition, prior to them moving permanently to the home. The visits were arranged to ensure the person was compatible with the existing residents, as well as to ensure the home had a full understanding of the person's needs and were able to meet them.

People were encouraged to be involved in their evolving care plans. Monthly key worker sessions and reports illustrated how and when people were consulted and the frequency of reviews. These placed a heavy emphasis on empowering people to lead their care. Where people did not consent to assistance, this was not offered. Alternatives were suggested, including coming back at a later time, or an alternative member of staff offering support. The person was always given the opportunity to drive the level of support they wanted and when they wanted it. The service worked towards empowering people to understand their rights, in line with the Human Rights Act. They were encouraged to be their own advocates as far as possible. Relatives spoke positively of the staff approach to empower people.

The service had a complaints procedure in place. We saw that issues were responded to as appropriate and within the company's stipulated time frame. A written record was maintained of all concerns and the feedback provided to the complainant. Where possible the service used this as a learning tool to prevent any similar occurrences.

People remained very busy with activities, both within and outside the home. We saw that timetables were personalised and responsive to people's preferences. Some people enjoyed attending activities in small groups, whilst others preferred activities on a one to one basis. The staff worked hard to ensure people achieved inclusivity within the community.

The Accessible Information Standard (2016) was well incorporated into the service. This legislation focuses on people receiving information in a way that they understand. The service ensured that information was presented in a format that people could use, including pictures, bold text, or simply documenting when information was discussed with the person. Where required issues were discussed with the person who was court appointed deputy.

The service did not currently support people on end of life care, although were in the process of developing and expanding on existing paperwork that could include the person's final wishes.

Good

Is the service well-led?

Our findings

The service continued to be consistently well-led and managed by a registered manager who had been in post for a number of years. 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.

The service had a clear vision of inclusivity. The registered manager drove the belief that all people and staff were equal irrespective of their race, disability and faith. A visual aid of inclusivity had been created that showed where all staff and residents were from on a world map. This was extended to include people's family and friends also. The visual aid was used to increase communication about people's experiences and reinforce that equality and diversity were at the centre of the home. The registered manager and staff team focused on empowering people to achieve their personal goals. Whether this was to complete independent tasks like preparing themselves cups of tea, to accessing the community.

The service continued to respond to feedback received from people, relatives, professionals and stake holders. Annual quality assurance audits were completed from which the registered manager created an action plan. This was used to inform the service as it continued to develop and progress, meeting people's changing needs. The key worker sessions, monthly team meetings, monthly house meetings and complaints were also used as part of the quality assurance process. Where changes were required these were planned and implemented accordingly. The process was seen as one to help expand the knowledge and experience of the people residing at Carisbrooke. Whilst seeking to use the process as one of continual learning and innovation.

The service continued to audit the home using monthly, weekly and quarterly schedules. Care documents, house safety checks, staff training and support checks, as well as medicine audits all showed compliance. The audits completed by the regional director highlighted where there was need for further development. An action plan often accompanied the regional director's audit. The registered manager ensured that all items were corrected, signing off when the task had been completed. The registered manager appropriately notified the CQC of any notifiable incidents.

The service continued to work in partnership with external agencies. Advice was sought within a timely fashion. The registered manager and staff strove to work with external agencies to ensure people were able to achieve their aspirations.