

Meadowview Care Limited

Bethany House

Inspection report

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Halstead
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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 

Overall summary

The inspection took place on 4 June 2015 and was unannounced.

The service provides care and support for up to two people with learning disabilities. At the time of our inspection one person was using the service.

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.

Staff were trained in safeguarding people from abuse and systems were in place to protect people from all forms of abuse including financial. Staff understood their responsibilities to report any safeguarding concerns they may have.

Risks to people and staff were assessed and action taken to minimise these risks. The person was encouraged to remain as independent as possible and any risks related to this were assessed.

Staffing levels meant that the person's needs were met. Recruitment procedures were designed to ensure that

Summary of findings

staff were suitable for this type of work and checks were carried out before people started work to make sure they were safe to work in this setting. New staff were recruited before posts were vacant.

Medicines were administered safely and records related to medicines were accurately completed.

Training was provided for staff to help them carry out their roles and increase their knowledge of the healthcare conditions of the people they were supporting and caring for.

Consent was given before care and treatment was provided. Staff had received training in the Mental Capacity Act (MCA) 2015 and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS ensure that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. Where people's liberty needs to be restricted for their own safety, this must be done in accordance with legal requirements. People's capacity to give consent had been assessed and decisions had been taken in line with legal requirements.

The person was supported with their eating and drinking needs and staff helped people to maintain good health by supporting them with their day to day healthcare needs.

Staff were very caring and treated people respectfully making sure their dignity was maintained. There was a lot of laughter and joking which created a very relaxed atmosphere. Staff were positive about the job they did and enjoyed the relationships they had built with the person they were supporting and caring for.

The person was involved in planning and reviewing their care and was encouraged to provide feedback on the service. The person was supported to play an active part in their local community and follow their own interests and hobbies. Thought had been given to the provision of adaptations to support the person's visual impairment.

No formal complaints had been made but informal issues were dealt with appropriately.

Staff understood their roles and were well supported by the management of the service. The service had an open culture and people felt comfortable giving feedback and helping to direct the way the service was run.

Quality assurance systems were in place and audits were carried out regularly to monitor the delivery of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

Systems were in place and staff were trained in safeguarding people from abuse.

Risks were assessed and action taken to minimise them.

There were enough staff to meet the needs of the person who used the service. Staff were trained to administer medicines and medicines were given safely.

Good



Is the service effective?

The service was effective.

Staff received training to support them to carry out their roles.

The service had followed legal requirements relating to consent to care and treatment.

The person who used the service was well supported with their dietary and healthcare needs.

Good



Is the service caring?

The service was caring.

Staff were patient, compassionate and kind and relationships between staff and the person they were supporting were good.

The person who used the service was involved in decisions about their care and their choices were respected. They were treated with respect and their dignity maintained.

Good



Is the service responsive?

The service was responsive.

The person who used the service was involved in assessing and planning their care. Support was provided in a way which catered for their individual needs and choices. They were supported to give feedback about their care.

The person was supported to play an active part in their local community and follow their own interests and hobbies.

Informal complaints were responded to appropriately and promptly.

Good



Is the service well-led?

The service was well led.

The person who used the service and staff were involved in developing the service.

Staff understood their roles and were well supported by the management team.

Quality assurance systems were in place to monitor the delivery and safety of the service.

Good



Bethany House

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 4 June 2015 and was unannounced.

The inspection team consisted of one inspector.

Before we carried out our inspection we reviewed the information we held on the service. This included statutory notifications that had been sent to us in the last year. A

notification is information about important events which the service is required to send us. Before the inspection the provider completed a Provider Information Return (PIR). This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with the person who used the service, two care staff, the registered manager, the operations manager and the provider. We also contacted a local commissioner of services who had placed people at the service.

We reviewed one care plan, one medication record, three staff recruitment files and staffing rotas covering four weeks. We also reviewed quality monitoring records and records relating to the maintenance of the service and equipment.

Is the service safe?

Our findings

The person who used the service told us that they felt safe. They said, “I don’t worry”. We found that systems were in place to reduce the risk of abuse and to ensure that staff knew how to spot the signs of abuse and take appropriate action. Staff were able to tell us what they would do if they suspected or witnessed abuse and knew how to report issues both within the company and to external agencies directly. Financial procedures and audit systems were in place to support people who used the service and took account of their particular disabilities.

We saw that safeguarding people from abuse was an agenda item on resident and staff meetings. Staff had received training in safeguarding people from abuse and this training was appropriately refreshed. Staff we spoke with were knowledgeable about safeguarding matters and one staff member told us they felt they would be confident if they had to report a safeguarding concern.

We saw that risks had been assessed and actions taken to reduce these risks. Risks associated with day to day activities such as accessing the community, eating and drinking and relationships as well as specific risks associated with a particular activity had been assessed. Each assessed risk had been recorded, reviewed appropriately and shared with the person, who had then signed it. Accidents and incidents were recorded and analysed for trends to see if care plans needed to be adjusted in order to keep the person safe and meet their needs more effectively.

There was a business continuity plan which documented how the service would continue to be delivered in the case of an emergency. We saw that the plan was detailed and contained clear and practical advice for staff to follow. The plan was not easily accessible and the manager confirmed to us that they would take action to ensure it could be located quickly by staff in the event of an emergency.

The person received care and support from a small staff team who knew them well. The service was fully staffed and the manager had recruited to two posts, which were about to become vacant, before the staff had actually left. This helped to ensure that the service was not left without the

required numbers of staff. Some staff worked at the two other services run by the provider which were located in the same road. This meant that staff were available nearby to cover in emergencies and for support and advice.

Rotas showed that staff covered core hours and also worked flexibly to meet the needs of the people they were supporting and caring for. Staff told us that they felt that there were enough staff and that they could get help from other staff at the sister services in the same road, if they needed to. There was a member of staff on duty each night and staffing was used flexibly to support people who used the service to go on an annual holiday which they told us they were looking forward to. They told us, “We are off to Caister and I’m going to go on the funfair. All three houses go together and we all get on well”.

Recruitment records showed that staff had followed an application process, been interviewed and had their suitability to work with this client group checked with the Disclosure and Barring Service.

Medicines were administered by staff. The person who used the service told us that they were happy with the way staff supported them to take their medicines. Where medicines were needed only occasionally, (PRN), there were protocols to inform staff when to use them and for how long before contacting a healthcare professional such as a GP for further advice. Staff we spoke with demonstrated an understanding of the medicines administered but had some gaps in their knowledge. The medication profile, outlining how the person who used the service liked to take their medicines or what they were for, could not be located. The manager told us they would address this straightaway.

Records showed that staff had received the appropriate training to enable them to administer medicines safely and three competency checks were carried out by senior staff before people were able to administer medicines unsupervised. There were appropriate systems in place for the storage, stocktaking, recording and disposal of medicines. We reviewed the medication administration records and found that these had been completed correctly. A monthly audit of medication procedures was carried out by the manager and actions noted were promptly dealt with.

Is the service effective?

Our findings

The person who used the service told us they were happy with the care and support they received and we observed interactions between them and the staff. We saw that staff met the person's needs in a skilled and competent manner which demonstrated that they knew the people well. The person who used the service told us, "I have settled in fine. The staff are pretty good really".

Staff told us they felt they had the training they needed to carry out their roles. One member of staff said, "The training is really relevant to what we do". Training records confirmed that staff received training and that the training was updated appropriately. The manager had recently arranged some external training for staff on a specific issue related to the administration of medicines as they had identified that this was an area that needed some additional input. The manager was also in the process of assessing whether staff needed to receive some training in supporting people with a visual impairment. This had not been deemed to be needed urgently as the person managed their disability so well. Issues related to the person's visual impairment had been discussed amongst the staff team during the assessment period before the person moved in.

When staff first started working at the service they received a comprehensive 12 week induction which covered all aspects of delivering care and support. New staff spent time shadowing permanent staff until they were confident to deliver care themselves. One member of staff had recently returned to work at the service after an absence of 18 months. They told us that their full induction had been repeated and that they had been given the time they needed to make themselves familiar with people's needs.

Agency staff had never been used by the service until the previous weekend. An agency member of staff had worked at the service for the first time due to an unexpected staff shortage. This person, along with two others, had already been interviewed by the manager and people who used

the service in case they ever needed additional staff. This meant that the staff member was already familiar with the service. They were trained to lone work and were provided with an in house induction and support from colleagues in the other services in the same street.

Staff received regular support and supervision from their managers. An annual appraisal system was in place and staff told us that they felt they received the support and guidance they needed from their managers and the provider.

We noted that the person's consent was asked for before care and treatment was provided and the management and care staff demonstrated an understanding of the Mental Capacity Act (MCA) 2005. We saw that people's capacity to make day to day decisions had been assessed and recorded. The service had not needed to apply to the local authority to restrict anyone's liberty in order to keep them safe but the manager understood the process should this be required.

There was a strong emphasis on healthy eating and staff provided the support the person needed to eat a varied and healthy diet. Food preferences were recorded in the care plan. The expertise of other healthcare professionals, such as a dietician, had been incorporated into the care plan and staff had joined a local slimming club along with the person who used the service and this had been a great success. We observed staff chatting supportively to the person about their weight loss.

The manager told us that they were planning to provide MUST training for staff. MUST is a universal screening tool for malnutrition and staff are taught how to support people to receive optimum nutrition.

The person was supported with their healthcare needs and staff worked in partnership with other healthcare professionals to meet their need promptly. The person were supported to attend healthcare appointments with opticians and dentists and information about their health conditions was in their care plans for staff to access.

Is the service caring?

Our findings

The person told us they were very happy with the way staff provided care and support. It was clear to us that staff had already built a good relationship with the person who had only been using the service for a few weeks. Staff chatted and joked with them in a relaxed way and were patient, compassionate and caring. Staff were there to support the person but also to encourage them to do as much as they could for themselves. The overall impression was that there was a lot of laughter and that the relationship between staff and the person they were supporting was one of equality.

The person who used the service had a visual impairment and some information was received by them in braille. The manager was in the process of establishing how good the person's braille was to see if care plans and other important information would need to be put into this format. Until this decision was taken staff assisted the person by reading out the information the person needed to know.

The service had involved a local advocacy service to support the person to make some decisions they needed to make about an aspect of their care during the period leading up to them moving in. Although the person was able to voice their opinions the manager felt that external and unbiased support would benefit the person and help them understand the issue better.

The service had recently started up 'Social Sundays' where the person who used the service and those from the other two homes in the same street got together to chat and spend time together. We saw that any issues raised during this time together were recorded by staff and fed back to the manager. A recent get together had discussed some new food options. People told us they really enjoyed these social occasions and friendships had developed from them. These meetings were in addition to keyworker meetings and resident meetings where people who used the services also had the opportunity to raise issues and give feedback about aspects of their care and support.

Staff practice promoted dignity and privacy. We observed staff providing reassurance and discrete support to the person during our inspection. The service had an Infringement of Human Rights policy and each person had a Client's Charter of Rights given to them. These spelled out the rights people had and detailed how they should be treated. The person who used the service told us, "I know my rights. I want to move on soon. I can if I want to". Contact details for various organisations, including the Care Quality Commission, were included in this information to signpost people to further help and guidance if they were not happy with an aspect of their care.

Is the service responsive?

Our findings

The person who used the service received care that met their needs and took into account their individual choices and preferences. They told us that they felt happy and settled at the service and enjoyed the increased independence it gave them. They said, “I am a lot more independent. I do all my own washing and I put it on the airer. I help with the food shopping, and the cleaning and I get people to sign my visitor’s book”.

Before the person began using the service a comprehensive assessment process had been carried out by the manager and their line manager. A care plan had been drawn up following this and clearly documented the person’s choices and preferences in detail. Their skills and abilities were documented as well as the things they needed help with. Consideration had been given to any adaptations which would be needed to support them with their visual impairment. We noted that the person had been able to say what adaptations they did and did not want. The person did however tell us that they wanted a gadget which would alert them when their cup was full of water so they could make a cup of tea without the risk of scalding themselves. We fed this back to the manager.

Care plans were subject to on-going review and reflected any changes in needs promptly. All staff had signed care plans and when there was a change to an aspect of care this was highlighted to staff via the communication book which helped to ensure staff were aware of the person’s current needs. The person’s placement had been reviewed at six weeks and they were now due for their 18 week review.

All staff had undertaken equality, diversity and inclusion training to help to ensure that people were given the support they needed in a way that was sensitive to their age, disability, gender, race, religion, belief or sexual orientation. Care plans recorded if people preferred to receive care, particularly personal care, from care staff of the same gender.

We saw that staff supported the person to play an active part in their community and to attend social functions, follow their own interests and hobbies. They had become friends with a person who lived in one of the sister services in the same road and both people attended an art and craft group together.

The person who used the service was due to go on a holiday with some of the people who used other services run by the provider. We saw that they had met together and took a vote to decide where to go and what kind of things they wanted to do when they were there. People were really looking forward to spending time at the seaside and spoke positively about previous holidays they had been on.

House meetings and individual keyworker meetings were held regularly and enabled people to discuss any aspects of their care and support that they were not happy with or wished to change. This meant that any informal complaints could be dealt with promptly. There was an accessible complaints procedure and details about how to make a complaint were included as an agenda item at each house meeting.

The service had a suitable complaints policy in place. There had been no formal complaints made to the service in the last year.

Is the service well-led?

Our findings

The service had a positive and open culture. The registered manager worked regular shifts at the service and the provider was well known to staff and residents. Staff told us that the manager was very supportive and provided advice and guidance when they needed it. One member of staff said, “One of the really good things is that the management support you if you have concerns”.

People from all the services run by the provider were routinely involved in the recruitment of staff if they wished and were encouraged to provide feedback on all aspects of the service through their house meetings, keyworker meetings and annual reviews.

Staff surveys were completed and four were available for us to view. Each contained positive feedback and gave people an opportunity to comment on how the service could improve. These suggestions were then considered by the manager. Staff were invited to add their own agenda items to the regular staff meetings via a book held at the service. This meant that staff had the opportunity to be involved in developing the service and raising any concerns that they had.

The culture of the service was based on a set of values which related to promoting people’s independence, celebrating their individuality and providing the care and support they needed in a way that maintained their dignity. Staff we spoke with were clear about how they provided support which met people’s needs and maintained their independence and we observed this during our inspection. There was a real commitment from the manager and staff

to ensure that the people who used the service lived independent lives as part of their local community. The manager told us that they tell the staff, “Everything you do the people we support could do - and they do!”

There was a clear management structure in place, with the registered manager in day to day charge and their line manager visiting the service regularly and providing them with support and guidance. Communication was good between these two people and the registered manager told us they felt well supported by their manager. The registered manager understood their responsibilities and had previously sent all of the statutory notifications that were required to be submitted to the Care Quality Commission for any incidents or changes that affected the service. Feedback we received from a service commissioner was positive and commented on the efficiency and good communication of the manager.

There were systems in place to monitor the quality of the service. A training matrix gave an overview of the training provision at the service. Other records for the people who used the service and staff were well organised and clear, which meant that important information could be located easily and quickly.

Regular audits were carried out by the manager to monitor the quality and safety of the service. A monthly audit monitored various aspects of service delivery including medication, finances, maintenance, health and safety issues, completion of records relating to the person who used the service and attendance at healthcare appointments. An analysis of incidents and accidents took place to see if there were any patterns and trends and, where these were picked up, we saw that action was taken promptly.