Care Quality Commission

The Hampshire Isle Of Wight And Channel Islands Association For Deaf People Limited

Easthill Home for Deaf People

Inspection report

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29 June 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

Easthill Home for Deaf People 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.

At our last inspection in November 2015, 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. The service was meeting all relevant fundamental standards of care. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

This inspection took place on 14, 15 and 29 June 2018 and was unannounced.

The home accommodates up to 15 people and specialises in supported older deaf people whose primary means of communication is British Sign Language (BSL). At the time of our inspection 10 deaf people, were living at the home. The home was based on three levels connected by stairwells, a passenger lift and a stair lift. All bedrooms had sink facilities and bath or shower rooms were available on each floor, together with communal areas where people could socialise.

There was a registered manager in post 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 and associated Regulations about how the service is run.

People felt safe living at the home. Staff knew how to identify, prevent and report abuse. They assessed and managed risks to people and risks posed by the environment effectively.

Arrangements were in place for the safe management of medicines. People received their medicines as prescribed. The home was clean and hygienic and staff followed best practice guidance to control the risk and spread of infection.

There were enough staff to meet people's needs in a timely way. Appropriate recruitment procedures were in place and pre-employment checks were completed before staff started working with people.

People's needs were met by staff who were competent, trained and supported in their role. Staff acted in the best interests of people and followed legislation designed to protect people's rights and freedom.

People's dietary needs were met and they received appropriate support to eat and drink enough. Adaptations and improvements had been made to the home to make it supportive of the people living there.

People were supported to access healthcare services when needed. Staff made information available to other healthcare providers to help ensure continuity of care and supported communication between people and health professionals.

People were cared for with kindness and compassion. Staff knew people well and built positive relationships with them. They were skilled at communicating and engaging with people and adapted BSL to effectively meet people's communication needs.

Staff protected people's privacy and dignity. They encouraged people to remain as independent as possible and involved them in planning the care and support they received.

People's needs were met in a personalised way. Each person had a care plan that was centred on their needs and reviewed regularly. Staff empowered people to make choices and responded promptly when people's needs changed.

People had access to a range of activities based on their individual interests, including regular access to the community. They knew how to make a complaint and an accessible complaints procedure was in place.

Staff took account of people's end of life wishes and preferences. They supported people to remain comfortable and pain free.

People and professionals who had regular contact with the home felt it was run well. Staff were organised, motivated and worked well as a team. They enjoyed working at the home and told us they felt valued.

There was an open culture where people were consulted and staff enjoyed positive working relationships with health and social care professionals. There were effective quality assurance systems in place to help ensure the safety and quality of the service.

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 remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Care Quality Commission

Easthill Home for Deaf People

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 and 15 June 2018 and was unannounced. We returned on 29 June 2018 to speak with the registered manager as they had not been available on the first two days of the inspection. The inspection was completed by an inspector and a specialist advisor with experience of commissioning service for people with a sensory impairment. They were supported on 15 June 2018 by a British Sign Language (BSL) interpreter, who helped them communicate with deaf people and deaf staff.

Before the inspection, the provider completed a 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with five people who used the service. We also spoke with the registered manager, the deputy manager, five care staff, an activities coordinator and a cook. We received feedback from a GP, a community nurse and four health or social care professionals who had contact with the service.

We looked at care plans and associated records for seven people and records relating to the management of the service, including: duty rosters, staff recruitment files, records of complaints, accident and incident records, maintenance records and quality assurance records. We also observed care and support being delivered in communal areas of the home.

We last inspected the service in November 2015 when we identified no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe at Easthill. For example, one person told us they felt "safe" and "secure" and said nothing worried them.

Staff had received safeguarding training and knew how to identify, prevent and report abuse. They were confident managers would respond to any concerns they raised. For example, a staff member told us, "If I had safeguarding concerns, I'd raise them straight away and report to the [registered] manager. She wouldn't ignore it. She would want it in writing and would want to investigate." Records confirmed that the registered manager had reported and investigated incidents promptly, in liaison with the local safeguarding authority.

Individual risks to people were managed effectively. Risk assessments had been completed for all identified risks, together with action staff needed to take to reduce the risks. For example, two people were at risk of developing pressure injuries and we saw special pressure-relieving mattresses had been provided. Staff understood how to adjust the mattresses and there was a clear process in place to help ensure they remained at the right setting according to the person's weight. We saw that one person was also supported to use a pressure relieving cushion when they were sat in a chair.

People were involved in risk-taking decisions. For example, one person, who need support from staff to reposition when in bed to prevent skin damage had discussed night time checks with staff and asked to be supported to re-position in bed on a four-hourly basis, rather than two-hourly as recommended. The person had full capacity; they understood the risks and staff supported them in their decision.

Environmental risks were managed effectively. Gas and electrical appliances were serviced routinely and fire safety systems were checked regularly. Arrangements were in place to deal with foreseeable emergencies. All staff had completed fire awareness training and knew what action to take in emergency situations. Personal emergency evacuation plans (PEEPS) were in place that detailed the support each person would need if they had to be evacuated. There was also a business continuity plan that included an arrangement to use a nearby hall as a place of safety in an emergency. Staffing arrangements ensured there was always a hearing member of staff on duty, so they could call emergency services and communicate with attending professionals, such as doctors or paramedics. Staff had also received training in first aid.

The registered manager told us staffing levels were based on people's needs and we found there were enough care staff deployed to meet those needs at all times. Ancillary staff, including cleaners and cooks were also employed to enable care staff to focus on meeting people's needs. A visiting community nurse told us, "There's usually a good proportion of staff to clients."

Safe recruitment procedures were followed. These included pre-employment reference checks and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home.

People were supported to receive their medicines safely by staff who were suitably trained. One person told us, "I always get my medicines on time and if I need any extra I just ask." There were clear processes in place to obtain, store, administer, record and dispose of medicines in accordance with best practice guidance. Following some medicine errors, the registered manager had taken the decision to use two staff for all medicine administrations. This had reduced the number of errors and showed the service learnt from mistakes and took action to prevent reoccurrence.

All areas of the home were clean and there were systems in place to protect people by the prevention and control of infection. Staff had attended infection control training, had access to personal protective equipment (PPE), such as disposable gloves and aprons, and wore these when needed. One person had an infection that was resistant to anti-biotics; staff demonstrated a good understanding of the condition and the action they took to manage the risk. They also described how they processed soiled linen, using special bags that could be put straight into the washing machine to prevent cross contamination.

Good

Is the service effective?

Our findings

People's needs were met by staff who were skilled, competent and suitably trained. One person told us, "It's a good home and staff are very good." A healthcare professional said of the staff, "They understand and support people living with dementia well."

New staff completed a structured induction programme before being allowed to work on their own. This included a period of shadowing a more experienced member of staff and the completion of essential training. Staff who were new to care were supported to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. Experienced staff received regular refresher training in all key subjects and were supported to undertake other training relevant to their role, such as dementia and end of life care. Although some essential training was overdue, we saw this had been planned and was due to be completed shortly after the inspection.

A key aspect of the service was the ability of staff to communicate with deaf people. Everyone living at the home was profoundly deaf and used British Sign Language (BSL) as their main form of communication, with some using it in a very individual way. The provider employed a mix of deaf staff and hearing staff who were skilled in communicating with people using BSL. Hearing staff attended weekly training in BSL until they had attained a high level of competence. They were supported in their learning on a day to day basis by the deaf staff who had a greater understanding and knowledge of BSL and deaf culture. A social care practitioner told us, "All staff are very deaf-aware and all have a level of sign language. There is always someone there who can communicate fully with clients."

Staff told us they felt supported in their roles by managers. Each received regular one-to-one sessions of supervision, together with annual appraisals to discuss their role, their well-being, and any development needs. A staff member told us, "I feel valued. The [registered] manager says 'thank you' a lot." Another staff member confirmed this and said, "Everyone is caring and kind to one another as well as to the residents."

Staff protected people's rights by following the principles of the Mental Capacity Act 2005 (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 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. We saw MCA assessments had been completed where needed and best interests decisions had been made and recorded in consultation with relatives and professionals. Where people had capacity, we saw they had signed their care plans to indicate their agreement with the proposed care and support. Where people had appointed Lasting Power of Attorneys (LPoAs) we saw copies of these were kept with their care records to help ensure relevant people were involved with any decision making.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the

Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found staff were following the necessary requirements and a DoLS authorisation had been granted for one person. However, some staff thought DoLS had been authorised for other people too. This posed a risk that the liberty of those people might be restricted unlawfully. We discussed this with the registered manager who undertook to remind staff of people's DoLS status and to signpost them to the place where this information was recorded.

The environment of the home had been adapted to support people's needs. One aspect of deaf culture is the need for good lighting and an open environment where people can make eye contact with one another and use BSL effectively. Staff had recognised that people preferred spending time in a dining room adjacent to the kitchen where they could observe the comings and goings of staff, people and visitors. In response to this, and in consultation with people, they had converted this room into a lounge by adding comfortable chairs and changing the décor to make it a more pleasant and relaxing space for people. The provider had upgraded a stair lift to make it easier for people to access an upper floor that included a new dining room and an activities room. In addition, they had installed an accessible shower and renewed the flooring throughout most of the home. People commented positively on the improvements, saying it was "nicer" and "more comfortable".

People were satisfied with the quality and variety of meals. One person said, "The food is good, There's always a choice. If you don't want anything on the menu, you can ask for an alternative." Another person said, "I like the food; it's good." A cook told us, "I like to pamper to people's needs. Whatever [food] they want, they get it." People had access to drinks and snacks throughout the day and night and care records confirmed these were offered and provided consistently.

Some people needed a special diet to support their diabetes and we saw this was provided. Other people needed a modified diet, due to swallowing difficulties. They had been assessed by speech and language therapists (SALT) and their recommendations were documented in the person's care plans, recorded in the kitchen and followed by staff. Where people needed support to eat, this was done in a dignified and patient way on a one-to-one basis.

Each person had a nutritional assessment to identify their dietary needs and staff monitored people's weight to identify if they started to lose weight. Staff also supported people to remain hydrated. One person needed to drink regularly, due to a medical condition. They told us staff often reminded them to drink and we saw they had ready access to a variety of drinks at all times.

People were supported to access healthcare services when needed. Records confirmed that people were seen regularly by doctors, specialist nurses and chiropodists. Staff enjoyed positive working relations with healthcare professionals. A community nurse told us, "The staff interact with us well and help us communicate with the client, for example to help us gain consent [from the person]. They are quick to contact us if they identify any problems and follow any advice we give."

When people transferred to hospital or to another care setting, staff accompanied them, initially, to aid communication and ensure their needs were understood. In addition, they provided healthcare professionals with a written summary of the person's needs, together with details of any medicines they were taking. This helped ensure continuity of care for the person. Staff also supported people with routine. A doctor who had regular contact with the home told us, "They always send a carer with the patient to surgery appointments to help make sure the patient's needs are met and to facilitate communication with the patient."

Good

Is the service caring?

Our findings

People were supported by kind, caring and compassionate staff. Everyone we met spoke positively about the warmth of the staff and the friendly, homely atmosphere they created. One person said, "I like the staff and get on with everyone okay." A community nurse who had regular contact with the home told us staff were "definitely caring and compassionate in their approach". A doctor who had regular contact with the home said, "The staff seem caring and attentive to the patients' needs. They seem happy, as do the patients." A social care practitioner said, "It's a very homely environment. People love having other deaf people to talk to."

Staff spoke fondly of the people they supported, built positive relationships and clearly knew them well. One staff member said, "I love working here, looking after the residents and taking them to appointments. I can be a friend for them to talk to [using BSL]. We have a good rapport and I get on with everyone." Another staff member told us, "I like caring and being here for people. The residents are lovely, we have a laugh." A further staff member told us they had brought their children in to interact with people; as a result, they said people now "love talking about them and asking after them".

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. One person told us, "I am free to come and go as I want. I can go out on my own; there are no restrictions." A social care practitioner told us, "[Staff] promote independence; for example, if people can partially dress themselves, they encourage that." People's care plans also encouraged staff to promote independence. The care plan for one person described aspects of personal care the person could manage themselves and those for which staff should offer support. A staff member told us, "People have got older and are more frail. Some say they can't walk now, but we say, 'yes you can' and encourage them to exercise."

The provider had a policy that recognised people's diversity and cultural needs and the registered manager told us that they would adapt the care and support provided to meet people's ethnic diversity and human rights. For example, people were supported to follow their faith; a minister of religion, who used BSL, visited the home regularly to distribute Holy Communion to people who wished to receive it. In addition, two people were supported to follow a different faith in individual ways that were relevant to them. A staff member told us, "We always ask if they want to join in [with celebrations of other faiths] and sometimes they do; we don't just assume they wouldn't want to."

Staff understood the importance of protecting people's privacy and dignity and people confirmed that staff considered their privacy when providing personal care. A social care practitioner told us, "[People] talk highly of staff and how they support them and respect their dignity." A staff member told us, "I close curtains and lock bathroom doors. I wouldn't do otherwise at home, so why do it here? I treat people the way I would want my grandparents to be treated." People were given a choice of receiving support from male or female staff and their choices were respected. Before entering people's rooms, staff used a flashing light system to alert the person; they waited for a response and then sought permission from the person before entering. Confidential information about people, such as care records, was kept securely and computer based

records were password protected.

Staff were skilled at communicating and engaging with people. They understood how to adapt BSL to people's individual needs and used this effectively. Hearing staff were aware that communicating with one another verbally could exclude deaf people and deaf staff, and lead to misunderstandings. To overcome this, they made a point of always using BSL when they were in the company of deaf people or deaf staff.

Other means of communication were also used to help ensure information was accessible to people. For example, menus were provided in picture format, as were the fire procedures, and the provider's complaints policy. The complaints policy had also been translated into BSL on a DVD which people had watched.

People told us they were involved in discussing and making decisions about the care and support they received. Information in people's care records confirmed that they, and family members where appropriate, were involved in developing and reviewing their care plans.

Good

Is the service responsive?

Our findings

People told us they received personalised care and support that met their individual needs. One person said, "I get all the help I need." Another person told us, "I'm happy here. There's plenty to do and I can go shopping with [a staff member] if I want." A social care practitioner told us they had reviewed the care of two people living at the home and found it was "perfect for their current needs".

Assessments of people's needs were completed by one of the managers, before people moved to the home. This information was then used to develop an appropriate care plan in consultation with the person and their relatives where appropriate. People were also given the opportunity to spend time at the home before committing to moving there. This helped ensure they would be happy at the home and that staff could meet their needs effectively. Care plans contained comprehensive information to enable staff to provide appropriate care to people and were reviewed monthly, or sooner if people's needs changed. A social care practitioner told us, "Care plans are always up to date and the information is always available." A review of records of daily care confirmed that staff consistently provided care and support in line with people's care plans and their assessed needs.

Four people needed support with their diabetes and we saw each had a personalised care plan detailing their individual needs and the frequency of blood sugar monitoring. This was different for each of them and demonstrated a person-centred approach to care. A staff member told us, "I'm proud of the way we support people to meet their individual needs. We know them well as it's such a small home; it's like a little family."

Staff promoted choice and respected people's autonomy by empowering them to make as many of their own decisions as possible. People told us they could choose when they got up; when they went to bed; how and where they spent their day and which activities they took part in. For example, one person told us they recently fancied a lay-in and chose to stay in bed until 11:00 one morning as they felt tired. A staff member told us, "We try to encourage people to use the dining room at lunchtime as it's better for them [to be sat upright when eating]. But it's their choice, it's up to them." A social care practitioner told us, "[Staff] promote choice; for example, one person has breakfast in their room, but likes to have lunch in the dining room and they are happy to accommodate that." At lunchtime on the second day of the inspection we saw some people chose to use the dining room for lunch, while others chose to stay in the lounge.

Staff were responsive to people's changing needs. They knew people well, so could quickly spot changes in their health and well-being. A community nurse told us, "[Staff] recognised that one person was in discomfort and thought their catheter was blocked [which it was]. They called us right away." The registered manager said, "I'm proud of how we support people and how we spot little changes and then do something about it."

One person had started experiencing episodes of intractable pain that caused them to behave in a way that put themselves and others at risk. When normal strength pain killers had not worked, staff liaised with the person's GP and supported them to attend consultations with specialists. Staff were fully aware of the issue; they described the body language the person displayed when they were in pain and knew how to support

them in a way that kept them and other people safe. Another person was prescribed a sedative to take when they became anxious; however, their care records detailed other interventions staff should consider before resorting to the use of medicine. Staff told us these interventions were usually effective, which meant the person rarely needed to use the sedative.

Staff supported people at the end of their lives, to help ensure they experienced a comfortable, dignified and pain free death. People's end of life wishes were discussed with them and recorded in their care plans. Staff told us they did this in a sensitive way, "when the moment is right". For example, they had discussed end of life care with one person after they had experienced a bereavement and wanted to talk about death. Most staff had received training in end of life care and knew how to access specialist support. For example, they had liaised with the GP and a community nurse to obtain symptom control medicines for a person who was approaching the end of their life. A social care practitioner told us they had been involved with staff when they had been delivering end of life care; they said, "During that time, I was kept fully updated of their situation and what actions were being implemented. So effective was the communication and trust I had in them, I knew [the person] was receiving the best of care."

People had access to a range of activities, mainly organised by an activities coordinator with support from staff and two volunteers. These included art and crafts, games, quizzes and reminiscence. Trips to local shops and attractions were also organised and based on people's interests. One person told us they enjoyed playing cards with staff and did this often. Other people attended a weekly coffee morning with deaf people living in the community and the registered manager told us they were trying to re-establish a deaf club that they used to host every week at the home.

Staff made use of technology to support people to receive timely care and support. When people needed support, they used a call system that generated an audible signal for hearing staff and activated a vibrating alarm on pagers carried by deaf staff. This helped ensure people received a prompt response to calls for assistance. In addition, vibrating alarms and flashing lights had been installed to alert deaf people when the fire alarm activated.

Good

Is the service well-led?

Our findings

People were happy living at Easthill and felt the service was well-led. One person said, "I'm very happy here, it's a very good home." This was confirmed by professionals we spoke with. For example, a doctor who had regular contact with the home told us, "We feel the level of service [staff] provide is good. The home comes across as well run and organised." A community nurse confirmed this and said, "It's a very well-run home; they [staff] are all for the residents." A social care practitioner told us, "I've never had a problem with the way the home is run. They are always organised; there's always someone there to help and answer any questions."

There was a clear management structure in place consisting of the registered manager, the deputy manager, a head of care and senior care staff. Staff understood the roles and responsibilities of each team member and described all the managers as "approachable" and "supportive".

People benefitted from a service where staff were motivated and happy in their work. Comments from staff included: "We're lucky as we all get on"; "[The registered manager] is an excellent manager. I feel supported one hundred percent"; "We've got a good team and everyone wants the best for residents"; "I feel valued. I always get a 'thank you' and [managers] always say 'please'. Everyone is caring and kind to one another as well as to the residents. Even [the chief executive] praises us and says we are doing well"; and "Staff are friends as well as colleagues. We are like a family and look after each other".

We found staff were organised and completed delegated tasks in an efficient and effective way, ensuring all the work got done. They used 'handover meetings' to aid communication between shifts and ensure continuity of care for people. In addition, senior staff were available on call to provide advice and guidance to staff out of hours.

There was an effective quality assurance process in place, based on a range of audits completed by managers. These included the environment, medicines, infection control, staff training and care planning. Any issues raised during audits were rectified promptly; for example, a medicines audit identified a failure to record the date when inhalers were given to people and this had been addressed. An infection control audit had identified issues relating to staff wearing nail varnish and the need for a replacement foot-operated bin in the sluice room; we saw both issues had been resolved.

People were consulted about the way the service was run in a range of ways. These included "residents meetings" held every two months, yearly questionnaire surveys and individual discussions with people and their relatives. Any issues raised were acted on promptly. For example, some people had asked for another holiday to be arranged and this had led to a range of options being explored and discussed.

Staff meetings were held regularly and provided an opportunity for staff to contribute to the running of the service and to make suggestions for improvements. One staff member told us, "We can voice concerns and make suggestions. The [registered] manager asks for feedback." They gave an example of a time when they had suggested changing the arrangements for staff breaks and said these had been accepted. Another staff

member told us they had suggested the use of an alarm mat to keep a person safe and this had also been implemented.

The provider had a clear set of values. These included openness, equality of opportunity, respect for people, putting people at the heart of the service and the provision of high quality care. These were communicated to staff through an 'employees charter', during recruitment and through regular conversations.

The registered manager usually notified CQC of all significant events, although we identified one incident that had not been reported due to a misunderstanding about a category of incident that needed to be reported. We clarified this with the registered manager and they undertook to ensure CQC was notified of all such incidents in the future. In all other respects, there was an open and transparent culture within the home. The registered manager followed the duty of candour requirements and had notified family members in writing when people had come to harm. People had ready access to the management and visitors were welcomed. The home's previous inspection rating was displayed prominently in the entrance hall and on the provider's website.