The Royal School for the Blind

SeeAbility - Surrey Views

Inspection report

2 Wesley Road
Leatherhead
Surrey
KT22 8ET

Tel: 01372383005
Website: www.seeability.org

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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

Surrey Views is a residential care home for up to eight people. There were eight people living at the home at the time of inspection. The home supports people with sight and dual sensory loss, learning disabilities, mental health diagnosis and physical disabilities. Some people's behaviour presented challenges and was responded to with one to one support from staff.

People had varied communication needs and abilities. Some people were able to express themselves verbally; others used body language or Makaton (type of sign language) to communicate their needs.

The service was run by a registered manager, who was present on the day of the inspection visit. '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 were protected from avoidable harm. Staff received training in safeguarding adults and were able to evidence that they knew the procedures to follow should they have any concerns.

There were sufficient staff to keep people safe. Staff were seen to support people to keep them safe. There were robust recruitment practises in place to ensure that staff were safe to work with people.

Staff had written information about risks to people and how to manage these. Risk assessments were in place for a variety of tasks like personal care and the environment and were updated frequently.

People's medicines were administered stored and disposed of safely. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

People's human rights were protected as the registered manager ensured that the requirements of the Mental Capacity Act 2005 was followed. Where people were assessed to lack capacity to make some decisions, mental capacity assessment and best interest meetings were evidenced. Staff were heard to ask people for their permission before they provided care.

Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

People had sufficient to eat and drink. They had healthy home cooked meals. People were seen to be offered choice on the day of what they would like to eat and drink. People were supported to maintain their health and well-being. People had regular access to health and social care professionals.

Staff were trained and had sufficient skills and knowledge to support people effectively. There was a training

programme in place and staff competency was regularly assessed. Staff received regular supervision.

Positive and caring relationships had been established. Staff interacted with people in a kind and considerate manner.

People, their relatives and other professionals were involved in planning peoples care. People's choices and views were respected by staff throughout the day. People's privacy and dignity was respected. There were no restrictions on when friends and family could visit. People received a personalised service. Staff knew people's preferences and wishes and they were adhered to.

The service listened to people, staff and relative's views. The management welcomed and actively sought feedback from people and acted upon this if necessary. The management promoted an open and person centred culture. The registered manager was present in the home on a very regular basis.

Staff told us they felt supported by the registered manager. Relatives told us they felt that the management was approachable and responsive.

There were robust procedures in place to monitor, evaluate and improve the quality of care provided. Staff were motivated and aware of their responsibilities. The registered manager understood the requirements of CQC and sent appropriate notifications.

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.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of how to keep people safe.

Medicines were managed safely. Medicines were stored, disposed of and administered safely.

The provider ensured there were enough staff on duty to meet the needs of people individually.

Staff were recruited safely, the appropriate checks were undertaken to ensure suitably skilled staff worked at the service.

Written plans were in place to manage risks to people. There were processes for recording accidents and incidents.

Is the service effective?

Good

The service was effective.

The requirements of the Mental Capacity Act were followed. Staff asked people's consent when providing care.

Staff had the skills and knowledge to meet people's needs. Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities.

People were supported to be able to eat and drink sufficient amounts to meet their nutritional needs and were offered a choice of food.

Staff supported people to attend healthcare and social care appointments to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People were well cared for. We observed caring staff that treated

people kindly and with compassion. Staff were friendly, patient and discreet when providing support to people.

Staff took time to communicate with people and to engage positively with them.

People were treated with respect and their independence, privacy and dignity were promoted. People and their relatives were included in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's care was personalised to reflect their wishes and what was important to them. Support plans were reviewed and updated when needs changed.

Staff were knowledgeable about people's needs, their interests and preferences in order to provide a personalised service.

People their relatives and staff felt there were regular opportunities to give feedback about the service.

Is the service well-led?

Good

The service was well led.

There was an open and positive culture which focused on people. The manager operated an 'open door 'policy, welcoming and acting on people's and staff's suggestions for improvement.

The registered manager had robust systems in place to monitor the quality of the service provided and as a result continual improvements had been made.

Staff were supported by the registered manager. Staff and relatives felt comfortable discussing any concerns.

SeeAbility - Surrey Views

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 6 April 2016 and was conducted by two inspectors.

Before the inspection, we reviewed all the information we held about the provider. This included information sent to us by the provider in the form of notifications and safeguarding adult referrals made to the local authority. A notification is information about important events which the provider is required to tell us about by law. We contacted the local authority commissioning, quality assurance and safeguarding team to ask them for their views on the service and if they had any concerns.

As part of the inspection process, 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 improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with one person, three staff members, the registered manager and the deputy manager and two relatives.

We spent time observing care and support provided throughout the day of inspection, at lunch time and in the communal areas.

We reviewed a variety of documents which included two people's support plans, risk assessments, medicine records, four weeks of duty rotas, maintenance records, all health and safety records, menus and quality assurance records. We also looked at a range of the provider's policy documents. We asked the registered manager to send us some additional information following our visit, which they did.

The last CQC inspection was 26 February 2014 where no concerns were identified.

Good

Is the service safe?

Our findings

People were protected from harm. One person told us "I feel safe. I'm happy here, I always feel happy here." Relatives told us that they thought that people were safe at the home. One relative said "(Person) is certainly in a very safe environment and due care is always shown in the meticulous manner, the day to day running is well prepared."

Staff had a good understanding of what constituted abuse and the correct procedures to follow should abuse be identified. For example, staff explained the different types of abuse. One staff member said "If I see any concerns I will inform management, if I am not happy with their response, I would inform the safeguarding team and police."

There was a whistleblowing policy and safe guarding policy in place with contact details of CQC and the local authority. Staff spoke with people on a monthly basis regarding what abuse was and how to report it to. When safe guarding concerns arose the registered manager had contacted us and the safe guarding team.

Risks to people were managed to ensure that their freedom was protected. Staff had individualised guidance so they could provide support to people when they needed it to reduce the risk of harm to themselves or others. Support plans contained risk assessments in relation to people who required one to one supervision when in and out of the home, as well as individual risks such as road safety, bathing and attending various activities. Where needed there were risk assessments in place for people with identified risks and an action plan to on and how to manage them, or example falls, choking and managing behaviour that can challenge.

Relatives and staff told us that they were involved in planning the risk assessments; staff were able to describe individual risks to people and how to address these to keep people safe. For example a staff member told us when one person became agitated and anxious they could destroy property and people's belongings. Staff said they would give the person space and provide them with distraction. We saw this happen on the day and this approach was evidenced in the person's risk assessment.

There were safe procedures in place for the administration, disposal and storage of prescribed medicines. People required staff support to enable safe administration of their medicines. There were clear guidelines in place for staff so they knew how the person needed or liked to have their medicines administered. We looked at medication administration records (MAR) and blister packs that confirmed that people were having their medicines administered. The management told us to ensure that people received a more personalised service people had individual medicine cabinets in their bedrooms.

For people that were prescribed as required medicine (PRN), such as some pain relief, there were guidelines in place, signed by the GP and detailed the signs people would display that may indicate when the person needs the medicine administered.

Medicines were dispensed to people safely. We observed medicines being given to people in the way they preferred them. For example, one person had their medicines and were given water and honey to make it easier for them to take. This was detailed in their care plan as their preference. We also found that people who suffered from epilepsy had a 'seizure' record and treatment plan developed by the neurologist in order that staff could ensure they administered treatment in a safe way when people experienced a seizure.

There were enough staff to meet the needs of people. Staff and relatives told us they felt there were enough staff to meet people's needs. The registered manager told us that staffing levels were determined based on people's needs. Their dependency levels were assessed and staff were allocated according to their individual needs. Two people required one to one support whilst at home during the day and we observed this to be the case. The registered manager told us there are five staff members during the morning shift and we confirmed this to be the case. We saw from the rota that staff levels were consistently maintained. We saw that staff attended to people's needs promptly.

There were robust systems in place to ensure that staff employed were recruited safely. Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. Staff recruitment records contained information to show us the provider had taken the necessary steps to ensure they employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring Service (DBS) check. The DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

The registered manager had systems in place for continually reviewing incidents and accidents that happened within the home and had identified any necessary action that needed to be taken. Staff told us how they would respond to an incident and accident. For example, staff told us that if a person had a fall they would get help from another member of staff, use first aid if trained and call an ambulance if required.

The registered manager told us the home had an emergency plan in place should events stop the running of the service. People had personal emergency evacuation plans in place (PEEP) which guide staff on how to safely support a person if there is an emergency. Staff confirmed to us what they were to do in an emergency.

Good

Is the service effective?

Our findings

People's human rights were protected as the registered manager had ensured that the requirements of the Mental Capacity Act were followed. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Where people lacked capacity to make some decisions, there were mental capacity assessments and best interest decisions regarding people's medicines and the care received at the home. People's relatives and other health professionals were consulted on their behalf to ensure that decisions made regarding their care were in their best interests.

The registered manager and staff had an understanding of the Mental Capacity Act (2005) including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required.

Staff told us that due to people's communication needs, people consented to their care by using, gesture, Makaton (makaton is a language program using signs and symbols to help people to communicate) vocalisation or body language. Staff were seen to ask for peoples consent before giving care throughout the inspection using these techniques.

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). Some people's freedom had been restricted to keep them safe. For example, the front door was locked to ensure people's safety and one person required one to one support to keep them safe and they were assessed as unable to consent to that care. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible.

People were supported to maintain a health balanced diet. People had a choice of food and drink and plenty was available throughout the day. We observed lunch being served. The meal was prepared for by staff, with the help from one person. An alternative meal was offered to one person who did not want the cooked meal, the person choose the alternative meal. The meal time was calm and sociable. Staff interacted with people whilst eating, asking them if they enjoyed it. One person told us the meal was "Very nice."

People had a choice of snacks and drinks throughout the day. One person was supported to choose their dessert by touching the two options. People were encouraged to make their own drinks with support if required. There was a one stop kettle (staff fill this with water and people press one button which is

delivered into their cup) for people who found it difficult to use a traditional kettle.

People were supported to make their breakfasts. One person was supported with a rehabilitation worker (trained staff to support people to improve or maintain their independent living skills) to make their own breakfast.

People's weight was monitored on a monthly basis and each person had a nutritional profile which included the person's food allergies, likes, dislikes and particular dietary needs. One person on religious grounds were unable to eat certain foods, the staff were aware of this and this persons needs were catered for on the day.

Staff told us they felt they had the knowledge and skills to care and support people. Staff received training which included how to support people in a safe and dignified manner that may be at risk of causing harm themselves or others. Staff had access to a range of other training which included Mental Capacity Act, medicine management and manual handling.

Staff were seen to communicate with people using Makaton, using textures and objects of reference. Makaton was used by all staff to communicate with people throughout the day.

Staff were observed to undertake care practices that ensured that the dignity and respect of people was upheld. This meant staff developed essential skills to provide the appropriate support to people in a positive way.

Management supported staff to undertake the appropriate induction and training in their personal and professional development needs. The induction consisted of the Care Certificate (an induction programme that sets out standards for all health and social care workers), with a minimum of two weeks of shadowing other staff to observe the care and support given to people and an observation by the management team.

The registered manager and deputy manager held regular supervision sessions with staff which looked at their individual training and development needs. This was confirmed by staff and the records held.

People were supported to maintain their health and wellbeing. Support plans contained up to date guidance from visiting professionals and evidence that people had access to other health care professionals such as GP's, psychiatrist, speech and language therapist (SALT), health care specialists in epilepsy and chiropodists. People had health action plans and hospital passports in place, this identifies people's health needs and which health professional is supporting them.

Good

Is the service caring?

Our findings

People and relatives told us that people were well cared for and that staff and the management team were caring and kind. One person told us "The staff are good because they care. Staff are better than (person's previous home), they're kind." One relative told us "I am happy with the carers."

Staff had developed positive and caring relationships with people. We saw companionable, relaxed relationships were evident during the day. Staff were attentive, caring and supportive towards people. Staff engaged with people using humour and touch. One staff member told us "I like to make sure they are happy. If they are smiling and laughing I feel like I am doing a good job."

Staff knew people's individual communication skills, abilities and preferences. Staff knew they needed to spend time with people to be caring and have concern for their wellbeing. The conversations between staff and people were spontaneous and relaxed. People looked relaxed and comfortable with the care provided and the support received from staff.

Staff understood the different ways in which people communicated by using people's preferred communication method, using Makaton, key words and direction. We saw how staff supported people to make choices using personalised communication methods. For example, we saw staff use Makaton and finger spelling on a person's arm as they had dual sensory loss.

People were well dressed and clean. For example, with appropriate clothes that fitted and tidy hair which demonstrated staff had taken time to assist people with their personal care needs.

People were treated with dignity and privacy. Staff gave good examples of how they would provide dignity and privacy by closing bathroom doors when supporting someone with personal care. We observed staff calling people by their preferred names and knocking on bedroom doors before entering.

There were no restrictions on when people could visit their relatives. Relatives told us that they were free to visit at any time. Relatives told us that they felt involved in people's care and their care plans. This was evidenced in people's care plans. Staff told us they reviewed peoples' support plans regularly. They said where they can they would involve the person in reviewing their care and ask for input from relatives.

The registered manager and staff were knowledgeable about people and gave us examples of people's likes, dislikes and preferences. One staff member told us "(Persons name) likes puzzles; we support them once a week to go shopping where they chooses to buy a new puzzle."

Good

Is the service responsive?

Our findings

People's views were listened too. One person said "staff are quick at responding to me." One person told us that they had complained to the manager about the arm chairs and sofa that required repair. The registered manager acted upon this feedback and confirmed that new furniture was due to be delivered soon.

People receive personalised care. People's care plans were person centred, thorough and contained information such as 'my morning/evening routine, what I can do and how I like my support.' Plans included information on how to support people with their visual impairment, including 'what support and equipment I need walking in the house and in the community.'

Care plans were reviewed frequently and as and when people's needs changed. People had an 'I statement' in place. This is via the think local act personal initiative (TLAP). This is a partnership of Health and social care organisations with an aim to transforming through personalisation and community support. One persons' I-statement was based around using a computer based communication tool. Staff had made a referral to the rehabilitation staff in SeeAbility, who were in the process of assessing which tablet and computer programme was appropriate for this person to use.

A staff member said "To be responsive you need to understand the individuals care plan, the history and family." The staff member went onto say that peoples communication passports helped with being responsive to people's needs. People had communication passports in place that detailed how staff should support a person and what communication methods the person preferred. For example it said that one person needed staff to speak with them using key words only and use of directive language, we saw that staff were communicating with the person in that manner.

For those people who had behaviour that can challenge there were care plans in place detailing what the behaviours were, what the persons triggers were and what support they would need to keep the person or others safe should they display any behaviours. We observed staff supported people safely, calmly and responsively when one person displayed signs of agitation.

Relatives, health and social care professionals were involved in planning peoples care. There was a record of people's histories. People's preferences, such as food likes, and preferred names were clearly recorded. Care was given in accordance with these preferences.

People's health passports were regularly updated. A health passport is a useful way of documenting essential information about an individual's communication and support needs should they need to go into hospital.

Staff had monthly sessions with people to obtain their feedback on the care that was provided. Information recorded included if there are any personal issues, environmental issues are they happy with the food, any suggestions.

There was a keyworker system in place, which sought the person's views and supported them when planning activities, holidays and to access the community and updating their care plans. One staff member told us that one person they support loved to be pampered and thought that it was a good idea to suggest a spa break as a holiday. This was currently being planned.

Records we viewed and discussions with the registered manager demonstrated a full assessment of people's needs had been carried out before people had moved into the service. There was evidence in people's care plans that their needs were regularly assessed and reviewed and plans updated to reflect any changes

Staff knew people well. Staff could tell us about people's needs, likes and preferences; this was confirmed by reviewing people's care plans and observing the interactions between staff and people. For example one person liked to complete puzzles; we saw staff participate in this activity with the person.

Relatives told us that people had enough activities during the day "[Relative] seems to have something every day of the week."

People received 15 hours a week at the SeeAbility day service, where people choose the sessions they wished to attend. One person was supported to go shopping and have lunch out. Other people attended the day service. The registered manager told us that they also have volunteers come in to support people with individual activities and outings such as going out for coffee or an activity in the home. One volunteer supported a person to go swimming weekly and for a meal out afterwards.

People and relatives said they felt were listened to. The registered manager told us that one person had made a complaint that staff had missed pancake day. The manager had apologised and arranged for people to have pancakes the following day. as a result a list of important dates were displayed in the kitchen to ensure that staff did not miss dates other cultural or religious dates that were important to people. This was recorded in the complaints book.

The service also had a big red button. People could press this to advise staff that if they wanted to make a compliant or a suggestion. People could speak into the button and it would be listened to each day by the manager.

Good

Is the service well-led?

Our findings

One person told us "The service is good and so is the management. I like the quality care, it's good."

The service was well led. Staff said they felt supported by the management of the service. Relatives told us that they felt the management were approachable and dealt effectively with issues when they were raised.

There was an open and positive culture in the home which focused on people. We observed members of staff approach the registered manager during our inspection and observed an open and supportive culture with a relaxed atmosphere.

The management team interacted appropriately with people with kindness and care and knew people well. All the staff were clear about the aim of the service which was to promote peoples independence. The registered manager had stated in the provider information return (PIR) and the statement of purpose that the home is focused on promoting people's independence. This was reflected in what we saw.

Staff told us that they felt motivated; one staff said "If you are not happy with what you do you will not go far. I love my job; I love what I am doing. We have a very good team here. I can always go to management and they are really, really supportive." Another said "I can go to anyone with concerns. The area manager is available whenever you want to talk."

There were robust systems in place to ensure that quality care was always provided. The registered manager carried out an audit process to ensure the quality of the service and drive improvements in best practice. These included regular checks of support plans, staff competencies, all aspects of the environment and fire safety. There were quarterly monitoring visits in place completed by the organisations senior operational managers An action that had been identified from the latest audit was that end of life care plans should be implemented. The registered manager told us that this was being discussed at people's reviews and were being implemented.

Staff told us they had staff meetings regularly and could always request extra meetings if they wanted to talk about anything. We saw minutes of staff meetings, items on the agenda included CQC and inspections, people's needs and training. They said they were kept up to date in between meetings by the registered manager and during handovers these meetings acted as group supervision. Staff were clear about their roles and responsibilities. Staff showed us the handover sheets and daily routine sheets which detailed which staff member was supporting whom and what else they were responsible for during their shift.

All the policies that we saw were appropriate for the type of service, reviewed annually, were up to date with legislation and fully accessible to staff. The staff knew where they could seek further guidance and how to put the procedures into practice when they provided care.

The registered manager had a good understanding of the requirements of CQC and ensured consistently that the appropriate and timely notifications had been submitted when required and that all care records

were kept securely in the home.