Community Homes of Intensive Care and Education Limited

Carisbrooke

Inspection report

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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 care home which offers accommodation for people who require personal care and have a diagnosis of learning disabilities or are on the autistic spectrum. The home is registered to provide a service for up to six people and is currently running at full capacity. The home offers three bedrooms on the ground floor and three on the first floor, all of which are en-suite. The service further provides a summer house that doubles up as a sensory room. People have access to the company's psychologists and behaviour specialist team who work closely with the staff team to ensure that people's needs are effectively met.

The home is required to have a registered manager. The manager has been in post since May 2014, and has completed registration with the CQC. 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 knew how to keep people safe by reporting concerns promptly through a procedure which was displayed in the office. Systems and processes were in place to recruit staff who were suitable to work in the service and to protect people against the risk of abuse. There were sufficient numbers of suitably trained and experienced staff to ensure people's needs were met.

We observed good caring practice by the staff. Relatives of people using the service said they were very happy with the support and care provided. People and where appropriate their relatives confirmed they were involved in the planning and review of their care. Care plans focussed on the individual and recorded their personal preferences well. They reflected people's needs, and detailed risks that were specific to the person, with guidance on how to manage them effectively.
People told us communication with the service was good and they felt listened to, with regular team meetings being offered. All relatives spoken with said they thought people were treated with respect, and staff preserved their dignity at all times.

People were supported with their medicines by suitably trained, qualified and experienced staff. Medicines were managed safely and securely. Protocols for PRN (as required medicines) were detailed providing guidelines on when these should be given. Staff were able to verbally describe the protocol, and the Medication Administration Record (MAR) sheets did not suggest disproportionate usage.

People who could not make specific decisions for themselves had their legal rights protected. People's care plans showed that when decisions had been made about their care, where they lacked capacity, these had been made in the person's best interests. The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty.

People received care and support from staff who had the appropriate skills and knowledge to care for them.

All staff received comprehensive induction, training and support from experienced members of staff. They felt supported by the registered manager and said they were listened to if they raised concerns.

The quality of the service was monitored regularly by the provider, as well as by an externally commissioned auditor. A thorough quality assurance audit was completed quarterly with an action plan being generated, and followed up on during identified timescales. Feedback was encouraged from people, visitors and stakeholders and used to improve and make changes to 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?

Good

The service was safe.

People were safeguarded from abuse and staff understood how to report any concerns they had. Staff told us they were happy to whistle blow should the need arise.

Risk assessments, and emergency plans were in place. These were robust, providing clear details of what action to take.

The provider had a comprehensive recruitment procedure in place. People were kept safe with the current staffing ratios.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People and their relatives were involved in making decisions about their care. Where people did not have capacity to make decisions, support was sought from family members and healthcare professionals in line with legal requirements and safeguards.

People were offered choices of meals and drinks that met their dietary needs.

People received timely support from health care professionals.

Staff received regular supervision, training and appraisals. They received a comprehensive induction that was used as a foundation for further learning.

Is the service caring?

Good

The service was caring.

Staff worked in a caring, patient and respectful way, involving people in decisions where possible.

People's dignity and privacy was respected and maintained at all times.

Staff knew people's individual needs and preferences well. They gave explanations of what they were doing when providing support.

Is the service responsive?

Good

The service was responsive.

Care plans reflected people's needs and were reviewed regularly.

There was a system to manage complaints and people and relatives felt confident to make a complaint if necessary.

People and their relatives were asked for their views on the service and they felt confident to approach the management team with these.

A programme of activities was provided to suit people's interests. An activities co-ordinator arranged activities that were both community based and in house, responding to the needs of the person and the advice of professionals.

Is the service well-led?

Good

The service was well-led.

Staff, relatives and professionals found the management style approachable and open.

Effective processes were in place to monitor the quality of the service. This included out of hours spot checks.

Audits identified where improvements were required and action was taken as a result.

There was strong evidence of working in partnership with external professionals to keep people healthy and enhance their lifestyle.

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 5 April 2016, with follow up telephone interviews on 6 April 2016. This was an unannounced comprehensive inspection, and was completed by one inspector.

Prior to the inspection 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. A Provider Information Return was not received for this service.

During the inspection we spoke with four members of staff, including the shift leader, assistant manager, activity co-ordinator and registered manager. We spoke with three relatives of people who live at the service, and one person who uses the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. This focused on verbal and nonverbal communication.

Care Plans, health records, medication records and additional documentation relevant to support people were seen for all six people residing at the service. In addition a sample of records relating to the management of the service, for example staff records, complaints, quality assurance assessments and audits were viewed. Staff recruitment and supervision records for five of the regular staff team were looked at.

Good

Is the service safe?

Our findings

People were being kept safe, by robust recruitment procedures. This included obtaining references for staff in relation to their character and behaviour in previous employment and a Disclosure and Barring Service check (DBS). A DBS enables employers to determine whether an applicant has any criminal convictions that may prevent them from working with vulnerable people. A robust process had been implemented by management to ensure staff were suitable and able to carry out their duties safely and effectively. This included declaration of health and fitness, a documented interview process, reference character checks, gaps in employment explained – all of which were obtained and verified prior to employment being offered.

One person told us that they felt very safe at the service. They said, "The staff look after me". This point was reiterated by the family members who we spoke with. They told us they felt their relatives were kept safe. One family member stated: "Oh yes, definitely. As safe as anyone can be anywhere". Another relative stated, "[name] is always well looked after. I would know if [name] wasn't safe". Staff had a comprehensive understanding of safeguarding and whistleblowing procedures. They understood the types and signs of potential abuse. Training records showed all staff had undertaken training in safeguarding people against abuse, and that this was refreshed on a regular basis. Staff were aware of the external agencies that should be contacted in circumstances where the staff thought that either the registered manager or the organisation were involved in the abuse. This included the police, local authority, safeguarding team or the CQC. One member of staff when asked about reporting abuse stated "Oh yes, definitely. I wouldn't hesitate." The general consensus amongst staff was that staff were both confident with raising concerns, and that the registered manager would deal with this appropriately, to keep people safe.

People were kept safe by staff with the use of appropriate risk assessments. These were reviewed regularly; with evidence illustrating where appropriate relatives or representatives had been consulted with. For example, some people accessed the community with staff using public transport. It was felt this was safer than them going into the community alone, as well as enabled them to build on their independence skills. Risks were identified, assessed and the activity was engaged in safely.

Medicines were supplied by a community based pharmacist. They were stored safely in a locked medicines cabinet. Temperature checks were recorded and carried out daily. Medicines were ordered and managed to prevent over-ordering and wastage using a Monitored Dosage System (MDS). Each person's MDS held a copy of their photo, to reduce the risk of error. Medication Administration Record (MAR) sheets were signed and dated correctly, with no medicines errors seen. Audits of the MAR sheets were carried out by the registered manager frequently, to identify any errors, and deal with them as soon as possible.

We found the guidelines of 'as required' (PRN) medicines provided sufficient information on when they should be administered. This is a document that gives guidance to staff on what action to take prior to offering a person PRN medicines. This is to ensure that medicines are only given when necessary, reducing the possibility of over medicating or dependency. The MAR sheet was checked in relation to the frequency of these being used, and was found not to be a frequent measure employed by staff. Staff were able to describe appropriately when PRN medicines should be administered.

Systems were in place for trends to be monitored should incidents or accidents occur. These would alert the registered manager to complete guidance to prevent the likelihood of similar incidents.

Each person had their own personal fire evacuation plan. The staff were able to correctly identify what actions needed to be taken in the event of a fire. Fire drills were regularly undertaken, so to ensure that both staff and people were familiar with the procedure. Records illustrated that all residents would evacuate the building and follow the procedures. Fire equipment was regularly checked to ensure it was safe to use. A contingency plan had been prepared for staff to follow should an emergency occur resulting in the building needing evacuation. This contained alternative accommodation address, contact details for staff and professionals to call in case of the emergency.

All maintenance safety checks were up to date for example: fire systems, emergency lighting and legionella checks. Routine maintenance checks were carried out at the service, to ensure that the premises remained safe for people using the building.

The registered manager told us that four staff worked on early shifts and three on late shifts with two staff awake on the premises each night. Rotas showed staff shortfalls were initially covered from within the team, if this was not possible, bank staff from within the company were used, to maintain consistency in care and practice. There were sufficient staff working per shift to keep people safe.

The home was clean and tidy. Personal protective equipment (PPE) such as gloves and aprons were readily available for staff to use as required. Colour coded systems for cleaning products and kitchen equipment was visible throughout the home, this reduced the risk of cross contamination, and followed infection control procedures.

Good

Is the service effective?

Our findings

People were provided care by a staff team that received regular supervision. This provided both the staff and the registered manager the opportunity to discuss staff job role. Areas where additional support or improvement was needed, as well as areas where staff excelled, were identified. The supervision process was used positively to improve both personal practice and that of the service, with staff being given the opportunity to suggest new innovations. Records illustrated that annual appraisals were carried out in addition to the scheduled supervision. The registered manager had introduced "person centred supervision", which was random. This was designed to discuss the member of staff general well-being, and was described by one staff as a "positive touch" to the formal process. Staff told us they found both the supervision and appraisal process useful. One said, "I can raise issues, deal with them and move on. It is a very useful thing."

All staff completed a comprehensive induction process. This included completion of the company's mandatory training. In addition the registered manager sourced training that he felt would be useful. For example, staff had received training in effective communication with people who had learning disabilities and autism spectrum disorder (ASD). This covered areas of understanding the principles of the diagnosis, and what this means from the person's perspective. This was effective in helping staff to understand the people with whom they worked, and why they may communicate in a particular way. Before commencing work staff shadowed experienced staff until they felt confident to work independently. The training matrix showed that all training was up to date, and had been booked prior to when it was due to expire. This was effective in ensuring that staff knowledge and skills were continually updated. The registered manager told us that he checked the competency of the staff team following training, so that he was confident staff were able to put into practice the learnt theory, and therefore ensure effective care was delivered.

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 made on their behalf must be in their best interests and as least restrictive as possible. 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 and hospitals 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 saw staff seeking consent by asking people if they wanted to do something and giving appropriate explanations. Staff were able to describe examples of best interests decisions, for example whether the person should be able to access the community independently. They could tell us who had been involved in best interest meetings and the importance of involving people who knew the person well to help make an appropriate decision. This was evidenced within the care files for relevant people. Each person had a decision making profile in their care plan indicating those decisions which required a best interest decision. The registered manager told us everyone living at the service had been reviewed in line with recent changes

to DoLS. This was to ensure people's freedoms were not restricted unnecessarily.

Each person had a nutritional profile and health plan in place. If a person had any specific dietary requirements for medical, cultural or religious reasons, these were catered for. Documents were prepared through multi agency working with, for example a dietitian, which meant a comprehensive care plan had been prepared to meet individual needs. This minimised the potential for error of preparing wrong foods, and ensured effective management of health and dietary needs at all times.

People's health care needs were met. Care records provided evidence of all visits to or from health professionals including GP, optician, dentist, in house psychology and Speech and Language Therapy (SALT) team. Information arising from their advice was included in the care plan and health plans. Hospital passports were created for all people using the service. This was a document that provided essential information about the person, including personal preferences, important contacts, as well as medical information. This enabled hospital staff to offer a person appropriate care in the event of an admission.

People were involved in planning their meals. Meetings were held to decide the menus and were presented in a pictorial format for effective communication. A four week rolling rota of foods, agreed by people, was used at the service. If a person wanted food that was not on the agreed menu, this would be accommodated where possible. Alternative meals were always offered to prevent this occurrence. During the lunchtime observation, we saw people were asked what they wanted for a hot sandwich. People were offered second helpings of food, and fruit or yoghurt for dessert. Staff ate with people which provided a homely atmosphere. Small dining tables were set up in the dining room, allowing people choice of where to sit. We observed staff used this as an opportunity to converse with people about things of interest to them, as well as things that were happening at the service – for example the activity scheduled for later that afternoon.

Drinks and snacks were regularly offered to keep people hydrated. Staff showed people the various options available, so that an informed choice could be made. Where possible people were offered the opportunity to make a drink with staff assistance should this be required.

Each bedroom had their own en-suite, which was adapted to meet the person's needs. For example, one person found clutter an issue. The bathroom was designed as a wet room, to eliminate the need for a curtain. All personal items were kept locked securely, and only taken out at times of personal care. This was an effective way of working with the person. It prevented the possibility of increased anxiety and enabled the person to maintain their independence in using their bathroom.

Good

Is the service caring?

Our findings

The service was caring towards the people supported. Staff were observed speaking to people with respect and were generally approachable – smiling and welcoming. People appeared comfortable approaching staff for assistance or for general interaction. One person reported, "I am well cared for here, they look after me... I love living here." There was a calm and peaceful atmosphere within the home. People were able to access communal areas at all times, except for the kitchen, which was with supervision. Positive interactions were observed during lunch time and during people's participation in the indoor activities. For example, we saw one person approach staff to help select music to play on the computer. Staff engaged with the person, sitting with them until they selected the music they wished to listen to.

People were encouraged to gain independence and strive towards achieving this. The registered manager told us how it was important as part of this that people were able to practice their faith. For example one person would regularly be supported to attend their place of faith. Another example was of a person who retained close family ties. The service was involved in organising a holiday with the person and their family. They attended the holiday, so to ensure consistency was maintained, as well as maintain an independent relationship with their family. The family reported, "I've got nothing but wonderful things to say… We're thrilled with the care… We had a lovely holiday."

"Group service user meetings" were held monthly. This was used as an opportunity to address generic house related issues with people using the service. A pictorial format was used to communicate with people unable to communicate verbally. They were actively encouraged to express their views and be involved in making decisions. We found examples of this with menu planning. People were able to advise of which foods they would like to eat. This was documented, and where possible, implemented within the menus. In addition activities were discussed for group outings that could be agreed and facilitated by the service.

The home emphasised the importance of respecting people's dignity. A dignity charter was on display identifying how staff should work to ensure this was maintained. One member of staff was identified as the dignity champion.

People's privacy and dignity was respected and maintained. A number of examples of people being asked discreetly if they wanted to use the bathroom or checking to see where people were, were seen during the inspection. Staff told us they maintained dignity for people by doing things like making sure people's clothes were properly adjusted and clean. One member of staff stated that it was important to ensure that the service felt like a home for people as this reinforced a caring and dignified support package.

All documentation was kept securely and confidentially. Staff ensured they did not converse about people in areas of the home that could be overheard by others. Where necessary conversations took place in the office, so to preserve people's privacy at all times. One member of staff stated, "You have to treat people how you would like to be treated. I don't want people talking about me in front of others…"

Good

Is the service responsive?

Our findings

People had their needs assessed prior to them moving into the service. The service was at full occupancy, with a group of people who had their needs assessed in relation to compatibility, social and health needs, and how these could be met by the provision.

Care plans focussed on the individual. Information such as, the person's background, how they liked things done and how they communicated their everyday care needs were included. These were reviewed six monthly, however where necessary they were reviewed more frequently to ensure the service was responsive to people's changing needs. Relatives of people, where appropriate, were involved in the care reviewing process. One relative stated, "I'm involved to a limit with the care plan. I don't need to be. I know the home do the best for [name]." People and their relatives felt that the home aimed to provide a high level of care that met the needs of the people. Another relative reported, "[I'm] Thrilled to bits with them".

People were able to be involved in decisions related to their care. A key worker system had been implemented within the service. This meant that one member of staff held primary responsibility to ensure that all documentation related to the care the individual received was in line with their needs and how they wished to have a service delivered. The care plans were reflective of this, for example we found that where appropriate these were written in the first person, with "I would like staff to help me with…" The care plans were also reviewed with the individual where possible. For people who were non-verbal a pictorial system was used to assist with communication. One person, whose needs were significantly greater due to heath reasons, had their care plan reviewed more frequently. Staff would complete a comprehensive document that was then used by the key worker to advise any changes needed to the care plan. It was evident that all staff had read the care and support plans for all people within the service. A list was retained on file detailing date read and signed by each staff. Staff knew the needs of each person in detail and how they wished to be supported, as well as what their likes and dislikes were. This information was then shared with the team, through updated plans, handovers, and team meetings. Documentation related to this in the team meeting minutes and we observed this during a handover before a community based activity. The key worker process further allowed the person to develop a trusting and confidential relationship with one member of staff in particular.

We observed that staff were responsive to people's needs. They were able to recognise when people were becoming distressed or needed assistance. For example, in one instance when a person was becoming upset due to not being able to find a ball. A member of staff approached the person, and sat next to them, gently conversing with them to establish where they last saw it. They then helped the person to locate it, and remained with them until they were no longer anxious.

The service was responsive to people's individual preferences and choices. At lunchtime we noted that people's food was presented differently being cut into various shapes. One member of staff we spoke with explained that each individual's preferences were being respected regarding the presentation of their food. Some people liked to have their hot toasties cut into small triangles as this helped them in independent feeding. We found these preferences were reflected within the care plans.

Another example, of this was the bedrooms. We found that each bedroom had been decorated differently, with a number of personal items on display. One bedroom was painted blue. This was the person's favourite colour and helped them to relax. Another person had posters over their walls of all their favourite bands. The person told us, "I like [band name]. I have my room decorated with posters of them. I love my room."

An activities co-ordinator was employed by the service. Her role was to develop both individual and group activities for people to engage in, within the community. These were currently under review. The activities co-ordinator told us the aim was to meet people's needs whilst encouraging them to gain independence. For example, if a person had a health assessment that identified a particular need, this would be incorporated into a fun activity for all people to engage in. This had proven to be effective. People's health needs were being responded to, whilst engaging them in activities.

There was a complaints procedure and information on how to make a complaint was displayed. People and their relatives told us they were aware of how to make a complaint. We reviewed the complaints log and noted that complaints had been appropriately dealt with. We asked the registered manager to explain the process of managing complaints. He told us that it was essential that the management of the concern was entirely transparent. A full investigation would be carried out, with the complainant being told of the outcome. People's relatives were confident that the service would correctly deal with a complaint. One relative stated, "They deal with complaints or concerns promptly". Another reported, "I have nothing to complain about… but am confident to speak with [name of registered manager]."

Good

Is the service well-led?

Our findings

At the time of the inspection the registered manager had been in post for almost two years. Within that time staff reported that positive changes had been implemented which had improved the culture of the home. One member of staff stated, "I've been working here for [number] of years. This house is very homely. It's one of the best places I've worked" The registered manager had an open door policy. People using the service, staff, relatives or other professionals had the opportunity to raise any concerns or complaints with the registered manager at any time. During the course of the inspection we observed people were comfortable to knock and enter the office to have a general chat with the registered manager, or seek reassurance about an activity. The registered manager would engage within the home, and not base himself entirely in the office. This made him available to all.

There was an honest and open culture in the home. Staff showed an awareness of the values and aims of the service. For example, the emphasis of the service was to promote community living and individuality. One staff member said, "It's a great place to work. You know you're service users and what they can achieve…it's about being with them and supporting them with this." Staff told us the registered manager regularly checked on the care provided, whilst engaging with people. In addition the registered manager completed unannounced spot checks of the service in non-office hours. Records related to this showed that some of these had been completed on weekends or late in the evening. A report was written by the registered manager, with action plans written if any shortcomings were noted.

The registered manager completed weekly and monthly audits of paperwork. We saw evidence that these were completed. In addition quality assurance audits were completed quarterly by the operations manager. These generated an action plan, where issues were noted, and a timeline noted for the registered manager to work towards. An external contractor was used annually to conduct surveys related to the experience of people, families, stake holders, commissioners and visiting professionals. The data was analysed and a report prepared for the registered manager to use, to implement any changes required.

Staff told us they felt able to voice their opinions or seek advice and guidance from the registered manager at any time. They told us he was open and approachable and created a positive culture but was not afraid to speak to staff if they did not perform to the standards expected. One staff member said "His approach is something different, very good. He knows his job, he's a proper manager" Another said, the registered manager: "[name] is a strong leader, good role model. Explains things and wants people to learn and gain knowledge." This was replicated with a relative stating, "Oh he's very good. I'm very confident of his approach". We saw evidence in the complaints and compliments folder that showed neighbours and visiting professionals had further emphasised the good leadership of the service. They had stated they were confident of the way in which concerns were dealt with, both effectively and transparently.

The registered manager had considered the concerns raised and responded to them appropriately. The registered manager referred to the Duty of Candour, which emphasises the importance of transparency when dealing with a complaint. This illustrated that management were transparent in their handling of complaints and concerns.

The communication within the home was good. Handover and shift planners were used. These were verbally worked through and completed on paper so reference could be made to them during the course of the shift. A communication book was in place which allowed supplementary information to be passed onto staff. A diary was used to detail appointments, schedule meetings and indicate training bookings. Monthly team meetings were effectively used to promote change and introduce topics of discussion amongst the staff team.

We found there to be good management and leadership. The registered manager was supported by an operations manager who offered on going guidance and support. The registered manager stated that he did not hesitate to ask for assistance to ensure the service was well led. In addition the service had access to in house services including psychology and behaviour specialists, all of whom visited the service frequently, to review people's care files with staff. There was strong evidence of working in partnership with external professionals. Care files contained evidence of advice sought, and how this was incorporated into people's care. This was frequently reviewed within a multi-disciplinary team, to ensure the advice remained up to date.