Vista

Simmins Crescent/Whitteney Drive

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

This inspection visit took place on 17 November 2016.

We last inspected the service in 2013 and found that the service was meeting the requirements of the regulations.

Simmins Crescent/Whitteney Drive provides accommodation for up to 15 adults who need personal care and support. The service provides care for people who have a learning disability and sensory impairment across three bungalows. At the time of our inspection there were 15 people using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were systems in place to keep people safe. There were good systems for making sure that staff reported any allegation or suspicion of poor practice and staff were aware of the possible signs and symptoms of abuse. Staff were confident to report through safeguarding or whistleblowing procedures.

Potential risks to people had been assessed, such as risks associated with people's health conditions and the environment. Risk assessments were reviewed and updated to reflect changes in people's needs and abilities.

The provider had ensured that effective systems were in place to ensure medicines were stored, administered and managed in a consistent and safe manner.

Staff received training and support that provided them with the knowledge and skills required to provide people with effective care. We observed staff were confident and skilful in their interactions with people and demonstrated that they fully understood their roles and responsibilities.

People were supported to meet their healthcare and well-being needs and encouraged to maintain a healthy lifestyle. Staff made appropriate use of a range of health professionals and followed their advice when provided.

We found the requirements to protect people under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards had been followed. Staff sought people's consent before supporting them and respected their right to decline care.

Throughout our inspection we saw examples of good care that helped to ensure people felt included and consulted in their care. People and, where appropriate, relatives were involved in the planning of the care.

People were treated with dignity and respect and encouraged to maintain and develop their independence.

Staff working in the service understood the needs of the people who lived there. We saw that staff and people communicated well with each other and that people were enabled to make choices about how they lived their lives.

Staff were knowledgeable about the people they supported and demonstrated that they knew their likes, dislikes and interests. Care plans had been developed to focus on people as individuals and described their preferences, choices and how they wanted their care to be provided. People were provided with a range of activities to pursue their individual interests and hobbies.

The registered manager assessed and monitored the quality of care and provided clear leadership to the staff team. All areas of the service were quality assured through a series of internal audits. People, their relatives and staff were supported to share their views about the service and these were used to develop and bring about improvements within 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.

The risks to people's safety and welfare had been assessed and managed effectively. Staff understood their responsibilities to keep people safe from harm. People were supported by sufficient numbers of staff. There were systems in place to ensure people received their prescribed medicines safely.

Is the service effective?

Good

The service was effective.

Staff undertook the training they needed to enable them to be effective in their roles. Staff ensured people's best interests were managed and worked within the principles of the Mental Capacity Act (2005). People's needs were regularly assessed and referrals made to other health professionals when required to ensure their nutritional, health and well-being needs were met.

Is the service caring?

Good

The service was caring.

The staff were caring and kind and had positive relationships with people. People's right to privacy and dignity was respected and upheld. Staff encouraged and supported people to make choices about their care and maintain their independence.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. People had access to one-to-one and group activities to pursue their interests and hobbies. There was a clear complaints policy and procedures in place to support people to express concerns or make complaints if people needed to.

Is the service well-led?

Good

The service was well-led.

Staff spoke positively of the registered manager and felt supported and involved in the service. People and their relatives were enabled to share their views about the service and these were used to bring about improvements. Audits were carried out to check on the quality of the service.

Simmins Crescent/Whitteney Drive

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 visit took place on 17 November 2016 and was unannounced.

The inspection team consisted of one inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had experience working with people who have learning disabilities and use non-verbal communication.

We gathered and reviewed information about the service before the inspection. This included the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications we had received from the provider. Notifications are information about key incidents and events within the service that the provider is required by law to tell us about. We also contacted local authority commissioners who fund some of the people using the service to gather their views of the care and service.

We used a variety of methods to inspect the service. Some people's needs meant that they were unable to verbally tell us how they found living at the service, but they communicated using gestures and facial expressions. Two people were able to provide us with limited responses about how staff supported them. We spent time with six people which included observing them being supported in communal areas and at meal-times. We also spoke with the registered manager, the operations manager, a deputy manager and five care staff.

We looked at care records for three people, including records of their medicines and risk assessments. We also looked at four staff recruitment and training files and other records relating to the management and quality assurance of the service.

Good

Is the service safe?

Our findings

People using the service were kept safe. One person was able to tell us they would go to the staff or registered manager if they felt unsafe.

The risks of abuse to people were minimised because there were clear procedures for staff to follow in the event that they suspected that abuse was taking place. Staff demonstrated they were aware of procedures and who they could go to if they had any concerns. One staff member told us, "The organisation encourages you to speak up if you have any concerns. The organisation does not sweep things under the carpet. I know I can go to anyone within the organisation or outside of it, such as local authority, to report any concerns I may have." Staff told us they had undertaken training in recognising the various possible types of abuse during their induction and at regular training update sessions. We looked at staff training records which confirmed that all staff had undertaken safeguarding training and that this had been discussed and reviewed periodically to refresh staff knowledge.

Areas where people may be at risk were identified in people's care records. There were clear guidelines for staff about the possible risks to each person in a variety of situations, including personal care, going out and mobility. Each person's risk assessment identified the nature of the risk, the benefit to the person in taking the risk, what could be done to reduce the risk and if the nature of the risk was at an acceptable level for the person. For example, one person was at risk of causing harm to themselves and to others through behaviours that may challenge. We saw that their risk assessment identified the nature of the behaviours that may cause harm and actions staff needed to take to reduce the risk of harm. This included a strategy to keep the person occupied and staff training to ensure staff were able to respond to the behaviours safely and consistently.

Staff demonstrated that they were aware of the measures to take in relation to specific people in order to keep them as safe as possible. One staff member told us, "We encourage people to take risks but at the same time we have to be realistic and not set people up to fail. Risks have to be reasonable for that person to achieve what they want to. We are very aware of keeping people safe from danger. For example, making sure people are wearing their safety belts if they are using their wheelchair if this is required." We observed that one person required constant supervision as they were at risk of becoming disorientated or go into other people's rooms. We saw that staff provided this in a safe way whilst enabling the person to move freely around their home. Records showed that risk assessments were reviewed and updated regularly and when changes occurred. This meant staff had the information they needed to keep people safe.

People had fire evacuation plans in place. People's assessments took account of the support they needed to mobilise in an emergency. Staff understood the support individual people needed to evacuate the building. This meant that people could be evacuated safely in the event of an emergency.

The provider had systems in place to monitor accidents and incidents within the service. We saw that accidents and incidents were recorded in detail and included outcomes for people and details of any follow-up action required to reduce the risk of further occurrence. For example an increase in falls resulted in an

assessment and provision of specialist equipment to reduce the risk of further falls. The registered manager told us that they submitted monthly performance information to senior managers which included number and details of accidents and incidents within the service. This in turn was scrutinised by the board of trustees. This showed that the registered manager and provider were able to identify and respond to any trends or patterns in accidents and incidents and take the required action to keep people safe.

We saw that the provider had systems to make sure there were sufficient numbers of staff to provide people with the support they needed to keep them safe. The registered manager told us that the staffing numbers were determined by the needs and dependency levels of the people using the service. Staff confirmed there were enough staff to meet people's current needs. We saw that although staff were busy, they had time to spend one-to-one with people providing support both inside the service and out in the local community.

We looked at staff recruitment records. We saw that the provider ensured that all prospective staff were checked through a robust and comprehensive recruitment process. Checks included evidence of previous employment history, references, confirming people's identity and right to work in the UK and making checks through the Disclosure and Barring Service (DBS). The DBS provides employees with information to make decisions as to the suitability of prospective staff to work with people using the service. This meant that checks had been completed to help reduce the risk of unsuitable staff being employed by the service.

We looked at how people were supported to manage their medicines. We saw that each person's medicines were stored in a lockable facility within their bedrooms. Medicines were dated when they were opened so staff knew when the medicines were to be used by or disposed of. Protocols were in place for medicines that were required as and when, such as pain relief or rescue medicines used to manage specific health conditions such as epilepsy. Where people were prescribed topical medicines, such as creams and lotions, these were supported by a body map to guide staff on the correct area of application.

We looked at records relating to people's medicines, such as medicine administration records and checks of medicines. We saw there had been a number of medicine errors within the service over the last 12 months. Errors largely involved people not receiving their medicines as prescribed, for example, missed doses. We discussed this with the registered manager who told us they had responded by re-training all staff in the safe administration of medicines. This was through distance learning which staff worked through and was sent off to be externally accredited. The registered manager showed us that they had introduced medicine competencies for all staff and daily checks were made to ensure medicines had been given correctly. These were then checked by senior staff each week. When we looked at people's medicine records, we saw evidence of daily checks and that records had been completed correctly and accurately. This helped to ensure that people received their medicines safely.

Good

Is the service effective?

Our findings

Staff had the training and support they needed to enable them to provide effective care to people using the service. We talked with staff about how they provided effective care to individuals with differing needs. They showed that they knew each person's needs and preferences well and had the necessary skills to support people. For example, one staff member was able to describe how they knew a person was ready to get out of bed by looking for a specific pattern of behaviour and responses. They told us they waited until they saw this and then provided the support the person needed to get up. Another staff member was able to tell us how they supported a person to understand they were going out by swapping indoor shoes for outdoor shoes. We observed that staff reminded the person they were going out, using the change in footwear as a prompt. We saw that the person responded positively to this. This showed staff had the knowledge and awareness they needed to provide effective care.

All the staff we spoke with told us that they were well supported and received good opportunities for training and to develop themselves. One staff member told us, "I was shown lots of things when I first started but I wasn't pushed to do things quickly. They (managers) always ask if I am okay and understand what I have been shown or told. I shadowed (worked alongside) experienced staff during my induction which allowed me to be introduced to people, get to know them and read their care plans. We work as a team here and really support each other. I have completed training to enable me to understand people's needs, including sensory impairment. " Another staff member told us, "I have been here for some years and still undertake yearly refresher training to make sure I have the skills and knowledge I need to do the job."

We looked at staff training records. We saw that staff had undertaken an initial induction which included familiarisation with the building, key policies and systems and expected conduct. Staff also had the opportunity to work alongside experienced staff who shared their knowledge and expertise and supported new staff to learn about people's needs and preferences. Training records confirmed that staff had undertaken training that was essential to their role, for example, safeguarding, manual handling and mental capacity. Records showed that managers regularly reviewed training with staff to ensure it was kept up to date and to ensure it provided staff with the knowledge and skills they needed in their role. The registered manager told us they had introduced the Care Certificate for all new staff. This is a national qualification that supports care staff to develop the skills, knowledge and behaviours to provide quality care.

Staff told us they received regular supervision from their line managers. Staff told us they felt managers were supportive and helped them to develop in their roles by ensuring their training and learning was suitable for their individual learning needs. The registered manager told us they received regular supervision and support from the operations manager. This helped to ensure staff at all levels received the support they needed to be effective in their roles.

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. 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 provider was working within the principles of the MCA, and whether any conditions of authorisations to deprive a person of their liberty were being met. Records showed that mental capacity assessments were carried out for people who needed them. Assessments included the nature of decisions that people were able to make and the support people needed to make decisions. Where people were unable to make more complex decisions, staff had ensured that referrals had been made so that decisions were made in the person's best interest. For example, for invasive procedures to investigate changes in people's health and well-being. We saw assessments had been reviewed on a regular basis. Where people had DoLS authorisations in place, for example if they lacked the mental capacity to choose their home, these had been kept under review and care provided in line with conditions within the authorisation. This helped to ensure that the human rights of people who may lack mental capacity to make decisions were protected.

Staff we spoke with during our visit were able to tell us how they sought consent from people. We observed that staff asked people's consent before they supported them. People's care plans included guidance to inform staff on the actions they should take when people refused consent to treatment which was considered necessary, for example, personal care or food. This showed us the service was able to work in line with the legislation laid down by the MCA.

People told us they enjoyed their meals. One person told us his preferences for lunch and we observed he received these as his lunchtime meal. Meals were prepared individually and took into account people's preferences, dietary and cultural needs. We saw that people were offered a choice of where they ate their meals, with some people preferring to eat in their rooms whilst other preferred to eat at the dining table. Meals were served at different times to accommodate people's activities, waking times and preferences. Where possible, staff involved people in the preparation of their meals. For example, we observed staff supporting a person to make their lunch using hand over hand guidance [guiding by touch] and encouragement. We saw the staff member advising the person on what they needed to meet their nutritional needs whilst also acknowledging the person's likes and dislikes.

We observed that people were supported to have sufficient to eat and drink. Care records showed that people had an assessment to identify what food and drink they needed to keep them well and what they liked to eat. Care plans showed that people received support from other health professionals such as dieticians when necessary in order to assess their nutritional needs. For example, one person was assessed as at risk from dehydration and choking. We saw that the person was provided with a soft diet and staff recorded the person's daily fluid intake. This was in line with guidance from health professionals. This demonstrated that staff had information on how to meet people's nutritional needs.

People were supported to have their mental and physical healthcare needs met. Each person had a plan to show how their health needs were being met. Staff provided examples of when they had observed changes in people's behaviour which had indicated a change in their health and they had made referrals to healthcare professionals. For example, staff suspected that a change in one person's behaviour indicated toothache and resulted in a dental appointment being made to investigate. We observed that staff supported a person to manage their complex health condition effectively through timely intervention. Staff demonstrated that they provided support in line with the person's protocol and monitored the person to ensure they were not at risk. People were supported to have regular medical checks and, where appropriate, screening, in order to stay as well as possible. This showed staff had the knowledge and skill they needed to

support people to maintain good health and well-being.

Good

Is the service caring?

Our findings

Staff and managers knew the people using the service well. They spoke warmly of them and were able to explain their support needs, individual personalities and likes and dislikes. One staff member told us, "I enjoy coming to work. All the staff are very caring and enjoy supporting people." Another staff member told us, "It takes a long term to get to know people because of their complex needs. It's very rewarding when people trust you and I am always aware I am in their home."

We observed staff interacting with people and saw that people looked relaxed in staff company. There was verbal and non-verbal communication between staff and people which ensured that all the people were involved and included in the everyday interactions.

Staff demonstrated that they respected people's rights by affording them privacy when they wanted this. For example, on the day of the inspection we saw that staff discreetly asked people to go to their rooms to enable staff to provide them with clean clothing and freshen up. Some people chose to spend time in their bedrooms. We saw that people's preference to have their doors open or closed was respected and staff knocked or made themselves known before entering the room. One person became unwell and we saw staff support the person to go to their room and lie down to recover. We saw that staff were attentive to the person and sensitive to their needs.

People were supported to develop and maintain their independence as much as possible. For example, we observed that one person was supported to assist staff in making their own lunch. Another person was supported to undertake their shopping by staff escorting them and assisting them to manage their personal monies. People's care plans detailed their abilities, what they were able to do without support and the level of support they needed to undertake tasks. For example, getting dressed and maintaining their rooms and belongings.

We saw staff engaging with people and demonstrating that they knew their preferred method of communication. We saw that the information in people's care plans about their preferred method of communication was very detailed. For example, one person had a communication plan which detailed what words they used and what they actually meant. Another person's communication plan provided explanation as to what each gesture or movement might mean. Staff we spoke with were able to explain people's preferred method of communication and how they would express themselves if they were unhappy. Where people did not use verbal communication, staff showed they could interpret each person's gestures and facial expressions. Where people did not use English as a first language, some staff were able to converse with people in their first language and this had a positive impact on people. This helped to ensure staff involved people in making choices about their care on a day to day basis.

Good

Is the service responsive?

Our findings

Staff were available to help people to do the things they liked doing. People were supported to access interests and hobbies which were important to them. One person told us, "I like music and tv." They told us they liked to go the resource room to play their organ and to go shopping each week with staff.

The service had a sensory room which was readily available for people to use and had recently adapted a communal room into an art and craft room. The registered manager told us people were supported to attend a weekly session with an art and craft teacher but could also use the facility when they wanted to. One person told us he was going to the art and craft room to make invitations to a party and finish Christmas decorations. We saw that a member of staff later escorted him to the room and supported him to undertake the activity. Staff provided a range of one-to-one activities for people. These included shopping, meals out, discos and day trips. On the day of our inspection we saw that one person was escorted to go out shopping with a member of staff whilst another person was supported to attend a temple to pursue their religious faith.

People had an initial assessment of need and this was used to develop people's care and support plans. These were structured around providing step-by-step guidance for staff to follow to promote consistent support. For example, one care plan described how the person responded to different situations and provided guidance for staff on how to respond to reduce the person's anxiety. We observed that staff followed this guidance in practice.

People's care records contained detailed personalised information about people's background, people who were important to them, their life-style preferences and an outline of their personal history. For example, we saw that one person's care plan identified that it was important to the person to look nice and follow a beauty regime of their choice. We observed that staff had supported the person with this. Care plans included a description of the person's character and personality, how they liked their care to be provided and specific instructions for staff on how best to communicate with and understand the person. This gave staff insight into how the people they supported made their views known and gave staff the information they needed to provide care that was responsive to people's needs.

Records showed that people's care plans were regularly reviewed and updated to reflect changes in people's needs and wishes. For example, where a person's mobility needs had changed, we saw that their care plan and risk assessments had been updated to reflect the change in the level of support they needed.

The provider's complaints procedure provided step-by-step guidance to support people to express their concerns and make complaints. This was available in a variety of formats upon request. Staff were trained to identify if any of the people using the service were unhappy about any aspect of the service and advocated for them to put things right. People's care plans included information about how they would communicate if they were unhappy about something. Staff were able to tell us how they would tell if someone was unhappy and the actions they would take.

The registered manager told us that whilst they had not received any complaints regarding the service, concerns and complaints were welcomed and would be addressed to ensure improvements were made where necessary. They told us and we saw there were systems in place to report any concerns or complaints to the board of trustees each month who in turn scrutinised information to assure themselves complaints had been investigated and responded to in line with procedures and action taken to reduce the risk of further complaints. People could therefore feel confident that they would be listened to and supported to resolve any concerns.

Good

Is the service well-led?

Our findings

Most of the people using the service were unable to share their views with us about the management of the service. One person told us that they liked the staff, including managers. Staff who we spoke with told us that they felt valued by the registered manager and could approach her about anything. One staff member told us, "I know I can talk to her (registered manager) and I feel that if I did speak with her she is the sort of person to get things done." Another staff member said, "There is a low staff turnover here because staff are happy. The service is forward thinking. We are told there is no such thing as a silly question and managers take the time to explain things."

Staff received support to maintain a high quality service. Staff told us they had opportunities to contribute to the running of the service through regular staff meetings and supervisions. For example, staff were able to be involved in the development of the arts and crafts room. We looked at the minutes of the meeting held in June 2016. We saw this was well attended and covered a range of subjects including best working practices and opportunities for staff to be involved in discussions about making improvements and issues relating to people who used the service.

All the staff spoke positively about the leadership of the service. One member of staff told us, "We are encouraged to express our views and ideas in team meetings and one-to-one with managers." Staff spoke about a culture within the service that promoted teamwork and staff supporting each other. One new member of staff told us, "All the staff are so friendly and being new in the role I feel well supported. If I am unsure of anything I know I can always ask. [Name of registered manager] is fantastic!"

Our discussions with the registered manager showed that she fully understood her roles and responsibilities. She was able to describe and show progress on improvements that she planned to make within the service. This included promoting consistent systems and processes across all three bungalows, developing staff training and exploring alternative methods of staff recruitment to ensure staff vacancies were filled in a timely way. The registered manager received support from the operations manager and met with managers of other homes to ensure her knowledge was kept up to date and share best practice ideas. For example, ideas for developing staff training. This showed that the registered manager was committed to developing and improving the service.

The registered manager was aware of her statutory responsibilities to notify us about significant events and incidents within the service. Commissioners who we contacted told us that although they were made aware of incidents, they did not always receive information in a timely way. The registered manager told us they had taken this on board and would ensure that all parties were notified promptly in the event of any further incidents. This would help to ensure that relevant parties received the information they needed to ensure people were kept safe.

The operations manager provided support to the registered manager to develop and drive improvement within the service. We saw that there was a system of auditing the quality of the service. The registered manager completed monthly information for the provider in relation to key areas including safeguarding,

incidents, accidents, complaints and compliance with relevant legislation. Senior staff supported the manager to undertake monthly audits of records and working practices and these were recorded onto a monthly audit checklist. The operations manager also carried out regular audits which involved spot checks of records, such as medicines and care plans, observations within the service and collecting feedback from people using the service. Recent audits had shown that improvements were needed to ensure people received their medicines safely. The registered manager had already introduced new procedures to bring about improvement. Internal audits and checks were being reviewed and developed at the time of our inspection. These were then reported to and scrutinised by the board of trustees. The operations manager told us that representatives from the board of trustees also visited the service to monitor, check and review the service and ensure that good standards of care were being provided.

Relatives of people who used the service were supported to share their views of their family member's care through a relatives satisfaction questionnaire. This invited relatives to comment on a range of issues regarding their family member's care including quality of care, environment, staffing, information and meals. We looked at questionnaires sent out in June 2016. Most relatives had provided positive feedback about their family member's care. Where individual concerns or comments were noted, we saw that these had been followed up with a further meeting or a response with the relative. For example, one relative had requested more external activities for their family member and this had been discussed and planned with relevant staff. This helped to ensure that people and their relatives were able to share their views and these were used to develop and improve the service.