The Royal National Institute for Deaf People

RNID Action on Hearing Loss Roper House

Inspection report

St Dunstans Street
Canterbury
Kent
CT2 8BZ

Tel: 01227462155
Website: www.actiononhearingloss.org.uk

Date of inspection visit:
29 June 2016
30 June 2016

Date of publication:
18 August 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 29 and 30 June 2016 and was unannounced. At the previous inspection on 5 September 2014 we found there was a breach of regulation as detailed information about individual people had inappropriately been completed in general records so that people's privacy was not maintained. At a follow up inspection on 10 March 2015, the service had recorded people's information in way that maintained their privacy and dignity.

Roper House provides accommodation with personal care for up to 27 adults with a hearing loss. People have a range of additional needs including old age, learning disability, physical disability, mental health, autism, visual impairment and dementia. There were 21 people living at the service at the time of the inspection. The accommodation is over two floors and bedrooms can be accessed by a passenger lift. There is a communal lounge, lounge/activity area, dining room, kitchenette where people could make drinks and a large secure garden with seating. There was also a flat on the ground floor for people who were more independent. There were two people living there who had their own kitchen, lounge and garden area.

There had not been a registered manager at the service for five months. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The service had not consulted the local authority with regards to making DoLS applications, to ensure that people were only deprived of their liberty when it had been assessed as lawful to do so.

The service had not followed its policy in providing staff with regular supervision which offers staff support and learning to help with their development and to improve care for people.

People's records could not always be easily accessed and they did not always provide the information and guidance that staff needed to support people effectively.

Some aspects of the service did not promote people's independence nor value their contributions. A communal bathroom was locked but staff did not know why people did not have access; people in an independent flat had their medicines stored at the main house so they were not readily available; and mealtimes were not always effectively managed resulting in people queuing for their lunch in their own home. We have made a recommendation for the service to review its practices to ensure people are empowered in their everyday lives.

Assessments of individual risks to people's safety and welfare had been carried out and action taken to minimise their occurrence, to help keep people safe. Accidents and incidents were recorded and guidance

and assessments updated to minimise their reoccurrence.

Staff knew how to identify and report any safeguarding concerns in order to help people keep safe. Checks were carried out on all staff before they supported people, to ensure that they were fit and suitable for their role.

There were a number of staff vacancies and agency staff were used to ensure there were enough staff available to meet people's needs. Staffing levels were re-assessed and adjusted when the number of people who lived at the service changed.

A schedule of cleaning was in place to ensure the home was clean and practices were in place to minimise the spread of any infection. The service had a number of spaces for people to use and equipment and assistive technology was used to aid people to mobilise and remain safe in their home.

Safe systems were in place for the storage, recording, administration and disposal of medicines.

There was a rolling programme of essential training to ensure staff had the skills and knowledge to care for people effectively. Staff had received basic training in how to communicate with people through BSL and further training in how to communicate with people was part of their development. The diverse needs of the people who lived in the home were reflected in the specialist training that was provided for staff.

People had their health needs assessed and nutritional needs assessed and monitored. Clear guidance was in place for people with specialist health needs and professional advice was sought as appropriate. People were offered a choice at mealtimes, and where they needed support, this was provided and people were not rushed.

Staff were kind and friendly and knew people well. They understood deaf culture and how to effectively communicate with people. People regularly met with their keyworker and were involved in decisions about their care.

People's care, treatment and support needs were assessed before they moved to the service and a plan of care developed to guide staff on how to support people's individual needs. Information had been gained about people's likes and dislikes and staff understood people's individual choices and preferences.

People's views were sought in a variety of ways and they were able to raise any concerns with staff or members of the management team and they were informed of the complaints process should they need to use it.

The service had not been consistently managed. A new manager had been at the service since February 2016 and understood the changes and improvements that were needed to make the service more personalised.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

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 management of medicines ensured people received their medicines as prescribed.

Risks to people's health and safety had been assessed and action taken to minimise their occurrence.

People were protected by the service's recruitment practices and there were enough staff available to meet people's needs. Staff knew how to recognise any potential abuse and this helped keep people safe.

The home was clean and practices were in place to minimise the spread of any infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Restrictions to people's freedom and liberty had not been authorised by the local authority to ensure they were necessary to protect people from harm.

People were provided with care by a staff team that had not received the supervision they required to improve people's care.

Staff had received specific training so they could effectively support the people in their care.

People's health care and dietary needs were assessed and they had access to healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Some aspects of the service did not value or respect people's contributions or abilities.
Staff were kind and understood how to communicate with

people in a way they could understand.

People were supported by a staff team who were knowledgeable about deaf culture and who knew people well.

People were involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they moved to the service and staff knew how to support them.

People were consulted about activities and events and could access the community.

People understood how to raise a concern or complaint about the service.

Is the service well-led?

Requires Improvement

The service was not always well-led

The management of people's records was not robust to ensure they always reflected people's needs and were easily accessed.

There was a manager at the service, but they had not applied to be registered with the Commission, which involved assessing them as to their suitability for the role.

Quality assurance processes were in place and the service was working towards making changes for the benefit of people who used it.

People were provided with a number of forums where they could share their views and concerns.

RNID Action on Hearing Loss Roper House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 29 and 30 June 2016 and was unannounced. On the first day, the inspection was carried out by an inspector and an expert by experience who was supported by a British Sign Language (BSL) interpreter. An expert by experience is a person who has personal experience of using or caring for someone who uses a care service. A BSL interpreter helps deaf and hearing people to communicate with one another. They do this by interpreting spoken English into BSL. On the second day of the visit was carried out by one inspector.

We did not send the service 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 gathered this information during the inspection. We looked at previous inspection reports and notifications about important events that had taken place at the service. A notification is information about important events, which the provider is required to tell us about by law.

We spoke to seven people who lived at home. We observed how staff interacted with people and joined some people for lunch. We spoke to the deputy manager, team leader, three care staff, activity coordinator, chef, housekeeper and maintenance person. We also spoke with a Guide Communicator from Kent Association for the blind and a visiting nurse from the Intermediate Care Team (ICT). A Guide Communicator supports people who are deafblind with everyday tasks and to access the local community. An ICT nurse promotes independence by providing short term nursing and therapy after hospital admission, treatment or surgery. After the inspection we contacted the manager as they were not present at the inspection. We also received feedback from a care manager from the local authority, a community psychiatric nurse and a

commissioner of the service. .

During the inspection we viewed a number of records. We looked at the care notes in relation to three people and tracked how their care was planned and delivered. We looked at a number of other records including the recruitment records of the five staff employed at the service; the staff training programme; administration and storage of medicines, complaints log, staff and residents meetings, menu, health and safety and quality audits.

Good

Is the service safe?

Our findings

During the majority of the time of the two day visit, there was a calm atmosphere in the home and people's body language demonstrated they were relaxed and at ease in their home and in the staff's presence. People said that there were enough staff available to give them the support they needed and that staff gave them the medicines they required to help maintain their health.

Staff had received training in how to recognise and respond to potential abuse. They demonstrated they understood the situations and circumstances that would prompt them to speak to a more senior member of staff. Senior staff understood that safeguarding concerns should be reported to the manager and local authority, who are the lead agency in safeguarding adults.

The service supported people with a wide range of support needs and dependency levels. Some people were independent and able to go out alone in the community whilst other people needed staff to assist them with their personal care and to mobilise. During the inspection staff were available to support people when required with care tasks, to attend appointments and to communicate with people. Staffing rotas reflected the accurate number of staff who were on shift on the days of our inspection. The skills and experience of the staff team had been reviewed to ensure that there was a mix of deaf and hearing staff, and male and female staff on each shift. Due to the layout of the home and number of people, there were two awake and one sleep-in member of staff each night. In addition there were a range of auxiliary staff such as cleaning and kitchen staff.

There were four full time and two part time vacancies for care positions. The gaps in the staff rota were covered by agency staff to ensure that people's needs were met. The service used a small number of agency staff who knew people well. There were two agency staff present at the home on the first day of the inspection and they demonstrated they could effectively communicate and support people who used the service.

Appropriate checks were carried out to ensure that staff recruited to the service were suitable for their role. This included obtaining a person's work references, a full employment history and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. It is required that a photograph is kept of each member of staff to ensure their identity. Staff photographs were available at head office and a list had been made of all staff that required a photograph to be held at the service.

Medicines at the home were administered using a monitored dosage system (MDS). This is where medicines were pre-dispensed by a pharmacist to reduce risk of giving people incorrect medicines. Each person had a separate 'pod' with their name; the name and dosage of their medicines; and the time at which they should be given. A photograph of each medicine was recorded on the medication administrative (MAR) record to identify each individual medicine. Where a photograph of a medicine had been omitted, staff had written a clear description of the medicine. This meant if a person refused a medicine or a medicine error occurred the medicine could easily be identified. Daily audits were undertaken of medicines that were not able to be

stored in the MDS to ensure they had been given safely.

Only staff that had received the necessary training, administered medicines. When people were given medicines which required safe handling or variable dose medicines, two members of staff checked to make sure the correct medicines were given. Where people used prescribed creams, body maps were in place to guide staff to where they should be applied.

Medicines which required safer storage under the Misuse of Drugs Act 1971 to prevent them from being misused and causing harm, were stored securely. A fridge was available to store medicines that required a low temperature for them to be effective. The temperature of the fridge and medicines room were checked regularly to ensure medicine were fit for use. There were clear procedures in place for the disposal of medicines.

Regular checks were made of the service's equipment and utilities to ensure they were safe and adequately maintained. This included checks of fire alarm and equipment, first aid boxes, hoists and slings, vehicles and that water temperatures were at a safe temperature for people to use. Staff reported any items that required maintenance and these were attended to by a maintenance person who was employed five days a week.

Personal emergency evacuation plans (PEEPs) had been put in place which identified the support people needed to be evacuated in the event of a fire. Equipment was in place to ensure that people with limited and no mobility people could be safely moved from the first floor to a place of safety in the event of a fire. There was a programme in place to make sure staff took part in fire drills and the service had identified that a further fire drill was needed to ensure staff were competent to evacuate people safely. People were alerted to the fire alarm through a vibrating pillow if they were asleep in bed or flashing lights throughout the home.

A range of environmental assessments were in place to minimise the risk of slips, trips and falls. Each person's care plan contained individual risk assessments in which risks to their safety were identified, such as moving and handling, accessing the community, daily living tasks such as cooking and behaviours that may challenge themselves or other people. Guidance was in place for staff to follow about the action they needed to take to make sure people were protected from harm. For example, for people who accessed the community by themselves carried an identification card with the phone number and address of the service and staff spoke to the person about road safety in keyworker meetings.

Accidents and incidents were recorded together with details of what had occurred and the immediate action taken in response to the situation. These reports were sent to the manager for review to establish if there were any patterns or trends. If a major incident occurred such as a significant medication error, this was sent to the provider. A representative then contacted the service immediately to check what action the service had taken to ensure people and staff were kept safe. Assessments of risk and related guidance was updated after an incident had taken place to help minimise the event reoccurring. The service had a business continuity plan for emergency situations such as severe weather or a major power failure.

The home was clean and odourless. Housekeeping staff understood their roles and responsibilities and followed a schedule of cleaning to ensure the home remained clean in all areas. Staff had received infection control training and personal protective equipment was available and used. There was a large laundry room with separate areas for dealing with dirty and clean laundry and procedures were in place for managing soiled laundry. These actions helped to avoid cross contamination to minimise the spread of any infection.

Requires Improvement

Is the service effective?

Our findings

People said it was important that staff were able to communicate with them effectively in a way they could understand. They said they preferred staff to be proficient in British Sign Language or if not, to be able to read their handwriting if they communicated by written words. Health and social care professionals said there was good communication and successful joint working between them and the staff team. They said the service was proactive in contacting them they needed specialist advice and support and that they followed any advice they gave. People told us that staff supported them to attend medical appointments.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Six months ago the service had identified that applications were needed for three people. The service's action plan identified that applications were required, this had been discussed in staff meetings and staff told us that there were people at the service for whom an application was needed. However, no applications had been made to the local authority to ensure it was acting lawfully.

This failure to ensure people are not unlawfully deprived of their liberty was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all staff were effectively supported. Supervisions and appraisals were undertaken by a member of the management or senior staff team. The service's policy was that staff should have a yearly appraisal and supervision every six to eight weeks. The majority of staff appraisals had been undertaken. However, a number of staff had not received formal supervision for a significant period of time. One staff had not received supervision since May 15, another since June 15, for two staff it was January 2016 and an additional two staff had not received supervision since February 2016. One of these staff had returned to work after an absence and had received no supervision since their return. The management team were not aware of these shortfalls in supporting staff. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. This meant that staff did not receive regular feedback about their performance so they could develop their practice to improve care for people.

Not all staff had received appropriate supervision to make sure they were competent in their role. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans gave staff written guidance about people's health needs which included information about people's medical conditions and medical history. For people who had been identified as at risk of losing weight, their weight was monitored on a regular basis. However, there was an inconsistency in recording everyone's weights as part of monitoring their physical well-being. Where it had been identified that people had specific health care needs, referrals had been made to relevant health care professionals such as community nurses, speech and language therapist and dietician. A record of all health care appointments was made, such with the dentist, optician, district nurse or doctor. This record included any

advice that was given by the health professional. Supportive relationships had been developed with these professionals. Detailed guidance and daily routines were in place for people who required specialist interventions. These set out staff's responsibilities. Staff followed this guidance, carried out each required tasks and recorded that they had done so. This was to ensure that people received the specialist health care support they required.

People had a wide range of health and medical needs and professional advice and support had been sought to give effective support to people with complex needs. This included training in percutaneous endoscopic gastrostomy (PEG) and the administration of insulin via injection. A PEG is a tube that feeds directly into a person's stomach. Insulin is used to control blood sugar in people who have a specific type of diabetes. The service was seeking further guidance to make sure that staff's competency in these areas was regularly assessed by a suitably qualified person. Staff had received training in diabetes care and supporting people who were deafblind. Some staff had received training in understanding epilepsy, people living with dementia and mental health problems. Senior staff and managers were booked to attend training on medicines and people with mental health problems. Therefore, the service provided staff with training to help them support the people in their care.

New staff completed an in-house induction which included gaining knowledge about the services' policies and procedures, their roles and responsibilities and a corporate induction at the provider's head office. They also shadowed senior staff to gain more understanding and knowledge about their role. In addition, new staff completed the Care Certificate. The Care Certificate includes the standards people working in adult social care need to meet before they are assessed as being safe to work unsupervised. Staff were encouraged to complete Diploma/Qualification and Credit Framework (QCF). To achieve a QCF, staff must prove that they have the ability and competence to carry out their job to the required standard. Staff had either completed or were registered to complete levels two or above in Health and Social Care. The deputy and senior support workers had all completed level 5 Diploma in leadership which is for people in a management or senior management role in a care service.

Staff said they had received the training they needed to enable them to carry out their roles. There was a rolling programme of staff training to ensure staff knowledge was up to date and they had the skills they needed to carry out their role. Training covered essential topics such as safeguarding, moving and handling, health and safety and fire safety. Most people used BSL to communicate. New staff undertook BSL level 1which enabled them to take part in simple, everyday conversations. As part of their development staff undertook BSL level 2. Level 2 enabled staff to have a longer and more varied conversation. Staff who did not have or who were not yet proficient in BSL told us they used signs, body language and visual expressions to communicate with people.

Some people told us they were unhappy with the atmosphere in the home due to 'Shouting' and 'Arguments' that broke out between people who used the service. One person told us, "I don't like it if people shout; I don't like it if people get angry; I like it when it is quiet". Another person told us, "There is a lot of swearing. I get angry with people but you have to keep calm". Care plans identified that some people could present behaviours that were challenging to themselves or other people. This included verbal and physical challenges. Guidance was available for staff about what may trigger a behaviour and how to respond appropriately. Staff had a good understanding of people's characters and what may lead to certain behaviours. Incidents were recorded together with the triggers to assess if there were any reoccurring features to a person's behaviour. Professionals said that staff gave people clear boundaries which had resulted in their behaviours decreasing. Staff were aware of the disagreements that people shared with us and they had been discussed at keyworker meetings. People's care managers had been informed about any significant events and support and discussion was provided for the both parties after any event involving

verbal and/or physical challenges.

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 the best interests and as least restrictive as possible. Staff had received training in mental capacity and understood that people had the capacity to make their own decisions and choices on a day to day basis. They said that some people's capacity fluctuated so they did not have the capacity to make specific decisions. In these situations meetings had been held with the person, other relevant professionals and their next of kin to act in the person's best interests. If people did not have a next of kin an Independent Mental Capacity Advocate attended to help the person express their needs and wishes.

Staff said members of the staff team communicated well with one another although sometimes it was more difficult as some team members first language was BSL and some staff members were not proficient in this way of communicating. However, teams were made up of a mix of deaf and hearing staff with a team leader who was proficient in BSL to aid communication. Staff meetings were held monthly to share information and discuss practice.

People's need in relation to food and fluids were assessed and the support they required was detailed in their plan of care. For people who required support to eat via PEG tube there was a comprehensive food regime in place which gave clear guidance to staff about the amounts of fluid and food they required. At lunchtime people who required help to eat were supported in a quiet environment where communication was easier. Staff explained to people how they were going to assist them before doing so. People who were independent ate their lunch in the main dining room. There was a four weekly menu planner and at lunchtime people were offered a choice of two main meals. The chef was aware of who had special dietary requirements such as people who were diabetic and the food alternatives that were available for them. They had also supported one person to develop their menu and choices to meet their individual dietary needs. Menus were available in picture format so that they were easier for some people to understand. People were able to make their own drinks throughout the day.

People had access to two lounges, one of which had an area which was used for arts, crafts and games. Each person had their own room, the majority of which had an ensuite bath or shower. People had facilities to make their own drinks during the day. There was a large garden to the rear of the home with a sheltered seating area for people who smoked. Attached to the home were four one bedroom flats with a separate kitchen and garden to enable people to live more independently. The ground floor of the home had been decorated and plans were in place to decorate the first floor in December 2016 and lay a new carpet which looked worn in places. A maintenance person was employed five days a week to attend to any repairs and ensure the environment was safe for people and staff.

There was a range of equipment throughout the home to promote independence. There were handrails throughout the home, two specialist baths that could be assessed by people who needed to use a hoist to mobilise, a shaft lift so people could access all areas of the home and a kitchen on the first floor with height adjustable work surfaces so it could be used by people in a seated position. Assistive technology was also in place to support people with hearing loss. Flashing lights were used to inform a person that someone wished to enter their room and a mini-com was available for people to make and receive telephone calls.

Requires Improvement

Is the service caring?

Our findings

People told us their privacy and dignity was respected. They explained they were able to lock their bedroom door and if someone wanted their attention, a light flashed in their room to let them know. They said there were routines in the service such mealtimes, but they were able to get up and go to bed when they wanted to. People spoke positively about staff and the support they gave, although some people did have a particular member of staff who they had got to know well and with whom they found communication easier. One person described a member of staff as "Bright and clever". Another person told us, "The staff ask if I am happy and if it is ok to talk with me before having a conversation". Another person told us, "The staff are very nice". Professionals told us that staff were always friendly and welcoming when they visited the service and they treated people with dignity.

One of the aims of the service was to ensure that people's independence was promoted. People were encouraged to take part in independent living skills such as doing their own laundry, some light cleaning, managing their money and making their own drinks. A few people were responsible for self-administrating their own medicinal creams. However, some aspects of the service did not value or respect people's contributions or abilities. People could not enter one of the bathrooms on the first floor as it had a key code. Staff could not give an explanation as to why this bathroom was locked. The bath had been serviced and the room was kept clean, but no one had used the bath since September 2014 as this was the last date when a record had been made of the water temperature. Some people lived in a flat with its own living space, kitchen and garden. However, these people's medicines were kept in the main house so they had to go to the main house or staff had to transport their medicines to them, to ensure they received them which did not promote their independence. At lunchtime people formed a queue to receive their lunch which made the dining room appear more like a canteen that a dining room in their own home. Improvements had been made to breakfast arrangements, which was presented in a buffet style, so people could serve themselves form a range of options.

People who are deaf have their own culture with a set of social beliefs, values and history. They share a perception of the world which differs from hearing people. The service employed people from the deaf community who shared this culture and therefore had a common identity and greater understanding of the people who used the service. This ensured that people were supported by a staff team who understood their unique culture and value system.

Information about people's past lives and history had been obtained and a summary of what was important to each person, such as family and other relationships was recorded at the front of each person's care file, so it was easily available to staff. Staff demonstrated they knew people well, including their personal preferences and personal histories. Trusting relationships had been developed between people and there were humorous exchanges between people and staff. Staff also understood that everyone was an individual so some people needed clear boundaries, some people did not understand specific types of humour and others enjoy periods of quiet when they did not want to communicate.

Staff were kind, listened to people and talked to them in an appropriate way so they could understand. They

knew the importance of communicating with people through body language and facial expressions as well as specific signs. When communicating with people using BSL, sometimes we could not understand what people were trying to tell us as some people used signs that were specific to them. In these situations staff supported us to ensure people's views and opinions were understood and make sure people did not have to keep repeating themselves unnecessarily. Staff moved closer to people who had limited vision to ensure they could see the signs which they were using to communicate.

People were involved in decisions about their care, such as what they wanted to wear and what they wanted to eat and how they wanted to spend their time. "I like staying in my room and I can do this", one person told us. Each person had a keyworker and they met with them on a monthly basis to discuss their needs and goals. A monthly residents meeting was also held where people discussed any concerns and any activities they wanted to undertake. The minutes of these meetings were recorded in an easy read format with pictures to help people understand the information they contained. One person had informed staff they wanted to keep a pet and staff had enabled them to keep two guinea pigs. The pets had their own care plan and the person was responsible for following the plan to ensure their animals welfare.

The service had acted to ensure people's views were understood and heard. BSL interpreters and advocates were accessed when needed to help people to communicate their views, wishes and choices. BSL Interpreters were always booked when people attended medical appointments or review meetings about their care to ensure effective communication in these complex discussions. However, although people whose first language is not English are entitled to an interpreter, a BSL interpreter was not always available when they attended hospital appointments. Staff had contacted a representative from the National Health Service to raise people's concerns and as a result the situation had greatly improved with interpreters being available at the majority of hospital appointments.

We recommend that the service seek advice and guidance from a reputable source and review its practices to ensure people are empowered in all aspects of their daily lives.

Good

Is the service responsive?

Our findings

People said if they required assistance with personal care that staff helped them. One person told us, "It is good here because I am happy that people help me here". Some people said they were able to go out into the local town by themselves. There was a keypad on the front door and they had a key so they could leave and enter their home without staff support. People were complimentary about the range of activities on offer. "I very much enjoy doing the activities", one person told us. "I like drawing, cross stitch, embroidery and making pillows. I get help to make things. Union Jacks and hearts and paint pictures. Flowers in the field". Another person told us, "I do knitting and jigsaws with the others. We get to go outside on the bus to Canterbury. I get letters from my brothers and my keyworker helps me to write back. I last saw my keyworker yesterday. The staff take us away on holiday". Someone else told us "I play cards. On Tuesday I went bowling".

An activities coordinator was employed from Monday to Friday. They consulted with people about the activities and events people wanted to take part in at monthly resident meetings. During our visit activities took place in the activity room. This included a visit by local hairdresser, making flags, paper flowers, embroidery, cooking cheese straws and gardening. A greenhouse had been delivered for one person to enable them to grow their own produce. Regular sessions included cooking, needlework, art, a shopping and lunch trip into town, a coffee morning and chair aerobics. A photo library was kept of the different projects in which people had participated. Special events were celebrated. The Queen's birthday had been celebrated with a special cake and people had made Union Jacks to decorate their home. People had made costumes and dressed up to create a mad hatters tea party. Some people had painted their own furniture and been supported to paint and decorate their own rooms. One person showed us their room which they had chosen to paint in bright colours and use stencils. They had also placed flashing lights around their mirror. They were delighted with the result of their own design and work.

A group of people had returned from a holiday at Centre parks which they had gone on with staff support. Another person who had specific needs had a goal to go on a short break. Staff were supporting them to look into the options available and suitable provision had been sourced.

One professional told us the service had responded effectively to a person who enjoyed taking apart and putting objects back together. The person had focused their behaviour on objects in the environment which was potentially unsafe. A range of meaningful activities were offered to this person as part of the service's activity programme. Therefore, this person was able to continue undertaking an activity they enjoyed in way that was safe to themselves and other people. Another professional told us they had instructed staff how to support a person to promote their mobility. They said staff had followed the plan of care they had provided and as a result the person's mobility had improved.

Before people came to live at the service, they were visited to make a joint assessment as to whether the service could meet their needs. The person looked around the service to see if it met with their expectations. During our visit the deputy manager visited a person at their home to gain additional information about their care needs and to ensure they knew a familiar face when they moved to the service the following week.

The service also obtained information about a person's individual needs from the local authority or previous care home as appropriate. Once the person had moved to the service, they were assigned a keyworker who had the role of getting to know the person and working with them to develop a plan of care with guidance for the staff team about their support needs in relation to their health, social and personal care.

People's care plans contained information about their daily routines, likes and dislikes and staff understood people's choices and preferences. There was a one page profile which gave clear information about the person's main needs and what was important to them. The plans included all aspects of people's health, social and personal care such as how people communicated, what medication they received, dietary requirements, how they liked to spend their time and any specific health care needs. Guidance was in place for staff so they had the right information to ensure people received personalised care which was responsive to their needs. People met with their keyworker each month to discuss their care and review how they were meeting their goals. Multi-disciplinary reviews also took place with people's care manager and/or health professionals. Staff made a daily record of how each person was feeling each day, how they spent their time, and details of any health care appointments. There was a handover between each shift of staff to ensure important information was shared and that people received consistency in how they were supported.

People told us that if they were not happy about something they could go to one of the managers. During the day people approached staff in the main office and in the managers' office to discuss various issues with which they needed help and assistance. Staff and the deputy manager responded to people's needs to their satisfaction. The service had a complaints policy that was on display in the entrance hall. It was written in a range of formats including braille and pictures of people using BSL. The policy made it clear that people could talk to the manager of the service if they felt sad, but also if they were happy about particular aspects of their care. There was also a photograph and contact details of the nominated individual, who could be contacted if people were not satisfied with how the service had responded to their concerns.

Requires Improvement

Is the service well-led?

Our findings

People knew the members of the management team and said the manager and deputy manager came and spoke to them from time to time. They said the deputy manager used BSL, but the manager was not able to communicate with them in this way. "The manager is always around", one person told us. Another person said, "The deputy manager always has time to say hello to me. If I had a problem I would go to them".

Aspects of records management were not robust. At our last inspection people had a separate health care record which clearly set out their health care needs so they could be effectively monitored and a hospital passport, but these records were no longer in use. People's health care visits were recorded in their daily notes and staff said it took them a long time to look through these detailed records to find the information they required, such as an important medical appointment. People used to have a hospital passport which provided staff with important information about the person and their health should they be admitted to hospital. However, these important guides had been removed from people's care notes so this guidance was not in place for everyone.

Some records were not easily accessible as there was an inconsistency over where they were held. People's assessments were held on the computer system and not on people's care files. Therefore, this information was not readily available to staff directly supporting people which was a useful guide until a detailed plan of care had been developed by the service. Some complaint records were kept on the computer and others in a paper record, so it was easy to get an overall picture of any trends or patterns. Staff told us that when people moved to the service they were given a copy of the Statement of Purpose, which set out detailed information about the service including the facilities, people's rights, staff skills and the service structure. However, this document was dated 2010 and therefore some of the information it contained was not accurate.

This lack of some records being available, easily accessible and accurate was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not consistently been managed. One staff member told us, "We have not had a consistent manager for three years. We had a vacancy, then one manager, then another and this manager started in February this year". Another person told us, "I've had three managers and they all make different changes, but it should be ok once this manager has been here for a while". The deputy manager had worked for the service for many years and knew people well. During our visit they communicated with people and people visited them in their office for support. A temporary manager was employed at the service after the previous manager left and they remained in post to ensure a smooth transition for the new manager of the service.

The manager of the service understood the complexity of the service which catered for people with a wide range of needs. They knew that changes were needed to ensure that a personalised service was delivered to each person and to reduce any institutional practices. The manager had a clear vision and was positive and motivated to move the service forward. They had identified that care plans and health plans required improvements that staff needed a better understanding of the consent and advertisements had been placed

at local colleges to widen the pool of potential staff. They were attending BSL level 1 training and professionals stated that they were able to communicate at a basic level with people. The manager said they received effective support from other managers in the group and plans were in place to meet with the new area manager.

Staff understood their roles and responsibilities and explained about some of the planned developments in the service and how they could contribute within their role. For example, the activities coordinator said that there were plans to develop a more personalised and structured activity programme and to support each person to make a name badge for their bedroom door which reflected their interests. Staff said the service was a good place to work as they enjoyed helping other people. Staff meetings were held each month where any changes were discussed and staff had been thanked for the work already undertaken.

The views of people who used the service were gained via keyworker and residents meetings. At the last meeting people discussed having a 1940's party and they were going to watch the film Bugsy Malone to get some more ideas about how to do this. Some people attended a local 'Meet and Eat' session for people who used services in the south east. This included speakers from deaf people, workshops on staying safe and a chance for people to express their views. People responded the day was useful and that they enjoyed the food, drama, meeting people and staff listening to them.

The provider carried out a national survey of people who used their services in 2014 and had published the action they were taking as a result. The aim of this action was to improve services and as a nation organisation for deaf people, to promote their rights in all areas of their lives. A further survey was taking place in 2015/2016.

The service undertook monthly quality checks to ensure that aspects of the service were delivered to a satisfactory standard. This included audits of medicines, records such as handover minutes and daily notes, health and safety, cleaning schedules, accidents and incidents and equipment. The head of service visited the service every three months to assess the quality of the service provided. However, due to there not being a manager in post at the service, they were based at the service from Autumn 2015 until May 2016. These enabled them to review the service in detail. A number of shortfalls had been identified and action plan was in place which detailed what needed to be done to address them. The service was working through this plan and had already made improvements and changes in the deployment and mix of staff on duty, the recording of incidents so they were immediately reviewed and staff having ownership of their keyworkers plans of care. The head of service was involved in the recruitment and support of the new manager so there was an effective handover of management of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not protected against being unlawfully deprived of their liberty as the service had not made the necessary applications to the supervisory body. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records of people's care and the management of the service were not all up to date or easily accessible. Regulation 17 (2) (c) (d) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not all received the appropriate supervision to enable them to carry out their roles and help them improve care for people. Regulation 18 (2) (a)