Somerset County Council (LD Services)

Spring View

Inspection report

Preston Grove
Yeovil
Somerset
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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection was unannounced and took place on 1 and 4 December 2015.

The last inspection of the home was carried out on 4 June 2013. No concerns were identified with the care being provided to people at that inspection.

Spring view is one of a number of services operated by this provider. The home provides care and support to up to six people with profound and multiple learning disabilities. It is has five bedrooms in the main part of the house and one bedroom in an attached, but self-contained, flat. The home has been adapted to meet the needs of the people who currently live there. It is situated in a quiet residential area of Yeovil.

The people we met had complex learning disabilities and not all were able to tell us about their experiences of life at the home. We therefore used our observations of care and our discussions with staff to help form our judgements.

There was a registered manager in post. A registered manager is a person who has registered with the Care

Summary of findings

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.

The atmosphere in the home was very relaxed and welcoming. There was an ethos that this was very much the home of the people who lived there. One member of staff said "This is their home. I am just privileged to be able to work here." People were cared for by staff who were kind and considerate.

The procedures for assessing and monitoring the health, safety and welfare of the people who used the service were not fully effective. Shortfalls identified at this inspection were similar to those found during an internal quality audit which had been carried out in April, September and December 2015 but had not yet been actioned.

Risks to people at night had not always been fully considered. One person was not routinely checked during the night and there was no risk assessment in place.

Staff knew people well however; people's care and support plans had not always been regularly reviewed and they did not always reflect people's current needs.

Between the hours of 2200hrs and 0700hrs there was one waking support worker on duty. All but one person was checked hourly during the night. People had very complex needs associated with their learning disabilities and all required staff support to meet all aspects of their needs. Staff told us there was no formal on-call system for obtaining additional staff if needed.

People received their medicines when they needed them. Medicines were stored securely and were only administered by staff who had been trained and deemed competent to carry out the task.

Staff knew how to recognise and report any signs of abuse. They told us they would not hesitate in reporting concerns and were confident action would be taken to ensure people were safe.

Staff received the training they needed which enabled them to support the people who lived at the home.

People were always asked for their consent before staff assisted them with any tasks and staff knew the procedures to follow to make sure people's legal and human rights were protected.

People were protected from the risk of poor nutrition and dehydration. Menus were based on people's preferences. Meal times were flexible and were determined by the people who lived at the home. People were provided with adapted cups and cutlery which met their needs and enabled them to maintain a level of independence.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Arrangements for ensuring people's safety at night could place people at risk of harm or injury because there were no formal systems for obtaining additional staff if required.

Risks to people at night had not always been fully considered.

People received their medicines when they needed them from staff who were competent to do so.

Requires improvement

Is the service effective?
The service was effective.

The service acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care.

Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

People were protected from the risk of poor nutrition and dehydration.

Good

Is the service caring?
The service was caring.

People were treated with great kindness and respect. Staff were committed to ensuring people enjoyed a happy and fulfilling life.

People were supported to make choices about their day to day lives and were supported to be as independent as they could be.

People were supported to maintain contact with the important people in their lives.

Good

Is the service responsive?
The service was not always responsive.

Some people's care was not planned in line with their current or changing needs. People's care was not always reviewed regularly.

People had opportunities to take part in a range of activities and social events.

People were supported to develop and maintain a level of independence whatever their disability.

Requires improvement

Is the service well-led?
Some aspects of the service were not well-led

Requires improvement

Summary of findings

The systems in place designed to monitor the quality of the service and the health and well-being of people were not fully effective.

People benefitted from a staff team who were supported to carry out their role.

Spring View

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 1 and 4 December 2015 and was unannounced. It was carried out by an adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries from and about the provider and other key information we hold about the service. At the last inspection on 4 June 2013 the service was meeting the essential standards of quality and safety and no concerns were identified.

At the time of this inspection five people lived in the main house and one person lived in a self-contained flat attached to the home. During the inspection we met with all the people who lived at the home and five members of staff. We met briefly with the registered manager and a provider's service manager.

We looked at a sample of records relating to the running of the home and to the care of individuals. These included the care records of three people who lived at the home and two staff recruitment files.. We also looked at records relating to the management and administration of people's medicines, health and safety and quality assurance.

Requires improvement

Is the service safe?

Our findings

There were sufficient staff on duty during the day to meet people's needs and help keep them safe. However; staffing levels at night could place people at the risk of harm or injury because risks to some people had not fully been considered. Between the hours of 2200hrs and 0700hrs there was one waking support worker on duty. All but one person was checked hourly during the night. One person lived in a self-contained flat which was attached to the main building. This person had very complex needs and behaviours and they required one to one staffing throughout the day. However at night, they were not checked unless staff heard them over a listening device. Staff confirmed that although there had been no incidents to date, there was potential for the staff member on duty not hearing if the person had woken if they were busy assisting people in the main house.

There was no night risk assessment in place for the person who lived in the flat. There was a typed document which provided information and guidelines for staff which included activities of daily living and "support at night." This instructed staff to "leave the flat by 2145hrs and turn the monitor on." This meant risks to the person during the night had not been fully considered..

The people who lived in the main house also had complex needs and all required staff assistance to transfer from their wheelchairs. Five of the six people who lived at the home suffered with epilepsy and some had been prescribed 'rescue medicines' to manage multiple seizures. Where these medicines proved unsuccessful the protocol was to call the emergency services. Staff told us they could ring another of the provider's homes if they needed advice. However; similar staffing levels in these homes meant that they would be unable to leave the home and provide support to Spring View. Two of the staff we spoke with had previously worked night shifts at the home. They told us they had not had to call other homes for advice however; when asked, staff told us there was no formal on-call system. They told us there was a file which listed staff who lived nearby but there was no guarantee they would be available if they were required. This arrangement could place people at risk of harm or injury.

There was a generic risk assessment for staff entitled "Lone working between 10pm and 7am." This provided information about the action to take where people may be left unsupervised in the lounge area whilst the staff member was assisting another person in their bedroom. The risk assessment instructed staff to ensure listening devices were switched on when people were left unsupervised. This would not reduce the risk of possible harm to people it would only alert the member of staff to a possible incident.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Other potential risks to people had been considered and there were care plans in place to manage risks. These included making hot drinks, travelling in a vehicle, moving and handling, assisting people to mobilise and the management of people's epilepsy. Staff supported people in accordance with their plan of care. For example; staff ensured one person had their walking frame and protective helmet on at all times. Staff told us about risks to one person who liked to make their own hot drink. They explained they emptied the kettle after supporting the person as they were at risk of scalding themselves.

There were procedures to ensure the safe management and administration of people's medicines and these were understood and followed by staff. We observed a member of staff administering medicines to one person who lived at the home. This was conducted in a safe and dignified manner. There was nobody at the home who was able to manage their own medicines due to their understanding. Medicines were administered by senior staff who had received training and had regular observations of their practice to ensure they remained competent to carry out the task. Medicines were securely stored and there were accurate records for each person which gave details of their prescribed medicines and when they should be administered. Records showed that people had received their medicines when they needed them.

Staff had been trained how to recognise and report any signs of abuse. Staff had a clear understanding of what may constitute abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Where concerns had been raised the registered manager had notified the relevant authorities and taken action to ensure people were safe.

Requires improvement

Is the service safe?

The home was well-maintained and regular health and safety checks were carried out to ensure the environment and equipment remained safe. These included checks on fire detection systems and alarms, hot water temperatures and overhead tracking and hoists. External contractors carried out fire, gas and electrical safety checks and maintenance.

Risks of abuse to people was also minimised because the provider had a recruitment process which ensured all new staff were thoroughly checked before they began work. Checks included seeking references from previous employers and carrying out checks to make sure new staff were suitable to work with vulnerable adults. Staff told us they were only able to start work once all checks had been received.

Good

Is the service effective?

Our findings

Staff were very knowledgeable about the needs and preferences of the people they supported. Procedures were in place to make sure staff had the training they needed to meet people's needs. Staff were very positive about the training available to them. Staff had been provided with specific training to meet people's care needs, such as caring for people who have epilepsy and the administration of "rescue medication", positive intervention, passive movement and caring for people with profound and multiple learning disabilities.

Staff knew how to make sure people's legal and human rights were protected. Staff had received training and had an understanding of the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Staff knew how to support people to make decisions and knew about the procedures to follow where an individual lacked the capacity to consent to their care and treatment.

Care plans contained assessments of people's capacity and best interest documentation which included the use of bed rails, administration of medicines and the management of personal finances. Throughout our inspection we observed staff asking people what they wanted to do. They obtained people's consent before assisting them and they respected people's right to change their mind.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Assessments about people's capacity to consent to living at the home had been completed and DoLS applications had been completed.

Staff ensured people were protected from the risk of poor nutrition and dehydration. Each person had a nutritional assessment which detailed their needs, abilities, risks and preferences. People were provided with adapted cups and cutlery which met their needs and enabled them to maintain a level of independence.

Menus were varied and were based on the preferences and needs of the people who lived at the home. Meal times were flexible and were determined by the people who lived there. For example, on both days of our visit we observed people arriving for breakfast and lunch at different times. Although people had limited or no verbal communication, staff used objects of reference, signing and simple language to support people to make meal choices. Two people had their own shelves in the pantry which they could access in their wheelchairs. This enabled them to make choices for themselves.

People were supported to access physical and mental health care services to help them maintain good health and well-being. People's care plans contained records of hospital and other health care appointments. There were health action plans to meet people's health needs. Care plans included 'hospital passports' which are documents containing important information to help support people with a learning disability when they are admitted to hospital.

Good

Is the service caring?

Our findings

The atmosphere in the home was very relaxed and welcoming. There was an ethos that this was very much the home of the people who lived there. One member of staff said “This is their home. I am just privileged to be able to work here.”

People enjoyed staff interactions and there was lots of laughter and friendly banter on both days we visited. People had very limited or no verbal communication and staff used gentle and appropriate touch to reassure and comfort people when required.

One person had an epileptic seizure which was quickly noticed by a member of staff. They comforted them and reassured them during the seizure and recovery. They remained with the person until they had fully recovered. The person responded by smiling at the member of staff and held their hand.

We read comments made by visitors to the home. These included people’s friends and family and health and social care professionals. Comments were positive and included; “A very happy home for all the clients.” “An excellent facility. Staff are well trained and they treat residents with dignity and respect.” “I have always found the staff very friendly and welcoming. All who live there seem happy and content.”

Routines in the home were flexible and based around the needs and preferences of the people who lived there. Staff told us there were no set times for people to get up in the morning, when they went to bed and what they wanted to do. We saw this to be the case on the days we visited.

Each person had a booklet which provided information about what was important to them, the level of support they needed and the important people in their lives. This helped staff to get to know people especially those who were unable to communicate verbally. We heard staff having meaningful conversations with people about the things that were important to them. A recently employed member of staff told us they found the booklets “really helpful.” They explained “It helps you to get to know people.”

People were supported to maintain contact with the important people in their lives. A member of staff explained how one person was supported to telephone their family every day which they really looked forward to. Some people were supported to visit/stay with their families.

One person liked to greet staff as they arrived at the home. Staff had put a sticker on the clock in the kitchen which indicted what time staff were due to arrive in the afternoon. Staff knew how important it was for the individual to know what time staff were arriving. This enabled the person to open the front door and greet staff as they arrived.

Staff respected people’s right to privacy. Each person had their own bedroom which had been furnished and decorated in accordance with the person’s tastes and preferences. People were able to access their bedrooms whenever they wanted. People were able to lock their bedroom doors if they chose to. Locks were operated by swiping a fob key on a panel which meant people who were able, could easily access their bedroom without staff support.

Requires improvement

Is the service responsive?

Our findings

People's care and support plans had not always been regularly reviewed and did not always reflect people's current needs. Also, care and support plans were bulky and contained historic information which made it difficult to locate current information. We saw the service was in the process of introducing a new care planning format but there was no timescale as to when this would be completed. Some staff were new to the service which meant they would not have up to date or accessible information about the people they supported.

For example, a behaviour support plan for a person who had very complex needs and behaviours which challenged others was due to be reviewed in May 2015. We checked with a senior care worker who confirmed that this was the most up to date support plan and that it had not yet been reviewed. We asked staff about the procedures they followed when the person's behaviours became challenging. They told us they would make sure the person was safe and then move away from the area, returning when the person was calmer. Whilst this was in accordance with the person's plan of care, two members of staff talked about "gently putting their hands over the person's eyes" as this "sometimes helped them to become calm." This intervention had not been included in the person's plan of care and there were no records to show this had been discussed or agreed by health or social care professionals.

A member of staff told us about a person who required their fluids to be thickened and their food pureed as they were at risk of choking. We asked the member of staff to go through this person's care plan with us as the volume of historic information made it difficult for us to locate a plan of care which detailed how this person should be supported with eating and drinking. There was a risk assessment which had not been reviewed since November 2014. This showed the person had been assessed as being at "medium risk" of choking and had previously had a "choking incident which required medical intervention." The risk assessment stated "avoid high risk foods, ensure correct positioning, ensure foods are blended to the correct consistency and drinks are thickened to the correct consistency. However, there was no plan of care to manage this. There was no information about what the correct consistency was for food and drink. There was a report which had been completed following an assessment by a speech and language therapist but this was dated 18 April 2013. From this, a "recovery care plan" had been developed. This was dated 17/05/2013 and had not been reviewed.

There was no care plan in place to manage the continence needs of a person who was not routinely checked during the night. Staff told us the person was doubly incontinent and was dependant on staff to meet their personal care needs. They told us the person would often remove their soiled pad. Staff explained they only attended the person's flat if they heard them on the listening device. They told us they would only assist them with personal care if they were compliant. If the person displayed challenging behaviours they explained they would "make sure the area around their bed was clean and try and go back when calm." The lack of a care plan to manage the person's continence at night could place the person at risk of not receiving the care they needed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

People had opportunities to take part in a range of activities and social events. One person regularly attended a local day centre which they enjoyed. On the first day of our visit one person was very excited as a member of staff was taking them swimming. The member of staff told us "[name of person] loves swimming and we are going out to lunch afterwards which is always a hit." Another person was supported to go shopping followed by lunch out.

On both days of our visit we observed staff spending time with people and supporting them with meaningful activities. For example some people were involved in making Christmas decorations, some people benefitted from sensory activities such as different sounds and textures. A member of staff showed us some photographs of recent events and trips people had enjoyed. These included trips to London, local garden centres and sea-world. People had also enjoyed a visit from a miniature horse and the local fire brigade.

People were supported to develop and maintain a level of independence whatever their disability. For example one person helped staff prepare some potatoes ready for the evening meal. We observed this to be an activity they really enjoyed. Another person helped a member of staff wash some dishes. Some people liked to be involved in cleaning

Requires improvement

Is the service responsive?

their bedrooms and doing their laundry and staff were available to support them with this. One person liked to be involved in carrying out maintenance checks around the home.

Requires improvement

Is the service well-led?

Our findings

Systems for assessing, monitoring and mitigating any risks to the health, safety and welfare of people who used the service were not fully effective because action had not been taken to address all identified shortfalls within agreed timescales. For example, some people's care plans were not up to date or reflective of their current needs. Risks to people had not always been fully considered.

There was a manager in place who was registered by the Care Quality Commission. There was a manager in place who was registered by the Care Quality Commission. We only met with the registered manager briefly and we declined the registered manager's kind offer to be available for both days of the inspection as they were on a phased return to work following a period of sick leave. They ensured senior staff were available to assist us on both days of our inspection.

The provider employed service managers who were allocated a number of homes and they were responsible for overseeing and monitoring the quality of the service provided, health and safety, staffing and checking that people received safe and effective care which met their needs. The provider's service manager sent us copies of the findings of an audit which had been carried out on a selection of people's care and support plans in April 2015. The audits had identified some areas for improvement which were similar to the shortfalls identified at this inspection. These included out of date reviews, accessibility of information and the availability of up to date risk assessments. An action plan set dates for the shortfalls to be addressed in July and August 2015. An audit of one person's care plan in September 2015 showed that records had not yet been reviewed. The service manager provided us with a copy of their most recent audit carried out in December 2015. This again highlighted shortfalls in people's care plans which had not been addressed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

There was a staffing structure in place during the day which ensured senior staff were always available to support less experienced staff. As previously mentioned in this report, there is only one member of staff on duty during the night and we were informed they could contact staff at one of the provider's other home's if they required any advice. This could place people at risk of harm or injury.

It was clear from the staff we spoke with and from our observations that they were committed to ensuring the people they supported enjoyed a happy and fulfilling life. One member of staff told us "It's about encouraging people to be as independent as they can be and making sure they feel that they are important and really matter." Another member of staff said "I think this is a lovely home for the people who live here. They are all loved very much."

Staff received the support and training they needed to carry out their role. Staff told us they received regular supervision sessions which provided opportunities for discussions about their performance and any training requirements. The staff we spoke with said they had not had to request any additional training but felt confident any requests would be taken seriously and responded to. Staff were positive about the registered manager and described them as being "approachable" and "a good listener."

Regular staff meetings were held and the minutes of a recent meeting showed a range of topics had been discussed. These included updates on health and safety guidance, infection control and supporting people who lived at the home. There had also been discussions about the Care Quality Commission's key lines of enquiry and how we report on the five questions; Is the service safe, effective, caring, responsive and well-led?

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How this regulation was not being met**: Risks to people at night had not been fully considered and there were not always control measures in place to mitigate risks. Regulation 12(1)&12(2)(a)(b)&(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How this regulation was not being met.** People's care and support plans had not always been regularly reviewed and did not always reflect people's current needs. Regulation 17(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How this regulation was not being met:** There were systems in place to assess and monitor the health, safety and well-being however; these were not always fully effective in ensuring that areas for improvement are addressed. Regulation 17(1)