Leonard Cheshire Disability

Fethneys Living Options - Care Home Physical Disabilities

Inspection report

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Date of inspection visit:
20 June 2016

Date of publication:
29 July 2016

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

The inspection took place on 20 June 2016 and was unannounced.

Fethney's Living Options provides accommodation, care and support for up to ten people living with a physical disability or acquired brain injury. The aim of the service is to promote and build on people's independence skills so that they can move out of the home into independent or supported living accommodation. Fethney's Living Options is a large, older style, detached property situated close to the seafront and town centre of Worthing. All rooms are of single occupancy and communal areas include a large dining area/kitchen and a separate sitting room.

A registered manager was 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.

People were looked after by staff who had been trained to recognise the signs of potential abuse and knew what action to take. People's risks were identified, assessed and managed appropriately and their independence was promoted. There were sufficient numbers of staff on duty to support people and the home benefited from the input of volunteers which the provider had introduced. Medicines were managed so people received them safely from trained staff. People were protected from the risk of acquired infections and the home was clean and hygienic.

Staff had been trained in all essential areas and additional training had been completed to meet people's specific needs. New staff completed the Care Certificate, a universally recognised qualification. Staff received regular supervisions and attended team meetings. People were supported by staff who understood their responsibilities under the Mental Capacity Act 2005 legislation and put this into practice. People had sufficient to eat and drink and were encouraged to maintain a healthy lifestyle. They had access to a range of healthcare professionals and services.

Staff were kind and caring with people and positive relationships had been formed. People and relatives spoke highly of the staff at the home. People were encouraged to express their views and to be involved in making decisions about their care. They were treated with dignity and respect.

People were supported by their keyworkers, who co-ordinated all aspects of their care. They were encouraged to be as independent as possible, to pursue a range of activities in the home and out in the community. Care plans provided staff with detailed information about people and how they needed to be supported. Complaints were managed in line with the provider's policy.

People spoke highly of the service and attended residents' meetings. The provider obtained feedback from people, their relatives and staff on a national basis. Staff felt supported by the registered manager and of

the improvements that had been made since he came into post. A range of audits measured and monitored the overall quality of the service and actions were identified and implemented to drive improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were looked after by staff who had been trained to recognise the signs of potential abuse and knew what action to take. People's risks had been identified and assessed and were managed safely.

There were sufficient numbers of staff on duty at all times. Before new staff commenced employment, checks were undertaken on their suitability for the role.

Medicines were managed safely.

People were protected from the risk of infection because staff had received training in this area and put this into practice.

Is the service effective?

Good

The service was effective.

People received care from staff who had been trained in all essential areas as well as additional areas to meet people's specific needs. Staff had regular supervision meetings and team meetings.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

People had sufficient to eat and drink and were encouraged to maintain a healthy lifestyle. They had access to a range of healthcare professionals and services.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff and genuine relationships had been formed.

People confirmed they were involved in making decisions about

their care and that they were treated with dignity and respect by staff.

Is the service responsive?

Good

The service was responsive.

People were encouraged and supported by staff to be as independent as possible, with a view to moving out of the home into independent or supported living as the end goal.

People had free access to the community and followed interests and activities that were of importance to them.

Care plans provided personalised, detailed information about people and guidance to staff about how they needed to be supported.

Complaints were managed in line with the provider's policy.

Is the service well-led?

Good

The service was well led.

People, their relatives and staff spoke highly of the home and of the improvements they had noticed since the current registered manager came into post.

People and their relatives were asked for their feedback about the service with an annual survey sent out by the provider.

A range of systems was in place to measure and monitor the quality of the service delivered and the home overall.

Fethneys Living Options - Care Home Physical Disabilities

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.

The inspection took place on 20 June 2016 and was unannounced. One inspector undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including three care records, two staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with three people living at the service and spoke with one relative. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, a team leader, a care support worker and a member of the

administration team.

The service was last inspected on 20 August 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People were protected from abuse and avoidable harm and staff knew what action to take if they suspected abuse was taking place. However, according to a document which the registered manager submitted following the inspection, not all staff training in safeguarding was up to date. As at 20 June 2016, less than half of staff had up-to-date training in this area which equated to 16 staff. The registered manager was aware of this and had made arrangements to ensure staff completed this training as soon as possible.

Risks to people were managed appropriately. Care plans showed that people's risks were identified and assessed and there was clear guidance for staff on how to mitigate risks. Risk assessments for one person had been drawn up in the following areas: seizures, bed rails, moving and handling, skin integrity, medicines, accessing the community independently, together with an environmental risk assessment which related to the use of wheelchairs. People's level of risk had also been assessed as being low, medium or high. Two people received their medicines through a Percutaneous Endoscopic Gastrostomy (PEG). This is a flexible feeding tube which is placed through the abdominal wall and into the stomach allowing nutrition fluids and/or medicines to be put directly into the stomach, bypassing the mouth and oesophagus. Staff had been trained in the management of PEG and their competency to do so safely had been checked. People's risk of developing pressure ulcers had been assessed using Waterlow, a tool specifically designed for the purpose. Pressure relieving mattresses were in place where needed. Accidents and incidents were reported promptly and action taken appropriately. For example, one person had managed to climb over their bed rails and had fallen out of bed. As a result, a new bed had been ordered which could be lowered down to the floor, thus minimising the risk of injury to the person in the future.

There were sufficient numbers of staff on duty to keep people safe and meet their needs. The registered manager told us that their use of agency staff had been quite high recently in order to cover gaps in staffing levels. Staffing rotas showed that five care staff worked in the morning, five in the afternoon and there were two waking night staff. Staff we spoke with confirmed they were happy with the staffing levels. One staff member, when asked about the numbers of staff, said, "Yes, loads. Sometimes it's really busy, but the majority of the time we have time to spend with people". In addition to staff employed by the service, three volunteers also assisted at the home, with two volunteers on duty most of the time. The volunteers were not trained to deliver personal care, however, they supported people with activities and going out into the community and were a valued addition to the workforce. Safe recruitment practices were in place. Before new staff commenced employment, checks were made with the Disclosure and Barring Service to ensure they were safe to work in care. Two references were also sought to confirm previous employment or were character references.

Medicines were managed so that people received them safely from trained staff. Medicines were locked in special cabinets in people's rooms and timetables recorded the times when people were due to receive their medicines. Competency checks were undertaken annually to ensure staff administered medicines correctly. Medicines audits were completed monthly by a team leader. Medication administration records (MAR) showed when people had received each particular medicine, however, on occasion, some staff had neglected to sign the MAR to confirm people had received their medicines. Audits had identified this and the

staff concerned had to complete a further competency check to prevent similar omissions occurring in the future. Medicines were ordered, stored, administered and disposed of safely.

People were protected from acquired infections because the home was clean and hygienic. Clinical waste was disposed of safely and staff wore personal protective equipment when delivering personal care. Infection control audits were completed which identified any actions that needed to be taken, such as the cleaning of mattresses. In the past support staff had also undertaken cleaning duties, but following a discussion on this issue, a cleaner was now employed for 2.5 hours daily, so that support staff could devote their time to caring for people. A team leader was also the infection control lead which meant they had received additional training to advise and oversee staff in working safely in this area. The lead had also formulated an 'Infection Prevention and Control' flowchart which guided staff on the action they should take in particular instances. For example, what staff should do if someone had suffered with diarrhoea or vomiting. Staff were checked in their handwashing techniques.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Staff had received training in a range of essential areas such as health and safety, infection control, moving and handling, mental capacity and nutrition and hydration. Additional training was available to staff including behaviour support, dementia awareness and emergency first aid. A staff training plan showed the training staff had completed with areas which needed completion and the registered manager updated this monthly. New staff studied for the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. A team leader had been trained to assess staff as they completed the Certificate during their probationary period. They told us, "We have loads of training. There's always something and lots of free training from [named local college]". Some staff also completed training with other healthcare professionals, such as physiotherapists, in order that they could deliver daily physiotherapy to one person who lived at the home. Volunteers also completed an induction process and a team leader said, "They have an induction. You can pair them with residents who enjoy the same thing. Leonard Cheshire [the provider] always have overseas volunteers". Volunteers were also vetted to ensure they were safe to work with adults at risk.

Staff received supervision meetings with their line managers approximately every three months and staff confirmed this. One member of staff told us, "We aim for that. We can see [named team leader and registered manager] whenever we want" and added, "We've got some really good staff. We all help each other". A team leader who supervised staff said, "But they're more than welcome any time", referring to the fact that staff did not have to wait for their next supervision if they wanted to discuss any issues or concerns. Team meetings also took place and we saw the minutes of senior staff meetings and other staff meetings which showed what had been discussed and action points arising from the meetings. The last staff meeting had taken place in May 2016.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where necessary, advocates came to the home to support people to make important decisions that affected their lives.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had been trained to understand the requirements and their responsibilities under MCA and DoLS. No-one at the home was subject to DoLS and the registered manager told us that everyone was free to come and go as they pleased.

People had sufficient to eat and drink and were encouraged to maintain a balanced diet. Drinks were freely available to people throughout the day. Breakfast and evening meals were prepared for people by care staff. People and staff sat down together in the evening to eat their supper. In order to promote people's independence, they were supported to shop for, and prepare, their lunchtime meal and were helped in this by staff. People had a budget of £20 per week to buy food for their lunch. One person explained, "You go shopping for lunch and staff help you 1:1 with cooking. You start off doing this one day a week, then they build it up". This person told us they had enjoyed cooking bacon and tomato for one meal and mascarpone tagliatelle for another. We observed another person was supported by care staff in the preparation of pasta with pesto sauce on the day of our inspection. A kitchen area had been specially adapted to cater for wheelchair users, with 'rise and fall' work surfaces and accessible cupboards. Care plans included information about people's diets and mealtimes. One care record stated, 'What is important to me about food, drink and mealtimes? It is important that I feed myself, but I do require help to cut up my food. Things I want to achieve in this area of my life: To have 1:1 cooking sessions planned each week. To assist with making my own drinks. Things you need to know or do to support me with food, drink, diet and mealtimes'. There were photos on file of this person cooking and preparing their meals. Special diets were catered for. For example, one person was being weaned off receiving their nutrition via PEG and had been risk assessed to receive a mashable diet, with guidelines about their swallowing and risk of dysphagia [difficulty or discomfort with swallowing] for staff.

People received healthcare support from a local medical practice and, via the practice, could also access the Minor Injury Assessment and Minor Illness (MIAMI) Clinic for urgent medical advice and intervention. People also had their medicines reviewed by their GP on a regular basis. People's care plans recorded when they were seen by a healthcare professional and also included a health plan. Health plans documented information about people's general health, including vision, hearing, teeth and dental health and any health screening. Some people also had care passports which showed the involvement of healthcare professionals and actions taken.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. People could choose whether they were supported by male or female care staff. One person told us, "Staff are lovely. I have men as well and that was up to me". A relative of this person had sent an email to the home which stated, 'Thank you for all your help with [named person] and for doing such a great job. She's nothing but praise for you, [named registered manager] and everyone at Fethney's!' We observed that staff had formed meaningful relationships with people that were genuine. Staff encouraged people in building their independence and self-confidence in a friendly and nurturing manner and with a sense of humour.

People were supported to express their views and to be involved in making decisions about their care, treatment and support. One person said, "They're very thorough with my care plan" and confirmed that they were involved in this. Their care plan recorded, 'I have been involved in the development of my care plan. I have read it or have had it read to me and I am happy with the content'; this was signed by the person. A team leader described the importance of involving people in all aspects of their care and said, "For them to be able to direct their care and say I want things done this way. Just to empower them really".

People were treated with dignity and respect and we observed this on the day of our inspection. Staff knocked on people's doors and waited for permission before entering. We were asked if we would like to look around one person's room and that staff took care to ask for the person's permission beforehand. Another person referred to staff and said, "Just the way they've treated me with respect. They're very caring and always have been". They went on to explain how kind and supportive staff had been in helping them when they had a seizure.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Each person was assigned a keyworker who co-ordinated all aspects of their care. Keyworkers helped people to plan their food shopping and to complete individual planners which recorded the activities that people would pursue week by week. Staff attended daily meetings between shifts and communicated with each other about how people were feeling that day and what they had been doing. People were interested in a variety of activities and supported by staff in the community. Activities were also organised for people in the home. On the day of our inspection, people were making 'fairy doors' and painting hearts as part of an arts and crafts session.

As well as being involved in activities and hobbies that were of particular interest to them, people were also involved in housekeeping duties, for example, helping with the laundry and cleaning their rooms.

A relative had sent an email to the registered manager which stated, 'Since [named person] started at Fethney's, she and we have been very impressed with her care there. She was assessed for a bath during her first week and had three already, after having had none at [named previous home]. She's been bowling and swimming too and out to the cinema and even taken to church where she's been singing and given some flowers there to welcome her! She loves Fethney's. She's being supported buying her own lunches and cooking her own favourite dinners too! She's even being supported to join a performing arts group … and is delighted she'll have a chance to continue'.

People were supported to build on all areas of independence with the aim of moving on from Fethney's into a supported living scheme or similar environment. Areas covered included budgeting, travel training and emotional support. People were also supported to be as independent as possible with their personal care. One person described how their independence was being promoted and explained, "Staff said, 'Can you take your plate over to the sink?' I thought I'd drop it. They said, 'It doesn't matter, give it a go'. Now I can do it on my own. I feel more confident". They went on to say, "I'm terrified of crossing roads, or I used to be, and now I'm able to do it. Before, I used to ask staff to help me with my chair and I can do it myself now". A member of staff told us, "People have to learn to take responsibility". We observed one person was encouraged by staff to check their food stocks and to write a shopping list in preparation for food shopping later in the day. The person, at first, appeared reluctant to do this, but staff gave them some paper and a pen and eventually they started to write down the items they needed to buy from the shops.

We talked to a relative about their views on the home. They said, "It takes a long time to know [named family member]. How to get the best out of him can take a while. The change of management was disruptive to him". They went on to say, "This place has given him independence in terms of accessing the community. He has absconded in the past. They've taught him key parts of town, for example, Splashpoint and he can find his way home. He needs a structured environment. It's important for him to go to certain places on his own. That's been his greatest triumph. He has a mobile and he can ring Fethney's". They added that, "Worthing is gorgeous with him" referring to how friendly and helpful the public were who greeted him when he was out in the town.

Care plans provided comprehensive, detailed information about people and how they wished to be supported by staff. One care plan stated, 'How best to support me: communication with others, choice and control over daily life and routines'. There was information and guidance to staff on the person's nutrition, moving and handling, personal support, physical and emotional health and wellbeing. There was advice to staff on whether the person needed help to manage their money, on friendships and relationships, work, learning and leisure. People's plans for their future were discussed and recorded, for example, whether they wanted to live independently or in supported living. People's daily routine was recorded. Care plans, whilst detailing people's needs and how they should be looked after, also cross-referenced other documents which staff should read. For example, one care plan stated, 'My morning routine: 7.30am – 8am, gets up. Moving and handling risk assessment – you will need to read'. People's likes and dislikes were documented. Care plans were reviewed monthly, or as needed, and signed by staff.

Complaints were managed appropriately in line with the provider's policy. The complaints policy was also written in an accessible format to aid understanding. One complaint had been recorded in the year and this had been handled to the satisfaction of the complainant.

Good

Is the service well-led?

Our findings

People were actively involved in developing the service. Residents' meetings were held and a notice inviting people to the next meeting was displayed on the noticeboard in the communal dining room. We asked one person about their views on the home and they said, "It's fantabulous!" Staff we spoke with felt they were supported in their roles. One staff member, when asked what they thought was 'good' about the home, said, "The ethos of the place, the atmosphere. I just like being part of the way people live. We're a transitional service. One resident came from a nursing home and was unable to do anything independently, He's come such a long way". The provider sent out annual surveys to staff, people and their families, to obtain their feedback about the service and results were co-ordinated nationally rather than linked to a particular service.

The service demonstrated good management and leadership. A member of staff said, "It's got a lot better [referring to when the current registered manager came into post]. He's really open with staff and talks to us. It's not a 'them and us'". Another member of staff referred to the registered manager and said, "He's been really supportive and I can hassle him for training!" They added, "I feel everything's changed in the last year. It's improved massively and so has the staff morale". A relative felt the registered manager was, "Always very helpful and co-operative". Another relative had written in an email, 'Thank you very much for making [named family member] so welcome and happy. She loves it here. On Monday when we were taking her back she said, "I love home, but I also love coming back to Fethney's. It feels like I'm going on holiday!" She's never been so happy".

A range of systems was in place to measure and monitor the quality of care delivered and the home overall. We saw audits had been completed in medicines, infection control, environment including maintenance, and that areas for improvement had been identified with an accompanying action plan. Action needed showed what was required, who was responsible and the date by which the action should be completed.