Care Quality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

East View Housing Management Limited - 368 The Ridge

368 The Ridge, Hastings, TN34 2RD

Tel: 01424754703

Date of Inspection: 04 September 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Staffing	✓ Met this standard

Details about this location

Registered Provider	East View Housing Management Limited
Registered Manager	Ms. Sandie Cox-Standen
Overview of the service	368 The Ridge provides accommodation, support and care to six adults with learning disabilities and complex needs.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 September 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members.

What people told us and what we found

At inspection we met five of the six people living there. We also met five of the six staff on duty in addition to the manager and spoke with four in depth.

People living in the house had complex needs and communication difficulties. As a consequence they were unable to fully participate in the inspection process or tell us about their experiences, but we observed what they did and interactions with staff.

We looked at some care records and risk information, this was comprehensive and kept updated. Staff said they felt well informed about people's needs.

Records indicated that the service was mindful of people's specific dietary needs and where nutritional risks were identified.

We looked at how medication was managed. We found that staff had been appropriately trained and that systems to minimise risk to people were kept under review.

We noted the environment and furnishings were of good quality but experienced high levels of wear and tear. There were sometimes delays in works being carried out but these did not impact on the well being of people living there.

We looked at notifications of incidents. We found that staff had a good understanding and showed confidence in regard to their role and responsibilities around these.

From our observations and discussions with four of the six staff on duty, we were satisfied that staff felt that staffing levels were sufficient for the dependency of the people living in the house.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

We looked at the care records of three of the people we met with. The manager and staff had given us some information about each person and this matched what was recorded in their care files. We found that care records viewed were well organised with information about peoples support needs easy to find. We saw that individual care needs were comprehensively recorded with additional guidance to inform staff about how specific needs should be supported.

We saw that people's records had been updated. Staff told us that key worker staff were responsible for updating care plans. They told us that changes in care needs were notified immediately to all staff via the communication book. Care records were updated to reflect the changes. Minor changes were also discussed at team meetings which were held regularly.

We spoke with a visiting parent who said that they were satisfied with the care provided, but felt that the range of activities offered could be better. For example they queried whether it was enjoyable for someone to experience a bus ride into town three times weekly. When we spoke with staff they told us that people went out every day, and were involved in selecting the activities that made up their individual activity planner. Some of these could be repetitive because it was an activity the person liked to do. However, staff tried to introduce people to different experiences as much as possible and where this suited their own pace and preferences.

Staff said they used picture prompts, makaton and words to communicate with people about everything in their everyday routines and life. We were told that in addition to daily activities people also went out to some evening activities. For example gateway club, and to a night club specifically for adults with learning disabilities. For some people there had been a slow introduction with staff support to these activities, but everyone now enjoyed going to them and meeting people from other houses operated by East View Housing Ltd.

On an individual level some people went to specific events that interested them. For

example, one person enjoyed banger racing and was supported to attend events. The manager told us that everyone in the house was going to holiday together this year with people from other houses operated by the provider. This had been agreed to at the resident's forum meeting 'your shout'. Some people had friends in some of the other houses and visits were arranged from time to time.

We saw that the service was proactive in seeking to enable people to access routine healthcare and treatment, however long it took to familiarise the person with a health service. We saw that people had access to healthcare check-ups and health appointments. There was evidence of referral for specialist input from psychiatrists or psychologist.

We saw that there were a range of risk assessments in place and that these were reviewed to reflect any changes in needs. Records viewed showed that nutritional assessments had been completed and people were weighed weekly. Annual reviews by funding authorities have now picked up and are happening more frequently, interim internal reviews are also held by the service. Staff told us that some people had more frequent reviews due to complex issues.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and hydration.

Reasons for our judgement

We spoke with staff about how they knew what people wanted to eat and could eat, and how this influenced the development of the menu each week. Staff told us that the menu was developed usually on a Friday evening each week following individual consultation with each person.

Staff said they showed people pictures of food they liked to eat and gauged their reaction to this. Staff put together a combination of everyone's preferred meals and foods to create the menu each week. Staff said there were always alternatives available if someone indicated they did not like something once it was cooked and provided examples of where this had occurred. We were told that no one in the house had been placed on a specific diet for health reasons, although a few people were given diabetic style diets as a precautionary measure.

Staff said there were always two main meal choices on the menu each day, and that there were snacks and cakes available if people were still hungry. People in the house participated in baking cakes and therefore always had access to snacks like these.

People in the house took turns undertaking the food shopping with staff each week. Staff told us that sometimes people put things in the basket that they liked but which were not part of the shopping list. These were put to one side and the person paid for these out of their own money and these were kept for their use alone.

We asked staff how they ensured people had enough to drink each day as the kitchen was locked. Staff said that in hot weather jugs of water and squash were left out for people to access. We saw on people's files hot weather plans which looked at access to drinks. The manager said that letting people access drinks themselves had been less successful as a lot of drinks had been spilt or thrown about. Staff spoken with told us that if a person signed for a drink, or made known they wanted a drink in through some other method of communication, this would be provided. We observed this happening in regard to food, where a staff member made a small snack for someone who had signed that they were hungry. We saw that staff were meant to complete a fluid chart for people who were using this service. However when we viewed fluid charts we saw that some staff were not completing these or balancing inputs and outputs. We brought this to the attention of the manager.

A parent we spoke with said their main concern was that their son had lost weight following hospital treatment. They acknowledged that their son was now regaining weight but had underlying concerns about how this had happened. We took this into consideration when we viewed people's files.

Of the three we looked at we saw that people were being weighed weekly. We saw that each person was a little below their expected weight range. When we spoke with the manager they made it clear that all the people in the house had a good appetite, including the people whose files we had viewed. In conversation staff confirmed that some people were known to have second helpings. All the people attended well man and well women clinics annually. Individual's weights had been discussed with the GP and we were informed no concerns had been highlighted. We looked at one person in particular who was at least six pound lighter than their suggested lowest weight for their height. We looked at historical weight data and saw that their present weight mirrored similar fluctuations in previous years and had remained relatively stable.

We saw that whilst risk assessment of nutrition and hydration was in place, this made no reference to the fact that all of the people we reviewed were under their desired weight. We saw that this was an on-going issue but health professionals consulted had not highlighted any concerns. We looked at the weeks menu and found this provided a varied diet to people. However, the provider may like to note that records provided little evidence that dieticians had been consulted either about the low weights of people in the house, or that meals were sufficiently balanced and nutritious.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

CQC had recently received a small number of incident notifications and we decided to look at this during our inspection. We saw that staff were completing incident forms and notifications appropriately. Staff we met spoke with confidence about their role and responsibilities in respect of reporting and escalating incidents and safeguarding alerts.

Staff confirmed that they had received training in safeguarding and were given reminders from their head office and manager for updates. In conversation staff demonstrated an awareness of the Mental Capacity Act and Deprivation of Liberty safeguards. However, they were unclear how these worked in practice with the people they supported. We drew this to the attention of the manager and whether training content in this area needed review.

The manager spoke about one person in the house where best interest decisions had been taken with regard to health treatment. Individual staff members had been involved in putting into action the decisions of the best interest meeting. This involved a lengthy process to try and overcome the person's fear of hospital/dentist environments, and required staff and the person to undertake daily visits over a period of months to where the treatment would be provided. Staff told us there had been a very successful outcome for the person concerned because of this individualised level of preparation.

Staff said that people in the house sometimes exhibited challenging behaviour. The triggers for the behaviour, how it manifested and should be managed was well documented. New behaviours were recorded and would be made known to the manager and local manager who would review the risk assessment and behaviour management guidance. Staff said that they received training in positive behavioural support. Debriefs were provided to staff by the manager regarding behavioural incidents they were involved in. Staff said they found behaviour guidelines were informative and helped them to understand what people did and how this should be managed. We saw that where people had sustained minor injuries body maps were completed to support this.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

People living in the house were on low levels of medication. However, we had noted when reviewing incidents that there had been a few medication errors in recent months. We asked the manager what action they had taken to minimise recurrence and they reported that the medication administration process had been strengthened. There were several additional checks to ensure the administering person, and the shift supervisor, were responsible for signing that medicines had been administered appropriately.

We saw that people's medicines were kept in their own medication cabinet in their room. These were kept locked and the keys were held by staff. None of the people in the house had been assessed as able to self-administer. We checked two medication cabinets. We found medicines were in date, and corresponding medication administration records for the person had been completed appropriately. The provider may find it helpful to note that where boxed medicines were received mid cycle these had not been dated upon opening to aid auditing.

When we spoke with staff they told us that they had received medicines training. Staff said they were not responsible for ordering medications or for booking them in as received. This was the responsibility of the manager and deputy manager. We saw records of the quantities received and relevant staff signatures on medication records.

We saw that people in the house had individualised guidelines for the administration of their medication including 'as required' medicines. We saw that handwritten changes to the Medication administration records (MAR) were signed for. On one record we noted a change to the prescribed time of administration for an evening medicine. When we asked the manager about this we found that the persons evening medication regime impacted on their quality of life and prevented them from taking part in evening activities. As a result the service discussed this with the GP and a later time was agreed for the administration that would enable the person to access evening activities. This arrangement was working well.

Staff understood the process for disposal of spoiled medicines and a returns book was in place which was completed by the manager. We were told by the manager and staff that medication records were reviewed at every handover to ensure that there were no omissions. All administrations were checked by shift leaders. A monthly audit of

medication was also undertaken.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

Although we did not assess this outcome fully we noted during our inspection that in some areas of the house there were outstanding decorative upgrading works required. In particular a front activity room where some repainting and plastering work was needed. In addition we noted in a person's bedroom that there was an underlying smell of urine. This was thought to be caused by faulty flooring allowing seepage, and was to be referred to an external contractor to try and address.

We discussed these issues with the manager who assured us that budgets were available for the maintenance of the premises. She was able to show us where requests for these to be attended to had been made.

We saw that although requests for repairs had been approved, the provider may wish to note that progress on these works had been delayed. Whilst there was no direct impact on the people living in the house, their completion would enhance the environment for the people living there and how they may be perceived by others.

We spoke with a parent who told us they thought that the house was generally well maintained whenever they had visited, which was frequently.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

Staff said they worked well with each other and felt supported by their manager and colleagues. One staff member said of the manager, "you can always go to her and ask if you don't know something. She doesn't just give you the answer she points you in the direction of where to find the answer, she makes you find it yourself. This is much better, and helps you to learn." Staff said they felt able to raise issues at staff meetings or to talk separately to the manager.

All staff said they had experienced a period of induction when they commenced work in the house. They told us that although induction lasted for some months until they had completed necessary training, when they started work they were supernumerary to the rota for approximately one week. This had given them time to learn about the routines of the house, policies and procedures and each person's care needs.

Staff told us that they received lots of training. They thought they had been given the skills and knowledge to do their job. Two staff members told us that they were booked for formal training in respect of the use of Buccal Midazolam. This was the only training area that they felt had been outstanding, and they were pleased this had now been booked for them. Staff said they received refresher training for mandatory courses and were reminded when these were due.

We observed that staff were able to undertake a good level of supervision of people in the service during our visit. Staff told us that people had varying support needs dependent on where they were, what they were doing and with whom. They said that some people needed one to one or two to one support in the community, and some people also needed one to one supervision when at the house.

Staff said they thought there was always enough staff on each shift to work with people in the home safely. Activities were scheduled to ensure that there was always enough staff available, if necessary additional staff were booked onto the rota to cover where a shortfall existed. Staff said they did use agency staff, but only from the same agency. These were usually agency staff who were familiar with the routines of the house and the people living there.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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