Royal Mencap Society

Royal Mencap Society - 34-35 Huddleston Close

Inspection report

Bethnal Green
London
E2 9NR

Website: www.mencap.org.uk

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11 October 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this announced inspection on 9 and 11 October 2017. The provider was given notice of this inspection as it provides a service for people who may be out during the day. At our last inspection on 7 September 2015 we rated this service "Good". At this inspection we found the service remained "Good".

34-35 Huddleston Close is a small care home run by the Royal Mencap Society for up to four adults with learning disabilities. It consists of a three bedroom house with a shared lounge, kitchen and garden. Upstairs is a self-contained flat where one person lives with support. There were three people living in the service.

The service had a registered manager, who had been in post since May 2014. 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.

Since our last inspection, there had been some changes in people's needs and the risks they faced through reduced mobility, health conditions and behaviour which may challenge. The provider continued to assess these risks and informed staff to carry out risk management plans to address these in a way which promoted people's independence and positive risk taking. There had been changes to the building to address these, such as the use of sensor systems and high visibility tiling and flooring and there were measures such as streaming devices, objects of reference and sensory profiles in order to provide an environment which met people's needs. There were support plans in place to manage people's long term health conditions and to address behaviour which may challenge.

Staff continued to receive effective training and supervision to meet people's needs, which was overseen by an effective system which also prompted managers to carry out observations of people's practice. There had been one new member of staff recruited, and there were systems of safer recruitment and appropriate inductions for new staff and agency staff. Staffing levels remained suitable to meet people's needs, and the provider was in the process of recruiting volunteers to support people to access the community.

There were detailed communication profiles in place to enable staff to better understand the needs of people who were non-verbal, which had continued to develop since the last inspection. Where there were concerns about people's safety, these had been reported and investigated in line with safeguarding procedures and there was evidence of the provider learning from these and addressing poor practice. There had been improvements made to medicines procedures in response to a medicines error and an external audit, and staff were supported to learn from these, with medicines safely managed by staff who had been trained and observed as competent to do so. There were suitable checks of the safety of the environment and measures in place to ensure a safe evacuation in the event of an emergency.

Staff were encouraged to reflect on their practice and there was an open, listening culture from managers.

There were systems such as daily shift reviews and recording of positive interactions to promote a culture of routinely learning from people's experiences. Managers maintained systems to ensure that tasks were planned and carried out promptly and carried out innovative systems of audit which took a person centred approach to meeting people's needs and promoting good health and inclusion.

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 remained good.	**Good**
Is the service effective? The service remained good.	**Good**
Is the service caring? The service remained good.	**Good**
Is the service responsive? The service remained good.	**Good**
Is the service well-led? The service remained good.	**Good**

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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 9 and 11 of October 2017 and was announced. The provider was given 48 hours' notice because the location was a small care home for younger adults who are often out during the day; we needed to be sure that someone would be in. The inspection was carried out by a single inspector.

Prior to carrying out this inspection we reviewed notifications of significant events such as incidents and allegations that the provider is required to tell us about. The provider also completed a Provider Information Return (PIR). The PIR is a form which asks the provider for information about what the service does well and areas for future development.

In carrying out this inspection we looked at records of care and support for the three people using the service and records relating to all three people's medicines. We reviewed records relating to the management of the service such as health and safety checks, rotas and team meeting minutes and records relating to the recruitment and supervision of five support workers.

We spoke with one person who used the service. Where people were not able to speak with us we carried out observations of their care and support and spoke to two other professionals involved in planning and reviewing their care. We spoke with the registered manager and three support workers.

Good

Is the service safe?

Our findings

The provider continued to have systems in place to safeguard people from abuse and improper treatment. An incident had recently occurred where a person had sustained a minor injury, and the provider had investigated this as a potential safeguarding issue and appropriately reported this to the local authority and to the Care Quality Commission. This had been investigated by a manager from a different service, and the registered manager had taken action to address some poor practice which had been identified as a result. The local authority informed us that they were satisfied that the service had addressed the issue.

The provider had a whistleblowing policy displayed for all staff informing them how they could raise issues of concern. Support workers we spoke with were confident they could report concerns to the registered manager and that these would be taken seriously, with one staff member telling us "Whatever happens here, we don't hide it." A person using the service told us "It's a safe place to live, I'm happy here."

The provider continued to maintain a register of risk assessments which had been put in place around relevant areas of support and routinely balanced managing risks against promoting people's independence and wellbeing. We saw that where people's needs had changed since the last inspection, these assessments had developed accordingly. For example, one person had been identified as being at risk of choking and a suitable assessment put in place with input from a Speech and Language Therapist. Staff we spoke with told us they had had training on how to support people who had choked and were able to demonstrate how they would respond to this.

There were additional measures in place to support a person at increased risk of falling who lived in an upstairs bedroom, which respected their freedom. The provider told us they were reluctant to address the risk of using the stairs by asking people to move rooms, as they felt people using the service would be unable to consent meaningfully to this, and that there were risks to the person's mobility from not using the stairs. All the provider's risk assessments included clear information on the risks of not carrying out an activity, which meant staff were encouraged to think about positive risk taking. The provider had assessed the risks from using stairs with support from an Occupational Therapist, and reviewed this risk assessment quarterly in team meetings. There were clear instructions, including diagrams, on how best to support the person in a way which would prevent them falling; staff we spoke with understood this well and understood their responsibilities not to disturb others whilst completing this task.

Similarly, where a person was at risk of falling from bed, the provider told us they felt the use of bed rails to be unnecessarily restrictive, and instead had a risk management plan involving the use of a bed sensor and a crash mat, which staff checked was working on a nightly basis. The person's hospital-style bed was due for servicing, which the registered manager arranged during our inspection, however we saw that this bed was safe, because the provider carried out detailed monthly checks of its safety using the manufacturer's guidelines. There were also risk assessments for people living with long-term conditions such as epilepsy and diabetes. Where a person's blood sugar level was not well controlled, the registered manager had consolidated guidance from other professionals into a clear flow chart for how to respond to high or low levels.

Since our last inspection, the provider had revised their evacuation plan, which continued to involve joint working with the service next door, which had the same registered manager. This involved keeping fire safety and key documents in a box by the front door, and the provider continued to carry out six monthly evacuation drills and regular checks of call points and emergency equipment. There was now an evacuation mat in place for people who could not use the stairs in an emergency, which staff practiced using in team meetings. Other health and safety checks, including daily fridge temperatures and monthly checks on appliances and first aid, remained satisfactory. The landlord arranged monthly checks of water temperatures and thermostatic valves. People were protected from financial loss or abuse by a suitable system of financial transaction recording, which was checked quarterly by the registered manager.

Since our last inspection, the provider had only recruited one new staff member, but had followed suitable measures for safer recruitment including obtaining identification and carrying out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's backgrounds, including convictions, to help employers make safer recruitment decisions. Support workers we spoke with told us they thought there were enough staff; the provider told us they always had at least two staff on duty, with an additional member of staff at certain times so that two staff members could support a person in the community in line with their risk assessment. We reviewed four weeks of rotas and saw these staffing levels were maintained.

The provider maintained and had developed systems to ensure people received their medicines safely. This included clear medicines profiles for each person, weekly checks of medicines administration recording (MAR) charts by the registered manager and guidelines agreed with the person's GP for how people's medicines were given to them. All support workers had had a check of their medicines knowledge in the last six months and yearly observations of medicines administration.

Where potential errors were identified, the provider had a procedure for addressing this with support workers, including reviewing the error and whether this identified anything that needed to change as a result. Staff described how errors were addressed and how they were supported to avoid a repetition. A safeguarding concern had recently been raised as a person's prescription was mislaid, and the provider's checks, and those of the doctor and pharmacist had failed to detect this. In response to this, the provider had brought in a prescription tracking process to ensure that prescriptions were logged in and out of the service. The provider continued to maintain a monthly audit of medicines. An annual external audit had identified areas for development, such as ensuring that tallies of medicines were checked and daily checks of temperatures in storage cupboards, which the provider had implemented.

Good

Is the service effective?

Our findings

The provider continued to work in line with the Mental Capacity Act (2005) (MCA). The Act 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. The provider continued to carry out a detailed four stage capacity assessment with relation to specific decisions. People's decision making abilities were considered as part of the needs assessment, which was reviewed yearly, and contained information about how people were supported to make decisions. We saw evidence of this system being used in keyworking meetings with people.

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 saw that the service reviewed people's care regularly to assess for any potentially restrictive practice, and support workers described measures they took to ensure that these were applied in the least restrictive way possible. We saw that DoLS applications were made promptly before the previous one was due to expire, and that conditions such as providing access to advocacy were met.

The provider maintained a computer system for ensuring that staff received training and observations in line with the service's requirements. This included yearly training in areas such as manual handling, risk assessment and safeguarding and observations of finances and medicines administration. Comments from staff included "I think Mencap are good with training, whenever it's due the manager will book you in" and "The quality of the training is really good, it keeps us up to date and makes us want to come back." Staff received quarterly appraisals of their performance, which gave them an opportunity to discuss any practice concerns or development needs. The provider also had a system for recognising talented staff and offering support to them to develop further.

One support worker had joined the service since the last inspection, and we saw records of their induction. This included an activity pack to document their learning in areas such as security, support plans, nutrition and hydration, risk management and medicines. There were also work books completed in areas such as medicines, fire safety, moving people, maintaining dignity and promoting food hygiene. This induction system formed part of the staff member's probationary review.

The provider continued to have measures in place to promote people's health, such as recording appointments they had attended and outcomes from these, and maintaining health action plans and hospital passports, which help people with learning disabilities to access health services by providing hospital staff with key information on how best to support them. The provider also maintained a system for checking that people had had regular check-ups with their GP, dentist and opticians. There were management plans in place for people with long term health conditions such as diabetes, including how to manage this through people's diets. There were personalised information boards where required in order to

support people to make healthy food choices and staff recorded people's meals to demonstrate they received varied diets.

The layout of the building had not changed since our last visit, including a self-contained flat which enabled a person to live independently with support from staff in the main house. The provider had arranged for certain adaptations to the environment to meet people's needs, such as high visibility flooring and tiling for a person with limited vision, and handrails to promote the person's mobility. For one person, the provider had assessed their sensory needs and had provided edible and sensory plants for the person to smell, touch and taste, and we saw the person doing this. They had also worked with a specialist charity to order a suitable chair for a person in order to enable them to sit down and stand up independently.

Good

Is the service caring?

Our findings

The staff team continued to have measures in place to enable communication with people. This included the use of communication support plans and dictionaries for people who were non-verbal, which contained detailed information on how a person may communicate certain needs and wishes such as needing the toilet or wanting to go out. We saw that staff had added to these documents as they had learnt new things about how people communicated and that these documents were reviewed yearly. Communication documents included specific responses for staff to follow in order to aid consistency and promote effective communication. There were objects of reference such as photographs in people's working files and displayed in areas of the house to support better communication. Staff we spoke with were able to describe how people communicated their needs and had a good understanding of people's preferences. This knowledge was reinforced with the use of one page profiles, which described things which were important to people, things they were good at and areas they wanted and needed support with.

There was evidence that staff were supported to learn better communication. Makaton signs were practiced as part of the team meeting, and there was a sign of the week board displayed in the hallway. These signs were relevant to the time of year, for example our visit occurred in October, and there were Makaton signs referring to bonfire night and fireworks.

The staff team had developed a sensory profile for one person, following observations from the staff team about how the person responds to certain smells, sights and sounds. For example, support workers had observed that strong smells kept the person awake, and so had developed a plan to reinforce the time of day by using unscented cleaning chemicals in the evening and at night. The person liked to explore cupboards in the kitchen, and so some cupboards were clearly labelled as being only for the storage of items that the person could explore such as water bottles.

The service had a sensory room, but this was not in use as people preferred to use the lounge to spend time in. The lounge included a projector which was attached to a streaming device, this was used to project videos and play music of the person's choice in a way which provided a relaxing environment. We observed a person being supported to use a foot spa, in line with their sensory profile which stated they enjoyed scented water.

We saw that people had access to advocacy in line with the requirements of orders which restricted their liberty, these were carried out by an independent advocacy service on a monthly basis when required. Staff we spoke with described the measures that they took in order to promote people's dignity and privacy, including encouraging people to go into their rooms if they wanted to undress and measures they took to address this behaviour whilst supporting people in the community.

Good

Is the service responsive?

Our findings

We found that the provider continued to review people's needs on a yearly basis. This assessment was comprehensive in its scope, and included reviewing people's support needs in areas such as daily living, medicines, access to the community, maintaining good health, finances and meeting people's cultural and religious needs. A social worker told us "I've always found the staff there to be responsive and well informed about the needs of the service users there."

The provider had introduced a new system called 'What Matters Most?' This involved looking at key areas such as rights and choices, safety, happiness, money, friendships and inclusion. Within these categories desired outcomes were identified and reviewed regularly to see if these goals were being met. The registered manager told us that the aim of this was to ensure that meeting needs such as friendships and social inclusion were given equal importance to managing people's money and health needs, and that they were continuing to develop plans in a way which reflected this.

People continued to have varied activity programmes both in and out of the house. These included outings to the community, with one person owning a car to facilitate this. Activities in the house included relaxation sessions, nail spa sessions and stories. The provider had recruited volunteers to help with activities in the house and in the community. One person told us that she often ate downstairs and was encouraged to do so by staff, the registered manager said "We are trying to balance promoting independence and inclusion."

There was an accessible complaints policy displayed in the kitchen, although there had been no formal complaints since our last inspection. However, we saw evidence that the provider routinely learnt from people's experiences. For example, one person had requested that a particular staff member not support them anymore. We saw that the manager had met with the person and the staff member separately in order to identify the reasons for this and identified that the person was not happy with the way she was supported around cleaning. The manager agreed for the staff member not to support her in future and arranged for a cleaning support plan to ensure greater consistency in future. The staff team had a system of shift reviews in place, where they were encouraged at the end of a shift to reflect on what had gone well, what had not gone well and whether anything needed to be addressed by managers. There was evidence of this being discussed in team meetings and changes made as result.

We also saw that the provider had maintained extensive records of possible triggers for behaviour which may challenge and there was an analysis carried out of this. The registered manager told us that this had identified some triggers but was no longer productive, and that they had now switched to a system whereby they recorded positive interactions and the circumstances leading up to these, in the hope of further improving their practice.

Good

Is the service well-led?

Our findings

The service continued to be well-led with a focus on continuous development and learning. Some areas of the management of the service were distinctive. Comments from support staff about the management were positive and included "He's very supportive and approachable, he's always there if there's something you don't understand" and "He tries to understand everything from the root and to find resolutions." Other comments from staff included "I think the team is great as well" and "I've worked in other places, I love this place a hundred times more." Staff expressed values in line with those of the organisation, for example one support worker said, "Our main priority is supporting the people here…I'm completely biased about this place, I love it, I think we're doing very well" and another said "We are trying hard to meet people's needs."

A professional involved in assessing one person who used the service told us "I was quite impressed [the registered manager] would chase it up as well as me, he was as involved as I was, he'd take things to the next step without me having to push." A social worker told us "[the service] appears to be well run." The registered manager also managed the service next door, and staff told us that he was always available and contactable. We saw evidence of working with other agencies, for example, where the staff team had had concerns about a person's reluctance to clean their flat and had become agitated in response to this, they had worked with an Occupational Therapist in order to draw up a clear support plan in order to promote best practice and consistency, and had worked with another Occupational Therapist in order to draw up a plan of support to enable a person to use the stairs safely, this involved drawing up detailed guidelines, making changes to the house in co-operation with the housing association and working with staff to ensure that best practice was followed.

Where care plans were updated, staff appeared fully involved in these. Staff we spoke with expressed ownership and pride in their plans and told us that they worked together to implement these. For example, one person said "We have a technique, it has to be done in a specific way with 100% concentration. You won't have staff talking to you, the way we do it I think is perfect."

The provider had introduced a new system of audits in line with their "What Matters Most" initiative. This was designed in a way that gave equal importance to areas such as friendships, activities and access to volunteers to more established areas such as health and finance. For example, it required the manager to indicate on a monthly basis when the person last tried a new activity, and this prompted the manager to come up with an action plan to address this. The registered manager told us "It's given as much weight as the last GP appointment, it prompts me as a manager." The provider had made contact with another service where a person's friend lived in order to promote friendships outside of the service. The system was also designed to identify whether people accessed the community, and had their rights upheld, for example by identifying whether there was any restrictions on the person's movements, whether they were registered to vote and, for each area of support, whether the person was happy with the support and how this might be improved.

The audit was comprehensive in its scope, and prompted managers to provide monthly data on health and safety checks, staff supervision and training, and this was reviewed by a senior manager to gauge the

service's performance. Actions were clearly identified by this audit and carried out, for example to arrange observations of staff competency and environmental checks and improvements.

In addition to the provider's system, the manager maintained systems within the house to ensure that key tasks were carried out. A support worker told us "We know exactly what needs to be checked and when." For example, shift plans were in place on a daily basis including people's schedules and allocations for support tasks, medicines, activities, food, and prompts to carry out checks of health and safety, diaries and communication books. The registered manager maintained registers on the walls of the main office with a list of all the relevant documents for each person, including when they were last reviewed and when they next needed review. There was also a "read and sign" file to ensure that documents were reviewed by care workers for any changes. We saw an agency staff member receiving a brief induction to working in the service using a dedicated workplace orientation system. This included key information for new and temporary staff such as locations of fire equipment and evacuations, medicines, financial systems, how sensor systems worked and should be responded to. The agency staff member told us "It's so informative."

A support worker told us "The team meetings are very useful." The registered manager told us that there was often debate amongst staff about whether the support they provided struck the right balance, for example between managing risks and promoting people's freedom, and between independence and social inclusion. We saw that the provider had arranged a reflection day for staff where debate on these areas was encouraged and people's views considered and responded to by the registered manager. We saw that team meetings were taking place on a monthly basis, and included a discussion around the effectiveness of shift reviews, active listening exercises and drawing up an agreed action plan taking into account the views of the staff team, for example to make changes to shift plans. Team meetings were also used to review and discuss important documents such as risk assessments and moving and handling guidelines, and we saw evidence of resources used to demonstrate safer moving and handling, including examples of poor practice that should be avoided. The registered manager said "It's through these conversations that we change our practice."

There was an agenda for the next team meeting displayed in the main office. This included carrying out observations of how staff recorded financial transactions, which was highlighted as due by the audit system. Topics for discussion also included reviewing the use of the medicines procedures checklist and reviewing outcomes as identified for each person in line with What Matters Most.