

The Westminster Society For People With Learning Disabilities

Flat B 291 Harrow Road

Inspection report

291 Harrow Road
London
W9 3NR
Tel: 02072665396
Website: www.wspld.org.uk

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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 

Overall summary

This inspection took place on 28 and 29 May 2015 and was announced. Flat B, 291 Harrow Road consists of 4 separate bedrooms a communal lounge and a kitchen area. The service provides accommodation for people with learning disabilities. There were four people living in the flat at the time of our visit.

The service had a manager in post who was in the process of registering 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.

The service received referrals from social workers based in Westminster. Initial assessments were carried out by senior staff members to ensure that the service was able to meet people’s specific needs before they moved into the accommodation provided.

Summary of findings

Care plans were developed in consultation with people and their family members. This ensured people's support needs could be identified and met before moving into the service on a permanent basis.

People's risk assessments were completed and these covered a range of issues including guidance around accessing the community and personal safety. People using the service and their relatives expressed positive views about the service and the staff.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (2005) (MCA) and DoLS, and to report upon our findings. DoLS are in place to protect people where they do not have the capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others.

Staff had received training in mental health legislation which had covered aspects of the MCA and DoLS. Senior staff understood when a DoLS application should be made and how to submit one.

Staff were familiar with the provider's safeguarding policies and procedures and able to describe the actions they would take to keep people safe. Staff supported people to attend health appointments. There were protocols in place to respond to any medical emergencies or significant changes in a person's well-being.

People's independence was promoted and staff actively encouraged people to participate in activities.

Staff were required to support people to complete shopping tasks, design menu plans and prepare meals. Staff were aware of people's specific dietary needs and preferences and offered people choices at mealtimes.

There were arrangements in place to assess and monitor the quality and effectiveness of the service. This included annual surveys, house meetings and medicines administration auditing.

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 safe. Appropriate arrangements were in place to protect people from the risk of abuse.

Care plans contained up to date risk assessments that identified risks to people's safety and/or that of others.

People were supported to take their medicines safely.

The service followed safe recruitment practices.

Good



Is the service effective?

The service was effective. Care plans contained information about people's lives, past and present and were completed in full.

Staff had received training during their probation period which covered aspects of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain their health and independence and to access appropriate healthcare services.

People were given choices at mealtimes and supported to maintain a balanced diet.

Good



Is the service caring?

The service was caring. Relatives told us they were happy with the care their family members were receiving.

Staff were able to explain and give examples of how they would maintain and promote people's dignity, privacy and independence.

People and their relatives were encouraged to make decisions about the care and support they wished to be provided with.

Staff used a range of communication methods to support people to make choices in their daily lives in areas such as activities, meals and personal care.

Good



Is the service responsive?

The service was responsive. Staff accompanied people to annual health reviews with their GPs and made appropriate appointments to other healthcare professionals as and when needed.

People were supported to attend day centres, leisure facilities and community events.

The service had a complaints policy which was available in an easy read format for people using the service and their family members.

Good



Is the service well-led?

The service was well-led. Staff expressed positive views about the manager's approach to managing the service.

Good



Summary of findings

The service monitored the quality of care through regular contact with people and their family members either via phone, email or meetings.

Staff meetings were held on a monthly basis which gave opportunities for staff to feedback ideas and make suggestions about the running of the service.

Medicines administration was audited on a weekly basis.

Flat B 291 Harrow Road

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 28 and 29 May 2015 and was announced. The provider was given 24 hours' notice because we needed to be sure that someone would be in. The inspection was carried out by a single inspector.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection took place, we looked at the information the Care Quality Commission (CQC) holds about the service. This included notifications of significant incidents and complaints reported to CQC since the last inspection in May 2014.

During the inspection we spoke with the operations manager, the service manager and two support workers. Following the inspection we spoke with four relatives of people using the service and a further two members of staff. Records we looked at included care plans for all of the people using the service, four staff records and records relating to the management of the service. We sought feedback from two health and social care professionals with knowledge about the service and the people using it.

Is the service safe?

Our findings

Relatives told us they felt their family members were safe. One relative told us, “I feel good when I leave [my family member] after visiting, I can see that [they] are happy and content and I feel [they] are safe.” All the relatives we spoke with were confident that staff would take any concerns they may have about the health, safety and/or welfare of their family members seriously and investigate matters further if and when required. One staff member told us, “The manager monitors what we do and people are safe here.”

A range of risk assessments were completed in relation to the environment, personal care and fire safety. Records showed that care plans and risk assessments were reviewed annually or more frequently if required. People and their relatives confirmed that they had received copies of the care and support plans or would request copies if required.

Appropriate arrangements were in place to protect people from the risk of abuse. Staff were able to access information outlining the provider’s policies and procedures relating to areas such as safeguarding adults and whistle-blowing. Staff we spoke with were able to explain their understanding of these key policies and provide examples of how they related to their duties and responsibilities.

Staff had completed training in adult safeguarding prior to working with people who used the service and knew what to do if they felt someone they were supporting was being abused. Staff understood how to recognise the signs of abuse and told us they would speak to their manager and/or social workers if they had concerns about a person’s safety and/or welfare and ensure that the relevant incident forms and body maps were completed.

Relatives told us that changes in staff sometimes effected the level of support their family members received. One relative told us, “They change staff a lot, the temporary staff move on, [my family member] needs someone more constant who understands [them].” The manager told us they currently employed a mix of permanent, temporary, agency and bank staff but were in the process of recruiting new permanent staff members to join the team.

New applicants were shortlisted and invited to attend a group assessment and interview. Before staff were employed they were required to undergo criminal record checks and provide satisfactory references from previous employers, photographic proof of identity and proof of eligibility to work in the UK. We reviewed information which confirmed that people using the service were being cared for by staff who had satisfactorily completed these pre-employment checks.

Care plans we looked at contained up to date risk assessments that identified risks to people’s safety or that of others. Risk assessments were both generic and specific and covered areas such as accessing the community, road safety and personal care. For example, people using the service needed support when going out into the local community and the risks relating to this had been assessed and plans were in place to minimise the risks. Risk assessments were reviewed annually or before if required and all of the risk assessments we looked at were up to date.

Where staff were responsible for prompting people’s medicines, staff had completed training in medicines administration and first aid awareness. Medicines administration records (MAR) were signed accordingly. Medicines were stored correctly and that staff had access to gloves and aprons when needed.

Is the service effective?

Our findings

Each person living in the flat had a separate health care file which included information relating to health care needs and a health action plan. Staff made appropriate appointments for people to see their GPs as and when needed and accompanied them to all healthcare appointments. We saw evidence of people being seen by a wide range of healthcare professionals in the care plans we looked at. These included mental health specialists, occupational therapists, dietitians and district nurses.

We saw evidence in people's care records that easy read fact sheets had been completed. These fact sheets are designed to provide healthcare professionals with up to date information on how best to communicate with people and contain details relating to people's medical needs, medicines and allergies. Where people had complex healthcare needs or staff were unfamiliar with a specific procedure such as the management of epilepsy, the manager told us they sought relevant guidance from people's GPs and nurses with specialist training. Staff we spoke with confirmed that they would consult people's care plans for any specific guidance relating to support needs or speak to their manager to ask for advice if they were unsure about anything.

We discussed with relatives how staff monitored whether their family members were unwell or in pain. One relative told us, "If [my family member] was in pain, [their] behaviour would change and staff would spot that because they see [them] daily, observe, take note and pick up and notice if anything is wrong." Staff were aware of the protocols in place to respond to any medical emergencies or significant changes in a person's health and wellbeing. Staff told us that if someone they were supporting became unwell they would contact staff based in the office or contact emergency services. One staff member told us, "We know when something's wrong, if someone is crying or not responding in the usual way, we phone the GP for advice." Relatives told us, "They phone me straight away if anything happens, day or night, they're very good" and "Any problems or issues, they contact you and follow up an let you know. They're very efficient."

The manager told us that staff received training during their probation period which covered aspects of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Senior staff had completed internal service checklists to identify whether people supported by the service were subject to restrictions relating to issues such as one to one 24 hour support and supervision, locked doors, cupboards and secured appliances. People who used the service had been listed as being subject to these restrictions and were awaiting assessment by the relevant agencies.

Records showed that staff had completed mandatory training in areas such as person-centred planning, safeguarding and health and safety. Staff were also responsible for completing further training courses in areas such as autism awareness and non-physical approaches to managing behaviour that challenges. Healthcare professionals we spoke with told us they were very involved with staff training and that clinicians devised specific training for staff when and where indicated.

Staff told us they had received training in food hygiene and were aware of food safety issues. Where appropriate, people were supported with menu planning, food shopping and meal preparation. People were supported at mealtimes to access the food and drink of their choice. One family member told us, "[Staff] asked the family about what sort of food [they] like, and [they] go into the kitchen sometimes to help prepare food." We saw staff preparing meals using fresh ingredients and encouraging people to participate in and/or observe the proceedings. Where people had been assessed by speech and language therapists and dietitians, appropriate weight and food charts were in place and we saw that these were completed and up to date.

Staff confirmed they received regular supervision sessions and one member of staff told us, "Supervision enables me to get things off my chest and see how well I'm doing and what I can improve on. I've learnt a lot." We saw evidence in staff records that supervision was conducted on a regular basis and in various different formats.

Is the service caring?

Our findings

Relatives told us they were happy with the care their family members were receiving. Comments included, “I think [staff] do a great job” and “I have no complaints about the staff, they are fantastic.” We saw staff interacting with people using the service, explaining their actions and offering reassurance when needed. Staff we met during our visit and those we contacted following our visit were friendly, polite and informative.

We looked at people's files which included their care planning documentation, risk assessments, healthcare documentation and other records. Care and support records we read contained information outlining people's normal routines and activity preferences, details about the ways in which people preferred to communicate and strategies for supporting positive behaviour. Support plans were produced in an easy to read format and had been completed in full.

Staff supported people to make choices in their daily lives in areas such as personal care and grooming, activities and meals. Care plans contained detailed information about people's preferences and staff were well informed about people's lives, their family members and favourite past times. We asked a member of staff to tell us something

about one of the people they supported; “I talk to [them] about the things [they] like, [their] books and cars. We went to a vintage car show, we go to the library to a reading club. [They] like sweets and biscuits, [they're] very happy.”

The service was able to demonstrate that they were working to meet people's communication needs. We saw that people had their own communication profiles describing how best to engage with them. Staff used a range of communication methods such as, picture charts, objects of reference and voice recognition devices.

We observed staff encouraging people to make choices in the way they dressed by showing people various different items of clothing and allowing people the time to indicate their preferences. Where people were unable to communicate their choices and preferences using the above approaches, staff consulted family members and understood the importance of observing and interpreting people's body language, facial expressions and other verbal and non-verbal cues.

Staff told us that respecting people's privacy and dignity was an important part of their work and they always made sure they observed good practice such as asking people's permission, telling them what they were going to do and making sure doors were shut whilst people attended to or were being supported with their personal care. A relative told us, “[Staff] always ask people first, ask permission, they're patient and considerate.”

Is the service responsive?

Our findings

Before moving into the service people's care needs were assessed by senior staff. People's relatives told us they had been involved in the assessment process and were regularly invited to discuss the support and care needs of their family members. The manager told us they visited people in their homes or in the service they were currently living in and sought advice and guidance from family members, providers and professionals involved in people's care. People and their family members were encouraged to visit the service before arrangements were put in place for an overnight stay prior to moving in on an initial trial basis. Regular review meetings were held to monitor people's progress and welfare in order to ensure that people were happy and settling in well.

We saw that easy read support plans were in place for people using the service. Documents had been completed in full but signatures to demonstrate that people and/or their family members were in agreement were not included. However, relatives told us that they had attended meetings and had discussed their family member's needs before support plans had been agreed. One relative told us, "Things have improved since the meetings, [the management] has put plans in place."

Active participation in the local community was encouraged by people's families and staff. People were supported to attend day centres, leisure facilities and community events. Transport was available to take people on day trips and outings. For example, we heard that people attended book clubs, regularly went swimming and were supported to take holidays both in the UK and abroad.

The manager told us that they contacted people and their relatives on a regular basis to review the care and support they were providing. We were told that people's care was reviewed annually and more regularly if this was required. People were supported to feedback about their care at an individual and group level. We read the minutes of meetings held weekly for people who used the service. Discussions were based around the needs of people who used the service and the ways in which these needs were being met. For example, staff had discussed how they had located different leisure facilities for people and ensured that lifting equipment and access to these services was suitable, effective and safe.

Staff told us they entered information in people's daily logs. Information included a brief overview of the support given, activities participated in and details regarding well-being and behaviour. Relatives told us they were kept updated about any changes in the health and welfare of their family members.

Relatives told us they knew how to make a complaint and to whom. One relative told us, "I've never made a complaint but I'd speak to the manager if I needed to." The service had a complaints policy which was available in an easy read format for people using the service and their family members. The manager told us that complaints were managed as soon as they were received and that formal complaints were investigated in line with the provider's policies. A health and social care professional we spoke with told us that the service was closely monitored by their team of clinicians.

Is the service well-led?

Our findings

Relatives of people using the service told us, “[The manager] is doing the job well, there’s been lots of improvements since she started. There’s a lot more involvement with the family and we are very much kept in the loop.” The manager told us she operated an open door policy and that people who used the service, their relatives and staff, were able to contact him at any time during office hours.

The service monitored the quality of care through regular contact with people and their family members either via phone, email or meetings. People’s relatives told us, “There are yearly reviews but we wouldn’t have to wait for a meeting to discuss things. I feel very comfortable approaching staff at any time, they are all very helpful.” Another relative said, “I go to the meetings, you get a chance to input ideas, ask for changes and talk about any concerns.”

We were told that the provider conducted friends and family surveys on an annual basis. We looked at the results of the last survey carried out in 2014 and noted that there were no responses from family or friends of people who used the service. The manager told us that family members were contacted on a weekly basis and that any feedback received was used to monitor and improve the quality of the service.

The manager told us that staff meetings were held on a monthly basis which gave opportunities for staff to

feedback ideas and make suggestions about the running of the service. Minutes for staff meetings held in May 2015 and April 2015 and saw that issues such as training, safeguarding and reflective practice had been discussed.

Staff gave positive feedback about the manager of the service and said, “I’ve never had a better manager, she’s helped me build up my confidence and has helped me understand my role.” Another member of staff told us, “She really manages the service well, if she’s not there, she phones to find out what’s happening, if everyone is ok, if there are enough staff, if people have been to their activities and appointments, she monitors everything.”

The manager told us they audited people’s MAR charts on a weekly basis and that any errors or omissions identified were discussed with the relevant staff members. We saw records that verified this auditing process had been completed and staff confirmed that MAR information was checked on a regular basis.

Staff were aware of the reporting procedures for any accidents or incidents that occurred and told us they would record any incidents in people’s daily communication records and report the matter to senior staff. A health and social care professional we spoke with told us, “We work quite closely with [the provider] and we have very clear pathways and procedures around incident reporting. We meet regularly. This is one of the more responsive services in the area.”