

Octavia Housing and Care Miranda House

Inspection report

21 Penzance Place

London

W11 4PD

Tel: 020 7602 1516

Website: www.octaviasupport.org.uk/contact/our_scheme_locations/64_miranda_house

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Ratings

Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Good 

Overall summary

We inspected this service on 3 June 2015, the visit was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. The service was last inspected in August 2013 when it met all the regulations inspected.

Miranda House provides extra care housing for up to 20 people with a variety of care and support needs. Each person who uses the service is a tenant and has their own single self-contained flat comprising a bedroom, a

shower room and a combined lounge/diner/kitchen area. The flats are located on all three floors of the building and all had tenants at the time of inspection. People are referred to the service by the local authority.

There is an ordinary bath on one floor and two assisted 'walk in' baths, for those who prefer not to use a shower. People also have access to small seating areas on each corridor, a communal lounge and kitchen and two outside courtyard areas with benches. There is a laundry room on the ground floor which is operated by staff.

Summary of findings

A registered manager was in place. 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. The registered manager for Miranda House also had the same role at another of the provider's locations.

We found that Miranda House was a well-run service in which people were encouraged to be individuals with care plans adapted to make this possible. Staff were well-informed and proud of their teamwork. They understood that Miranda House was not a care home and people had tenants' rights. There was good evidence of learning from experience, well supported by the provider. People who used the service spoke well of staff and staff members spoke fondly of the people they cared for.

People were supported with shopping, food preparation and at mealtimes, if they had an assessed need for this. Staff supported people to take the right medicines at the right dose and the right time if they needed help with this. There were good links with local healthcare services which ensured people's healthcare needs were kept under review. People participated in activities of their choosing.

There was a complaints system in place, but people told us they had no cause to use it. Regular quality checks were carried out by the manager and her line manager.

The provider needed to develop their policies and procedures in relation to the Mental Capacity Act 2005 which they acknowledged. We have made a recommendation about this. Some information about fire and gas safety was not immediately accessible, because it was kept at the provider's head office, but we were sent it shortly after the inspection.

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. Staff were well informed about safeguarding processes if they spotted signs of abuse.

Staff recorded accidents and incidents clearly so it was possible to learn from them. Risks for individuals were assessed and some had been extensively developed in the light of experience.

The communal areas of the home were well maintained and kept clean and tidy.

Good



Is the service effective?

The service was not effective in one area. Staff needed further guidance in respect of the Mental Capacity Act 2005 in order to know who could make which decisions for themselves or others.

When do not attempt resuscitation (DNAR) forms were in place there was evidence that people had been consulted about their wishes.

People who used the service benefited from the service's participation in a local integrated care project which reviewed their healthcare needs and medicines.

Requires Improvement



Is the service caring?

The service was caring. People who used the service told us staff were kind and helpful.

Staff understood the rights people had as tenants and respected these. They spoke fondly of the people they cared for.

Good



Is the service responsive?

The service was responsive. There was evidence of a person-centred approach with care and support being delivered to fit in with individuals' life-styles.

The staff provided opportunities for the people who used the service to get together for group activities.

The registered manager liaised with healthcare colleagues to try to ensure smooth transitions to/from the service to hospital.

Good



Is the service well-led?

The service was well-led. Staff said the registered manager encouraged them, but also challenged them to improve their care practice.

The provider audited the quality of care quarterly, with strengths and weaknesses being appropriately identified and plans for improvement made accordingly.

Good



Summary of findings

There were six-weekly tenants' meetings and six-weekly staff meetings, as well as annual questionnaires in which both groups could air their views.

Miranda House

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 checked 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 3 June 2015 and it was announced with two days' notice, because it is registered as a domiciliary care service and we needed to be sure staff would be present to receive us. The inspection was carried out by a single inspector.

We tried various methods to ask people who used the service for their views including questionnaires, a letter through the door of each flat, speaking to people passing

through the reception area and, subsequently, phoning two people who used the service. As people who used the service were tenants we could not walk into their homes uninvited. We succeeded in getting the views of four people.

We spoke with six members of staff, including the registered manager, the administrator, a domestic, a senior care assistant and two care assistants. We also spoke with one care worker from another provider who provided support to an individual within Miranda House. We did not get any questionnaires back from any of the health and social care professionals we contacted as part of the inspection.

We looked at four care files, the recruitment documentation for the two most recently recruited members of staff and a range of the provider's policies, procedures and management records.

Is the service safe?

Our findings

Staff were aware of their responsibility to report any potential indicators of abuse and told us the signs they looked out for, such as changes in people's behaviour. There was evidence that the provider had reported safeguarding concerns to the local authority in a timely manner. Staff were familiar with the provider's whistleblowing policy, but said they had not had cause to use it.

There were risk assessments in place for each individual and staff were familiar with the content. We saw that one person's risk assessment had been extensively reviewed by a senior manager, in conjunction with staff members, in response to issues which had occurred. The associated risk management plan demonstrated that the service had changed its approach to try to meet the person's needs.

Risk assessments for the premises had been carried out by the provider's health and safety officer. Certificates were in place to show safety checks had been carried out by external companies. For example there was a current gas safety certificate in place and a current certificate of conformity for the fire extinguishers. There were records to show that water temperatures were regularly tested, as were fire alarms. We saw the registered manager had followed the matter up when a fire alarm test was missed on one occasion, which demonstrated she was monitoring safety.

The service had been issued with a fire safety order on 22 October 2014 with compliance due by 14 January 2015. Although we received an email on the day of the inspection from the provider to confirm that all requirements had been addressed, there was insufficient evidence of this on-site. For example, the provider told us that the fire service had not seen the most up-to-date fire risk assessment when they inspected, however the newer revised fire risk assessment was still not available within the premises, even though we saw an email from the registered manager requesting a copy. However, immediately following the inspection, the provider was able to send us their most recent fire risk assessment and their fire safety action plan which detailed the work that had taken place.

Staff told us they could meet people's needs within the current staffing levels. We noted that some people who

used the service also received care from other providers. In the case of three people the other provider's staff provided care for around 12 hours each day. Both Miranda House staff and a staff member from the other provider told us they worked well together and their respective responsibilities were clear.

We looked at some recruitment documentation for recently appointed staff and saw that checks had been made to establish they were of good character and had appropriate qualifications, experience or aptitude for the posts they applied for. The service had some vacancies which they were in the process of filling, the registered manager said it was taking longer than she would have liked, but she did not want to compromise her standards. In the meantime regular agency staff were covering vacancies and bank staff were used as well.

We found the service had disciplinary procedures in place and we saw they had been followed when required. The provider had produced a very clear poster which was on the wall next to a key safe frequently used by staff. It detailed the professional boundaries staff were expected to maintain and the consequences for them if they failed to.

Accidents and incidents were reported and followed up and there was evidence that they had resulted in learning. Staff wrote clear and concise reports from which it was easy to get a picture of what had happened and what they did in response. A staff member gave us an account of an emergency they had had to deal with and, as far as we could tell, they had covered every aspect appropriately.

People who used the service had an alarm they could activate if they needed assistance between planned visits to their flat. Staff members carried a device which identified which flat had issued the call. The same device also enabled care assistants to make and receive phone calls, they were pleased they no longer had to return to the office to answer the phone when the administrator had finished for the day.

People's medicines were kept in their own flats, except for one person who gave consent for them to be kept in the office, due to their particular circumstances. The medicines administration records we viewed were clear and had been completed appropriately. People's medicines were reviewed regularly by a GP and a pharmacist at

Is the service safe?

multi-disciplinary integrated care project meetings. Consideration had been given to the timing of medicines administration to ensure, whenever possible, it fitted in with people's preferred routines.

The communal areas of the service were kept very clean and tidy by domestic staff. Some people received support from the provider or external providers to clean their own flats. We saw multi-agency meetings had been held to try to address individuals' needs in this area if they were reluctant to accept assistance. Staff had received training in

infection prevention and control and cleaning equipment for the service was colour coded so staff knew where it was to be used. The service benefited from having two macerators in place to dispose of soiled pads. A member of staff from another agency drew our attention to the high standard of work by the domestic staff.

Staff described a prompt response to requests for repairs and maintenance and the communal areas looked well-maintained.

Is the service effective?

Our findings

The provider's policy in relation to the Mental Capacity Act 2005 did not reflect the Supreme Court judgement in 2014 which had implications for extra care housing. Staff did not have sufficient guidance about who had capacity to make which decisions or who could make them on people's behalf if they lacked capacity. However, we did not find any evidence of unlawful restrictions being in place.

Given that tenancies had been signed by or on behalf of most people who used the service and some people had their money looked after by the local authority there must have been information about capacity available which was not accessible to the service. The service had not been pro-active in seeking this out and considering the implications. Staff were alert to the need to seek advice if a person's ability to make their own decisions deteriorated once they had moved in. The provider told us senior staff were due to attend some training provided by the local authority and the policy and procedures would be revised immediately this had taken place.

We saw that some people had 'do not attempt resuscitation' forms prominently displayed on their files. These had been completed by the GP with full consideration of consent issues and they reflected individual circumstances.

We saw all staff within the service were up-to-date with their mandatory training unless away for an extended period. In addition, both day and night staff were encouraged to attend additional short courses relevant to the needs of people who had used the service, for example they had just learned how to calm people in distress and breakaway techniques in case calming methods were unsuccessful. The noticeboard listed staff members attending training in June, the topics covered were food hygiene, medicines and malnutrition. Some staff within the provider's organisation had trained to become trainers for certain topics so training was provided by a mixture of in-house and external trainers.

When we spoke with staff members they were able to give us full and informed answers to most questions we asked; we rarely had to prompt with any supplementary questions as they knew exactly what we meant. For example, when we asked one staff member what they would do if they suspected a person who used the service was being

abused, they were able to tell us about the provider's policy and procedures, as well as the wider human rights context. They were also able to explain people's individual likes and dislikes; this was confirmed in the care files.

New staff worked their way through an induction booklet with the assistance of their line manager and other colleagues. The content was in line with the common induction standards, but had been recently updated to reflect the new care certificate.

Staff received regular supervision from their line manager. We saw that it usually took place on a monthly basis. Staff told us they could always seek advice between supervision sessions.

A senior care assistant said, "I make sure I get all the supervisions [I am accountable for] done, as my manager checks at my own supervision." Appraisals were carried out annually and we saw they were helpful documents which acknowledged each staff member's strengths, but also noted areas for improvement.

There had been a few incidents of behaviour which challenged the service and others, due to the mental health of the people concerned. There was evidence that learning from these incidents had informed training, risk assessments and strategies for support. Staff were proud of the way they had all pulled together to support people who used the service and each other in difficult circumstances. An additional pressure had come from some external organisations who did not understand the more limited remit of staff working within people's own homes, as compared to a care home.

Staff within the service assisted people with an assessed need to shop and/or heat up meals. They also cooked very simple meals for some people. Staff told us they used temperature probes to check food had been heated through correctly. People made their own shopping lists or family members advised staff about people's favourite meals, so personal preferences and religious and cultural requirements were addressed.

A popular 'cook and taste' session was run on the premises for a six week period by a local voluntary organisation. A 'bring and share' breakfast had just been launched for Saturday mornings, whereby people supplied the ingredients and staff cooked them. Photos showed people tucking into a hearty breakfast. When we asked one member of staff what they were most proud of they

Is the service effective?

described their efforts to improve the food intake of a person who was at risk of malnutrition by gradually introducing new food items. Their success had been confirmed by the person's dietitian.

The service benefited from six-weekly integrated care project (ICP) meetings. The ICP ensured people's healthcare needs were regularly reviewed by a multi-disciplinary healthcare team, even if they were not obviously ill. The system particularly helped people who were not good at self-reporting and provided a learning

opportunity for the registered manager, which she valued. We saw that people were supported to attend medical appointments when needed; but those who attended independently had their privacy respected.

We recommend that the provider uses advice and information from a reputable source to review and implement their Mental Capacity Act 2005 policy and procedures so staff know exactly who can give consent for which decisions in respect of each individual who uses the service.

Is the service caring?

Our findings

Two people who used the service separately described the staff as “kind”, “helpful” and “nice”. One of them said, “They would do anything for you.” A third person said staff were “alright”. One person described how staff would phone them to check if it was convenient for them to visit or to alert them to visitors. They said this gave them the opportunity to say no, if they did not want to be disturbed.

One staff member told us, “This is where I want to end up [if I need care and support].” Another staff member said something similar. Both explained they tried to treat people as they would wish to be treated themselves. A third staff member said, “We are here [to meet the needs of] the tenants” and a fourth staff member told us, “If [the people who use the service] are happy, then [the staff] are happy.”

Staff spoke warmly of the people who used the service. They acknowledged that some people did not always appreciate their efforts to care for them, but they did not take this personally. One said, “It’s the illness talking, not the person.” The registered manager was proud of her staff for responding positively to new challenges presented by people who used the service.

Staff were very respectful of people’s rights as tenants and took care not to invade their privacy, except in an emergency. One person who used the service told us if they

did not need support to do something, staff did not invade their privacy. Sometimes this was a delicate balancing act, and we saw staff sought advice if their help was rejected when they had concerns for a person’s well-being. One person confirmed they knew staff cared about them, because they had alerted their GP to a health issue as they were worried about it. The inference was that the person was less concerned about the matter than the staff at the time, but, in retrospect, they were pleased the staff had used their initiative and understood why they had acted.

We noted that people were addressed by their preferred name and their basic life histories were known to staff. Care plans indicated that staff adapted their approach for each person in order to fit around their commitments and preferences. We saw staff supported people to maintain their previous life-styles, whenever possible.

People got the chance to express their views about their care in regular meetings with their keyworkers. Keyworker reports showed this worked well for most people, but they struggled for things to discuss if nothing had changed. Staff told us one of the things they found most difficult was knowing how much encouragement they should give people who appeared not to want to come out of their flats. The fact they thought about this was a sign of a caring approach, they wanted to respect people’s wishes, but they also wanted to make sure it was an informed choice.

Is the service responsive?

Our findings

A staff member told us, “We have to adapt [our working practices] for each tenant; what works for somebody, won’t work for another.”

The local authority assessed people prior to their referral to the service. There was evidence that this initial assessment was subsequently subject to regular review. The assessment informed individuals’ care plans. We found that people had made different choices about the way they wished to organise their days and this was reflected in the different patterns of care and support described within the care files. For example, some people were out a lot, attending day services or making the most of nearby facilities, others rarely left their flats. One person told us they were “too old to want to do anything else”, but staff “kept them company”. All this indicated that care and support was person-centred.

Staff members all confirmed that they made time to read the care plans and risk assessments. A typical comment from a staff member was, “How could we not [read them]? We have to refer to them to make sure we are doing the right thing.”

A staff member described how they always offered people alternatives at each meal, even when the person could be relied on to choose the same option each time. They did not want to make an assumption on their behalf.

We saw that people who used the service had requested a trip to the seaside. Planning for this was well advanced at the time of the inspection. It included a successful

application to a charitable trust to subsidise the transport costs, as well as a reconnaissance trip by a senior care worker to check out practical matters, such as toilet availability and accessibility. Staff also ran monthly karaoke evenings and weekly DVD nights in the communal lounge. Communal meals were prepared for bank holiday weekends and we were told August was “barbecue month”.

The service worked closely with a local voluntary organisation to run group activity sessions and to support people who needed escorts for trips, for example, to the bank. One person who used the service said they could do with more information about activities they could join in with in the local community, but they were happy with their social life within the home.

The provider had a complaints process in place, but had not received any since the last inspection. One person we spoke with told us they would have no difficulty making a complaint if one was needed, but they had never needed to use the formal process. Three staff members separately told us people who currently used the service were good at expressing their views about any perceived shortcomings within the staff team which gave them the chance to put things right. One said, “[People who use the service] are not backward in coming forward; we always try to do as they ask.”

We heard the registered manager negotiating a hospital discharge by telephone. She took steps to ensure the person would have appropriate community healthcare support on their return. This was evidence of the service working to ensure a smooth transition of care.

Is the service well-led?

Our findings

Staff were complimentary about the support they received from the registered manager and the provider. Both were described as “approachable”. They said their suggestions were always welcome and their requests were usually met and Miranda House provided, in the words of one staff member, “A very friendly working environment.”

A staff member said the registered manager, “Encourages you, monitors you and challenges you to do better.” Three members of staff told us they liked the way the registered manager “told it to you straight” if they needed to improve an aspect of their work.

We found the registered manager to be open and honest when we occasionally asked her for information she did not have. We saw evidence of regular visits by key members of the provider’s senior management team. The registered manager’s line manager carried out a quarterly audit to monitor the quality of the service and we saw, from the audit completed in April 2015, they found similar strengths and weaknesses to those identified by us. The registered manager herself carried out a monthly audit to ensure fire safety checks had taken place.

Each member of staff prided themselves on their teamwork. One staff member said, “We are all mature adults and [this contributes to] good teamwork.” Another member of staff said, “We problem-solve together.”

The registered manager described regular meetings with the local authority, alongside representatives from other Octavia Housing locations. They said this was an opportunity to discuss referrals and other issues. We saw other examples of partnership working in action, such as shared care arrangements for some tenants and participation in the integrated care project.

The provider’s managers worked together to provide out-of-hours support for all similar locations and met

together six-weekly to share information. For example, at the most recent meeting they had looked at the content of the new care certificate and considered its implications for their services.

When we asked the registered manager what events she was required to report to the Care Quality Commission (CQC) we found that she was very well-informed about this and we saw that relevant events documented within the service had indeed been reported to us.

We noted spot checks on the quality of the service at night were not taking place at the time of inspection. We were told this was because the procedure for this was under review. However, as the registered manager sometimes worked shifts we saw that she overlapped with the night staff so supervision sessions could take place. This was important for communication, because night staff did not attend the staff meetings which took place four to six-weekly, although they had access to the agenda and minutes.

Regular tenants’ meetings took place every six weeks. The minutes showed that people raised all kinds of things which were important to them and staff provided reassurance or took away actions to follow up. The provider ran a tenants’ steering group within its wider organisation, which one person from Miranda House had attended in the past. However, none of the current people who used the service wished to get involved with this group. There were two tenants’ noticeboards within the building, we saw they contained information about the provider’s activities and other relevant material, such as the provider’s monthly newsletter.

Both staff and people who used the service received an annual questionnaire from the provider to find out what they thought of the service. Staff said their questionnaire was sent direct to their home address and could be completed anonymously if they wished. The provider analysed the results and used them to inform service development.