Royal Mencap Society

Royal Mencap Society - Domiciliary Care Services - North London

Inspection report

Enfield Domiciliary Care Service
Unit 16 East Lodge Village, East Lodge Lane
London
EN2 8AS

Date of inspection visit:
14 May 2018
15 May 2018

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16 July 2018

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

This inspection took place on 14 and 15 May 2018 and was announced.

Royal Mencap Society – Domiciliary Care Services – North London is a domiciliary care service that provides care and support to people living in supported living schemes with learning disabilities and complex healthcare needs in and around North London. At the time of our inspection the service was supporting 37 people.

At our last inspection we rated the service 'Good'. At this inspection we found the evidence continued to support the rating of 'Good' and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Each person's individualised risk was identified and assessed to ensure people's safety. Risk assessments were comprehensive and gave guidance on how to reduce or mitigate people's risks.

The service continued to ensure that people received a safe service. Safeguarding policies and procedures were in place, understood and followed by all staff.

Medicines were managed and administered safely. Policies and processes in place ensured people received their medicines safely and as prescribed.

The provider ensured robust recruitment procedures were followed to ensure the recruitment of staff assessed as safe to work with vulnerable adults.

Care staff were supported through regular training, supervisions and annual appraisals.

A comprehensive pre-admission assessment was completed to ensure that the service was able to meet the assessed needs of the person.

People chose what they wanted eat and planned their own menus for the week. People decided the level of their own involvement with the preparation of their meal and where they required support. People had access to a variety of healthcare professionals and were supported by care staff where needed.

We observed caring and positive interactions between people and support workers that supported them. Relationships had been formed based on trust and mutual respect.

The provider and service demonstrated responsive practices on how people were supported in their daily lives which was highly responsive to their needs, choices and wishes. Staff that had been trained to deliver positive behaviour support which supported people emotionally and practically looked at triggers and

previously known behaviours and then worked with people in response to their needs to so that they were supported within any possible environment in the least restrictive way.

Care plans were person centred, comprehensive and detailed how people wished to be supported in order to meet their desired outcomes.

Care staff spoke with people with respect and promoted their independence. People were involved in all aspects of the care and support that they received especially through regular review meetings.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Complaints received were recorded and investigated according to the provider's complaints policy. People and relatives knew who to complain to if they had any concerns to raise.

A clear management structure was in place which allowed oversight and monitoring of service provision at each of the supported living schemes where people were supported with the regulated activity of personal care. A number of systems were in use to ensure that continuous monitoring, learning and improvement of services was implemented.

Further information is in the detailed findings below.

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

Royal Mencap Society - Domiciliary Care Services - North London

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.

This comprehensive inspection took place on 14 and 15 May 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the registered manager would be available to support us with the inspection process.

This inspection was carried out by two inspectors and two experts by experience. One inspector visited the office and two supported living schemes and the second inspector visited one other supported living scheme. The experts by experience made telephone calls and spoke with people and relatives using the service. An expert-by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and previous inspection reports before the inspection.

We also reviewed information we had about the provider, including notifications of any safeguarding or other incidents affecting the safety and well-being of people using the service.

Throughout the inspection process we spoke with three people who used the service and 14 relatives. We also observed interactions between staff and people using the service as we wanted to see if the way that staff communicated and supported people had a positive effect on their well-being.

We spoke with the registered manager, three service managers, one practice lead and seven support staff. We also looked at 14 staff files and training records.

We looked at 13 people's care plans and other documents relating to their care including risk assessments and medicines records. We looked at other records held at the home including staff meeting minutes as well as health and safety documents and quality audits.

Good

Is the service safe?

Our findings

Most people were unable to tell us whether they felt safe and whether they trusted the care staff that supported them due to the level of their learning disability. Some people were non-communicative and used expressions and body language to express their needs. During our visits to the schemes we observed people to be comfortable and happy in the presence of care staff. One person told us, "I feel safe living here and if I didn't I would speak to [service manager]." Relatives commented on people's safety and told us, "[Person] is safe. I have no problems" and "I think [person] is safe."

Risks to people's personal safety had been assessed and plans were in place to minimise risk. Risk assessments were personalised to their needs, gave guidance to staff about the nature of the risk and the steps that could be taken to minimise or mitigate the risk to ensure people's safety. Risk assessments were reviewed on a regular basis and modified if a person's needs had changed. People's identified risks included manual handling, choking, seizures, sexualised behaviours and managing behaviours that challenged.

Safeguarding policies in place ensured that people were kept safe from abuse and avoidable harm. We noted that the provider worked effectively with the person, their family and the local authority where issues or concerns were noted. Support workers were aware of the various forms of abuse which may occur and had completed training in safeguarding. This training was refreshed on an annual basis. Support workers told us there was a dedicated whistleblowing telephone number they could access if required to express their concerns without fear of recrimination. One staff member told us, "We learn to keep people safe, I have attended courses every year."

We found that the appropriate checks had been carried out to ensure that care staff were suitable to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Each file held documentary evidence confirming proof of identity, an application and an interview form as well as evidence of references and notes from the interview showing that people had the relevant experience to carry out their roles.

There were sufficient numbers of staff to support people's needs and the staffing rota showed that staff were organised in a way which accounted for people to be supported appropriately in the community so that there were no disruptions to other people who required support within their home. There were effective procedures in place to ensure sickness and annual leave was covered by the use of permanent staff or bank staff who knew the people who used the service.

There were appropriate procedures in place for ordering, recording and storage of medicines. Each person had a locked cabinet in their bedrooms where medicines were stored. People were supported with medicine administration where this was an identified need. Controlled drugs were stored and managed appropriately. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971. There were no gaps or omissions in recording and Medicine Administration Records (MAR's) were current and complete. Only support workers who had completed relevant training and

had been assessed as competent to administer medicines were able to do so.

Support workers recorded incidents and accidents on incident forms which were then reviewed by the registered manager. These were recorded on the provider compliance system and analysed on monthly basis to identify whether they were isolated incidents or there were any patterns which could be identified. This included looking at the types of injuries or behaviours, immediate causes, resolutions and further learning. In addition, support workers, practice leads, assistant service managers and service managers held de-briefing sessions and team meetings to ensure that appropriate reflection and learning could be explored.

All staff received infection control training as part of their induction and had access to a variety of Personal Protective Equipment (PPE) such as gloves and aprons.

Good

Is the service effective?

Our findings

One person told us that they felt appropriately supported by their support worker and told us, "They (support workers) have some skills, not sure what they are, but they are good in some ways and we all like the people we have got." Most relatives we spoke with expressed confidence in the support workers that supported their relatives and felt that they were adequately skilled and trained to carry out their role. Feedback from relatives included, "Some staff are skilled, some not" and "I'm impressed with some staff they are passionate about their job."

Support workers received comprehensive training appropriate to their role which included topics such as safeguarding, manual handling, first aid, positive behaviour support and medicine administration which was refreshed on a regular basis. Support workers confirmed they had received an induction when they started work with the service which also included a minimum two week shadowing period. This involved shadowing experienced members of staff, completing mandatory training and spending time with people who used the service. One support worker told us, "The training is quite good. We receive on-going training and we can ask for training as well." In addition to training support workers were also regularly supported through supervision and annual appraisals.

Pre-admission assessments continued to be completed prior to the service confirming that they were able to meet people's needs and achieve effective outcomes. Assessments looked at areas of need which included areas such as personal care, medication, mobility and general behaviour. Once completed the service developed a comprehensive, person centred care plan which detailed people's identified need, associated risks and support plan. Care plans were reviewed monthly or sooner where people's needs had changed.

Support workers supported people with nutrition and hydration needs where this was an identified need. Each scheme worked differently in terms of supporting people with their nutrition and hydration needs based on their level of need. Support workers devised menus plans based on what people's likes and dislikes were. Pictorial aids were used to support people in making their choices. One person had been supported to adapt their diet to support with healthy eating. Support workers had compiled a list of the foods the person really enjoyed by observing her reactions to the food that they ate. This was then translated into a menu plan for the person.

Care plans showed people who used the service were effectively supported to access appropriate health care services. Staff worked with associated healthcare professionals such as mental health teams, speech and language therapists, dentists and GP's to ensure that people's needs were assessed and care was delivered in line with recommended guidance.

Records we read confirmed there were effective systems in place to monitor people's health care needs, and to make referrals within a suitable time frame. Within the service care staff maintained regular logs of people's health and wellbeing, participation in activities, weight and behaviour charts so that support workers could work together to ensure people received effective care and support. Health records were up

to date and contained appropriate information. Staff implemented the recommendations made by health professionals to promote people's health and wellbeing.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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). However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team. We saw documents confirming that the service had applied for 'judicial DoLS' where required and were awaiting authorisation from the local authority.

We checked whether the service was working within the principles of the MCA. We found from observations, care records and discussions with staff, that people's rights to make their own decisions were respected. Senior managers as well as support workers members demonstrated a good understanding of the MCA and DoLS and the importance of obtaining consent. One staff member told us, "If the person wants to make decisions for themselves we help them to make those decisions. We give them examples of good and bad in the decisions they make."

People were not restricted from leaving the supported living accommodation and were encouraged and supported to access the community. We saw evidence that people went out to various places and people identified as being of risk when going out in the community had risk assessments in place.

Good

Is the service caring?

Our findings

One person told us, "They [support workers] are understanding, caring and communicate." Relatives gave mixed feedback about the caring nature of support workers. One relative told us, "Some staff are caring, some are not and some are just there for the money." A second relative stated, "It is a fundamental part of the house that the staff are caring, it is given that the staff are caring or they wouldn't be there – simple as that." A third relative said, "Some staff are caring but there is a high turnover of staff."

However, our observations of interactions between people and support workers was extremely positive. People knew the support workers that supported them really well and vice versa. Support workers spoke with people with dignity and respect and were not shy in showing affection to people which allowed them to feel able and confident in approaching them and expressing their needs.

One supported living scheme we visited, we were greeted by one person who opened the door and happily welcomed us into their home. The person expressed their happiness at our visit, asked us our names and who we were and then clearly expressed their needs and wishes to the support worker which included wanting a cup of tea and going out into the community to ride their bike.

Care staff knew the people they supported well and were very aware of their likes, dislikes, preferences and choices and most importantly their personalities and behavioural traits. With this knowledge care staff knew how to support people in a way which took into account their mental health needs and disabilities and supported them to maintain positive well-being.

We observed people were supported by support workers to maintain their privacy and dignity in varying ways which included knocking on people's doors before entering, supporting people to access private space and maintain boundaries in order to express their personal needs and offering them choice in all aspects of daily living. One person told us, "The staff give me privacy when I need it with my other half." Support workers understood the importance of maintaining people's privacy, dignity and respect and were able to give examples of this. One support worker stated, "We support with personal care, we help people with that, we give them the time to dry and dress themselves and we give them the privacy when they need."

Records confirmed that people and relatives were actively involved in making decisions about the care and support that they received. One person told us, "I like it because I am involved in my care." Records evidenced that relatives had been involved in the reviewing of support needs and outcomes for people. One relative stated, "I try and go to meeting about [person]."

People living at the schemes were supported by care staff in a way which promoted their independence. People held their own tenancy agreements and were responsible for maintaining certain aspects of their own care and housekeeping where possible. Care staff understood the importance of promoting people's independence. One care staff told us, "People we support play an active part in the community. We support them to go to the cinema and to go swimming."

People's needs in respect of their age, disability, sexual orientation and religion were clearly understood by staff and met in a caring way. We saw records confirming that people were supported to access their preferred place of worship. At one scheme, a priest had been asked to visit to bless the home, as per the request of people and with the permission of others living at the scheme.

Good

Is the service responsive?

Our findings

The provider and service demonstrated responsive practises on how people were supported in their daily lives which were highly responsive to their needs, choices and wishes. The provider proactively implemented a range of strategies to support people especially in areas such as behaviours that challenged and supporting people with their sexual needs. The provider had worked positively in partnership with a number of psychology professionals, social workers and speech and language therapists with a view to adopting strategies which were evidenced based in achieving positive outcomes for people. To achieve this the provider provided specialist training to managers and support staff and supported them to enable them to use these approaches in response to people's needs and behaviours.

Positive behavioural management and support (PBM and PBS) coaches were available within the schemes. Service managers and support staff that had received advanced training to deliver this type of support which helped emotionally and practically and looked at triggers and previously known behaviours and then worked with people in response to their needs to so that they were supported within any possible environment in the least restrictive way. We were able to look at records and speak with staff in relation to a series of incidents that took place with people living within the schemes. Support staff continued to use PBS pathways for emotional or communication support when the person was becoming increasingly upset. This showed good examples of the provider taking a holistic and individual approach to improve outcomes for people.

The service also worked responsively with people to support them in expressing their sexual needs and exploring their sexuality. The registered manager and staff recognised that people using the service have human rights the same as anyone else and that this should not be discriminated against just because of their disability. The registered manager was clear that they wanted to support people to live in and access the wider community whilst safeguarding their safety and the safety of others around them.

People's care plans were comprehensive and person centred and detailed each person's individual support needs, how to meet those needs and the goals people wished to achieve in the process of supporting them with their needs. Each care plan contained a one page profile which gave specific information about the person, what was important to them, what they found difficult and how they wished to be supported.

Support plans were individualised, personal and responsive to each person. These were compiled in partnership with the person, their relative and any involved healthcare professionals. Information was gathered on areas that were important to them and impacted on people's lives and included sexuality, behaviours that challenge, communication, maintaining relationships and friendships and how to support people safely within their home.

Each person was allocated a named key worker, who they knew and who was responsible for reviewing the persons care plan and risk assessments as well as reviewing their set goals and targets in relation to their health and social care needs. The key worker met with the person on a monthly basis to review their care and support needs and a monthly progress report was produced and shared with the support staff team.

People were supported to engage and take part in activities and outings that were of personal interest. Some people also attended structured sessions within day centres. We observed during the inspection that people were engaged and stimulated in a variety of activities on a one to one basis. Relatives feedback about people's participation in activities was positive. Comments included, "They take him to the park and take him out for days and for dancing – he likes dancing!"

The service only implemented end of life plans when a person's health had begun to deteriorate. The person along with their relatives' involvement had agreed to discuss and put in a place plans which reflected their wishes. Details that had been discussed and recorded on the plan included the person's preferred place of burial, music or hymns that they would like at their funeral, flowers that they would like and after the funeral where the person would like their family and friends to meet. The registered manager explained to us the importance of trying to help people remain in their own home as far as practicably possible to ensure continuity and responsiveness of care.

Staff were aware of how to manage complaints and stated that all complaints were documented. There were systems in place for reporting and analysing complaints by the provider. The registered manager and staff were able to describe how they would support people to complain if they needed to. Complaints that had been raised had been fully investigated by the service managers with the involvement of the local authority and the complainant with the provision of a full response to the complaint of the findings and resolution. People and relatives confirmed that they knew who to speak with if they had any concerns or issues to raise. One person told us, "I would complain to [name of service manager] if I had a problem."

Good

Is the service well-led?

Our findings

A registered manager was in post at the time of this inspection. 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.

Although people and relatives knew the registered manager, we were told that direct contact and relationships were held with service managers and the support workers at each of the supported living schemes where people lived. One person told us, "[Service manager] is the manager. I have never had any complaints." One relative said, "The manager is called [name of service manager]. He seems okay!" A second relative told us, "Manager is fantastic; If I'm worried I can call anytime. We have on going best interest meetings with the manager."

Care staff were positive about the way in which they were supported and told us that the service manager was always approachable and available for them when required. One support worker told us, "Our team is really supportive including the managers."

In addition to supervisions and appraisals, each supported living scheme held their own team meetings as part of a support mechanism, learning and information exchange process. Agenda items discussed included discussions about people's support plans, training briefings and staffing issues. Support workers confirmed that these meetings were productive and they were given the opportunity to share ideas and suggestions. One support worker told us, "Staff can bring things to the meeting for example learning and how to deal with situations."

The registered manager and service managers carried out a number of monthly and quarterly quality audits and checks to monitor the quality of care provided with a view to learning and improving. This included medicine audits, care plan audits, financial audits, environmental and health and safety checks. This was monitored and managed by the provider through a central system to ensure that where issues and actions had been identified these were completed in a timely manner. Service managers also completed periodic out of hours visits and night checks to ensure that people were being supported safely and according to their needs and requirements.

People and relatives were engaged in different ways at each of the supported living schemes depending on the needs and level of involvement people and relatives required. At a number of schemes the service managers organised meetings with people and their families on a quarterly basis to enable improvements with communication. In addition, a quarterly newsletter was produced to keep relatives regularly updated. Other schemes held monthly meetings with people where they discussed activities, menu planning and health and safety.

People and relatives had been asked to complete satisfaction surveys and comment on the quality of the care and support that they received. The most recent survey was completed in November 2017. One person

confirmed, "I had a questionnaire and staff helped me fill it in." One relative told us, "I fill in an annual questionnaire for the house and have also been involved in giving feedback to Mencap as well." Completed surveys seen were positive. We also saw a number of compliments that various schemes had received from relatives. One such compliment read, 'Please pass on our sincere thanks to staff, their commitment, support and kindness is truly marvellous.'

The service worked in partnership with other agencies to support care provision. We noted that that the service maintained links with a variety of healthcare professionals such as social workers, mental health clinics and GP's. The register manager also confirmed that they worked closely with other providers and attended local authority led provider forums to enable providers to learn and share good practices.

The provider and staff from a number of the supported living schemes were involved in a variety of a fundraising events organised in the community to support relationships and community presence. This included annual BBQ and music events and quarterly football events. In the last year a number of care staff completed a sky dive to raise money to go towards purchasing sensory equipment for people that they supported.