Royal Mencap Society

Royal Mencap Society - 36 Huddleston Close

Inspection report

36 Huddleston Close
Bethnal Green
London
E2 9NR

Website: www.mencap.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?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 22 December 2015 and was unannounced. We last inspected this service in January 2014, when the service was meeting the regulations we inspected.

36 Huddleston Close is a small care home for people with learning disabilities and autistic spectrum disorders. The service is registered to provide accommodation for three people, however at the time of our inspection there were two people living there, and the Provider has told us they do not intend to have a third person move into the service. The house consists of two bedrooms, a lounge, large kitchen, staff room and a third bedroom which is used as a staff sleep in room. The house is modern, clean and well-decorated. The service is managed by Mencap jointly with the house next door.

There was a registered manager who had been in post since November 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.

The service had extensive measures in place for ensuring people received a service which was safe. Risk assessments were thorough, personalised and regularly updated, and in several areas the service was innovative with how risk was managed. Staff were recruited through a safer recruitment process, which ensured that new staff were suitable for their roles.

The service was working in line with the Mental Capacity Act (2005). Where people did not have capacity to make their own decisions the service demonstrated that it was working in line with people's best interests. Where people's freedoms were restricted for their safety, the service took appropriate measures under the Deprivation of Liberty Safeguards (DoLS).

People who could not speak were supported to communicate through systems such as Makaton and objects of reference, including an extensive set of photographs which were specific to the individual. These were used to support people to make choices over their activities and food, to gain their consent for particular daily living activities and to teach people about road safety.

Staff had extensive training in areas related to their roles, and had a good understanding of their responsibilities under safeguarding and the MCA. Relatives expressed some concern about the skills of agency staff, however the service was in the process of recruiting more permanent staff.

Relatives praised the way the service addressed concerns and complaints. The service was frequently innovative, and was prepared to put measures in place above and beyond what was required in order to successfully meet people's needs. Where a person had required a stay in hospital, the service had arranged for this person to receive 24-hour care from a worker familiar to them in order to ensure that they received

the correct treatment. The service had consulted with external organisations in order to try innovative approaches to manage risk and meet people's needs. There were effective audit tools in place to ensure that high quality care was delivered.
People had varied and personalised activities including accessing places of interest in the local community, and communication tools were in place to allow people to choose their activities on a daily basis. The registered manager promoted an open culture whereby staff were comfortable raising concerns and areas for improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staffing levels were suitable to meet people's needs and had been changed in response to incidents. Staff were recruited in line with safer recruitment processes.

The service carried out regular checks on people's health and safety and had detailed risk management plans where people may not be safe.

Staff understood their responsibilities to detect and report abuse and were confident that the manager would take appropriate action.

Medicines were stored and managed safely by trained staff. Medicines were correctly recorded and audited.

Is the service effective?

Good

The service was effective. Staff had regular in training in key areas to support them to carry out their roles. We saw evidence of a detailed induction for new staff where people's skills and competencies were assessed during their first months working in the service.

The service was working in line with the Mental Capacity Act (2005) and DoLS. Staff understood this well, and we saw evidence that where people did not have capacity to make their own decisions, best interests meetings were held. Where people were deprived of their liberty, the service had taken appropriate steps to apply for authorisation from the local authority and to carry out the least restrictive action.

There were varied and health menus in place, and we saw that people had choices over what they ate. People had ongoing support to maintain good health.

Is the service caring?

Good

The service was caring. We saw regular keyworker meetings were in place to maintain caring relationships and to enable keyworkers to advocate for people.

People had varied daily activities which they planned with staff by using photographs. These photographs were personalised and added to by staff as new activities were undertaken.

We saw that people's privacy and dignity was respected.

Is the service responsive?

Outstanding ☆

The service was responsive. People had detailed and extensive care plans and communication tools, which were effective in ensuring they received personalised care. We saw that innovative steps had been taken to manage risks and that the service was prepared to go "the extra mile" to meet people's needs. The service showed signs of commitment to continuous improvement.

Concerns were handled satisfactorily by the registered manager, and relatives were happy with how these had been addressed. We saw signs of measures being put in place as agreed in response to concerns from relatives.

Is the service well-led?

Good ●

The registered manager ensured that there was an open culture for staff to raise concerns and develop their skills, and promoted the values of good communication and honesty. We saw that relatives of people who used the service praised the registered manager.

There were effective systems of audit in place to ensure high quality care was delivered.

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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 22 December 2015 and was unannounced. The inspection was carried out by a single inspector. Prior to our inspection, we looked at the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to CQC since the service registered in April 2014. In carrying out our inspection, we spoke with two relatives of people using the service, the registered manager and two care staff, as well as a commissioner from the Local Authority. As the people using the service were unable to communicate with us, we used observed care workers supporting people in order to understand their experience and the quality of their care. We reviewed both people's care files, including support plans and records relating to their care and reviewed the recruitment and supervision files of three staff. We also looked at documents relating to the management of the scheme, including rotas, staff training logs, health and safety checks and internal audits.

Good

Is the service safe?

Our findings

The provider had measures in place to ensure that the service was safe for people and people's relatives told us they thought the service was safe.

Staff files showed that pre-employment checks were carried out prior to people starting work in the service. These included checking people's identity, eligibility to work, obtaining a full employment history and taking up references with previous employers. Staff files and audits showed that the service had undertaken Disclosure and Barring Service (DBS) checks in order to ensure that they were suitable for their roles. However, as a corporate provider, Mencap's policy does not require staff to undergo regular DBS checks during the course of their employment or to make regular declarations of their ongoing suitability for their roles, although corporate policy states that they are obliged to inform their employer if there is a change in their status and that the Provider applied a risk based approach to reviewing staff suitability.

All staff had up to date training on safeguarding and a good understanding of their responsibilities to report suspected abuse. The service had an agreed protocol with the local authority for reporting safeguarding incidents. There was a 24 hour management on call system, with information when and how to access this clearly displayed in the staff room. Where a safeguarding issue had arisen, the service had reported this to the local authority and to CQC and the service had worked with other agencies to put guidelines in place to prevent a recurrence. Staff told us that they were comfortable raising concerns about people's safety to the registered manager, with one staff telling us "he would definitely investigate." There was also a whistleblowing policy in place, with staff understanding that they could report to another manager if a concern was not properly addressed.

A fire evacuation plan was in place for the service which had recently been reviewed and signed by all members of staff. There were also personal evacuation plans in place for both people who used the service. The registered manager had arranged an evacuation plan which took account of the needs of people in both services and required staff to work jointly to ensure people's safety throughout. Fire safety was discussed in staff meetings, and records showed that the service was carrying out regular checks of fire call points, the fire alarm and fire exits. Fire drills were carried out regularly, and the local fire service had carried out satisfactory checks in August 2015.

The service had extensive risk assessments in place to manage risks to people using the service. These were individual to the person receiving care and were reviewed regularly. Where measures were required to ensure people's safety, we saw that these were being carried out, for example a risk assessment concerning a person bathing required staff to carry out weekly checks of the water temperature which we saw were in place, and a risk assessment concerning conflict between the two people who used the service required a change in staff times so that there would be three people at particular times of the day, and this was in place. Risk assessments also covered areas such as behaviour which may challenge the service, support needs at night and accessing and using the kitchen. Risk assessments also covered the benefits of carrying out an activity and the risks of not doing it. This demonstrated a commitment to positive risk taking. The registered manager maintained a register of risk assessments and used this to ensure that risk assessments

were reviewed regularly.

The service had worked in partnership with the local authority in order to put risk management plans in place where people's behaviour may be a risk to themselves and others. For example, one person who used the service was likely to run into the road. We saw that the risk management plan required that the person be supported by two staff when accessing the community, which we saw taking place. The plan required that the person be shown pictures before leaving the house featuring the local area and showing that they needed to remain on the pavement, and we saw the person being shown these resources. The person was also wearing a high-visibility jacket when outside. The manager told us this was a last resort measure and said "it's not ideal, but safety is the highest priority." The plan was regularly reviewed in order to highlight what was working and what was not working well.

Risk assessments were also in place for staff managing people's finances safely. This required all transactions to be signed off by two staff, and transactions were reconciled and checked by the area manager and registered manager at the end of month, which records showed were being carried out. This reduced the risk of people suffering harm due to financial abuse or mismanagement.

Food was being stored safely in line with best practice. Fridge and freezer temperatures were checked on a daily basis, and all open containers in the fridge were clearly labelled and dated. Chopping boards were colour coded with separate boards for meat, vegetables and dairy. Cleaning tasks were clearly listed for the day. We observed that the kitchen, fridge and cupboards were in a clean and hygienic condition.

Health and safety checks were regularly carried out. These included electrical safety checks, checks of the first aid cabinet, water temperature checks, cleaning of shower heads, gas safety and weekly alarm checks. There was an alarm on the front door which would alert staff if somebody attempted to leave the building in a way which may not be safe.

The registered manager told us there were always at least two staff on duty, with a third member of staff during the day time in order to support one person to access the community safely. At night, there was always one waking night member of staff and a second staff member sleeping in who could be called on for assistance. Relatives of people who used the service agreed that this was a safe level of staffing, and rotas showed that staffing was being provided as described.

Medicines were being stored and administered safely by trained staff. A relative told us "I have no concerns about the medicines." Staff files showed that all staff had regular training on how to administer medicines, and had yearly observations of their competency to do so, which were carried out and recorded by the registered manager. People's files contained detailed information on what medicines they took, what they were for and what the possible side effects were. Where people had medicines to be taken "as needed", there were up to date and detailed guidelines for when these should be given. Medicines administration charts showed that these were being given as prescribed and were properly accounted for by staff, and these charts were checked on a monthly basis by the registered manager, who had signed to indicate this had been carried out. A medicines audit had been carried out in November 2015, and actions identified by this had been carried out. We saw that medicines were safely stored in a locked cabinet in people's rooms.

Good

Is the service effective?

Our findings

Staff had regular training in key areas such as first aid, fire safety, food hygiene, administering people's medicines and managing people's finances. The service had tools in place to ensure staff training was completed and was up to date. The registered manager had arranged for a care worker to monitor and update the training the staff team had undertaken as part of their own personal development.

New staff had an induction which was carried out centrally by the provider, which included assessment days in order to test the knowledge of new staff in key areas. We saw workbooks which demonstrated how the provider was testing people's knowledge during their probationary period.

The register manager showed us an induction file for new staff to read and sign their understanding, this included agency staff. Relatives of people who used the service told us "the regular staff all sing off the same hymn sheet, but some of the agency staff are not really trained." The registered manager told us that agency staff were always placed alongside more experienced staff, and the rotas we looked at showed that this was the case. We saw evidence that the service was recruiting more staff in order to reduce their reliance on agency staff.

Makaton training had been recently introduced for all the keyworkers, as one person who used the service used Makaton to communicate. The registered manager had put measures in place for supporting staff to develop these skills, for example we saw a "sign of the week" displayed in the staff room, common signs were displayed in the kitchen, and team minutes showed that the staff team practiced signing as part of every team meeting.

Staff we spoke to had a detailed knowledge of the Mental Capacity Act. 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. Staff understood their responsibilities under the MCA, and demonstrated a thorough knowledge of the key principles of the Act. As the people who used the service did not have capacity to make their own decisions, we saw that the service had followed a best interests process to show that the care plans protected people rights. We saw evidence of several meetings a year being held as part of this process and relatives told us that they attended these meetings and that they felt involved in the service.

The provider had a form in place for carrying out an initial assessment of mental capacity which clearly demonstrated how the key principles of the MCA applied to individual decisions. This was displayed in the staff room and aided staff understanding of the MCA.

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 are called the Deprivation of Liberty Safeguards (DoLS). Both people who used the service had restrictions on their

movement for their own safety, in that they were not able to leave the house without support. We saw that the service had met its obligations to apply to the local authority to deprive people of their liberty and subsequent authorisations were in date. Behavioural support plans which were in place to manage behaviour which may challenge the service clearly showed how to take the least restrictive option in line with the MCA.

We saw that food was regularly discussed in team meetings, and staff had devised menus for lunch and dinner. These were displayed in the kitchen with pictures of the meals, and we saw that these pictures were used to support people to make choices about what to eat for each meal. We saw that the fridge contained fresh fruit and vegetables, and did not see any evidence of processed or spoilt food.

Each person's care plan contained logs of all appointments people had been supported to attend, both planned and unplanned. These showed that people were regularly attending appointments with their dentist, optician, food clinic and, where relevant, had checks carried out on their hearts. Where a person had a particular health condition, there was detailed information on this condition available for staff, including how best to manage the condition and signs that this person may be deteriorating or becoming seriously unwell. We saw guidelines in place for how to support people to remain healthy during hot weather.

People who used the service had hospital and health passports, these were regularly reviewed and contained a summary of their health needs and communication needs so that health staff were able to support them better. We saw instructions for all staff that these needed to be taken to all health appointments.

Good

Is the service caring?

Our findings

Staff we spoke to had a good understanding of the needs and preferences of people using the service. A relative told us "Overall I'm happy he's there, I think he gets good care."

Caring relationships were maintained with people who used the service, for example by carrying out monthly meetings between the person and the keyworker. These covered areas such as the person's views on their activities, food and health. Since the people using the service were unable to speak, these records showed the person's actual response such as a gesture, facial expression or Makaton sign. The registered manager told us "Key workers are best placed to advocate on people's behalf." Goals had been identified with people and their families, and keyworkers regularly updated them through these meetings on the progress that had been made towards meeting these. These included going on holiday and visiting family.

As part of the recruitment process, potential staff visited the house in order to spend time with the people who used the service, we saw records which verified this, and at the time of our visit a candidate was due to the visit the service.

Detailed behavioural support plans were in place for both people who used the service. These had been compiled with the support of the learning disabilities team, and gave useful information about how to tell if the person was becoming upset and how best to respond. They also included information such as possible triggers for people's anxiety. These had been reviewed regularly and staff had signed to record that they understood these. There was evidence that there had been a noticeable improvement in people's behaviour since these were introduced.

People's support plans covered cultural needs such as a halal diet and food preparation guidelines were in place to ensure that food was healthy and culturally appropriate. A relative told us "They showed me it is halal food, I put my trust in them."

The service had made extensive use of photographs to record and document activities. These showed that people had been on day trips, for example to visit Old Trafford and showed the holidays people had been on. Staff displayed pictures both in books and on the noticeboard, and used these as communication tools for people to choose their activities and to make every day choices. Pictures were individual to the people who used the service and depicted them in places they regularly went to, including pushing a trolley in a supermarket and attending evening clubs. Staff maintained a pictorial consent file, and used a digital camera to add to these as new activities were undertaken. Other activities included visits to museums, bowling and visiting areas in London such as the River Thames and the Docklands Museum.

We saw examples of people using these pictures in order to choose their meals, plan activities for the day and for staff to reinforce the importance of road safety. This showed the service was able to build caring relationships with people who could not communicate verbally. Staff told us "seeing their pictures prompts and involves them, we can show pictures to emphasise too."

One person had a car which they were supported to purchase through Motability. This allowed the person to access the community safely. There were agreements in place for the other person who used the service to also use the car, but staff spoke of the importance of respecting that the car belonged to one person. The registered manager told us that the car had also been purchased to maintain the person's dignity and privacy due to continence issues. Relatives of people who used the service told us they thought staff afforded people "as much privacy as possible, although it's a small house."

Outstanding ☆

Is the service responsive?

Our findings

We saw many examples where the service was responsive to people's needs and wishes. For example, on arrival the registered manager was greeted by a person who used the service. The registered manager explained that this person liked to watch cartoons, particularly "The Pink Panther." He explained that previously the person had watched DVDs, however they handled these roughly and these had become scratched, resulting in the video not playing correctly which caused the person anxiety and frustration. The service had provided a streaming device for the person's television in their room, which meant they could now reliably stream videos of the person's choice from the computer in the staff room, and we saw that they were happy and laughing as a result.

People who used the service had extensive and detailed care plans. These included a one page profile which explained what was important to each person, their likes and dislikes, interests, what they were good at and what they found difficult to do. These provided clear guidance to staff and people's needs and wishes. We also saw that daily support logs were in place for each person, these were individual and covered areas such as what the person enjoyed, what they didn't enjoy, and where risks were identified for a person, staff recorded any experience that was relevant to this risk. We saw that support logs and feedback from staff were used to update people's care plans.

We also saw an early draft of a new person centred support plan which included detailed guidance on how a person liked to do tasks and how best to support them in particular areas of daily living. We saw evidence that this was in the process of being completed. The registered manager informed us that they intended to switch all support plans over to this format. This showed evidence that the service was committed to continuous improvement.

People had detailed communication passports, which recorded how they expressed themselves. These were personalised and extensive in what they recorded, and we saw that a lot of time had been spent learning and sharing information on how people communicate. We observed staff interactions where they demonstrated a good understanding of how each person communicated.

We saw that the service had responded to people's experiences. For example, an additional staff member was in place during the day time so that one person was able to go out at a time. We noted that one person did not like to get up early or to get ready quickly. We observed that staff did not rush this person and allowed them to take their time. The day staff member did not start until noon, which was usually the time the person was ready to go out. This staff member also finished later, at 8pm, and the registered manager explained that it was more effective to have this person in the evening where they could reduce tension between the two people who used the service. This showed that staffing was responsive to people's needs and their choices.

The service was innovative in how it addressed risks. For example, we observed an unusual type of alarm in the staff room which was designed to automatically close fire doors in the event of an alarm. The registered manager explained that this was put in place following advice from a fire safety specialist, as the previous

type of alarm was sound activated, and this was not appropriate as one person liked loud music, and would regularly activate this alarm with loud music. The registered manager also told us of a situation where one person was not using his seatbelt safely, and would remove it during the journey. The keyworker had contacted Remap, an engineering charity, who had built a bespoke solution to prevent the person from removing their seatbelt without compromising their safety during an accident. The registered manager had considered whether this would impact on the person's freedom, and had notified the local authority that they would try this out for two weeks. We saw evidence that this had been effective in preventing this behaviour and was no longer needed.

The registered manager told us of a recent situation where a person who used the service had to be admitted to hospital. The service had asked the GP to arrange admission for the person, rather than visit Accident and Emergency as this would be upsetting for the person. Due to their limited understanding of why they were in hospital, the registered manager explained there was a high risk of the person refusing treatment and becoming upset and possibly violent, and that therefore it was important for them to have continuous support from a staff member who knew them well in order to reassure them and support the hospital staff. The registered manager told us it was agreed that they would put this in place and "we will worry about the funding afterwards". Subsequently the service had provided support in hospital for 10 days, and had later agreed funding from the health service for this. Staff told us that the person had not refused treatment, and had made a good recovery from their illness.

We saw a note in the staff room thanking staff for their support and understanding during this hospital stay. A relative of this person praised the service and the registered manager for how they had addressed this situation, saying "It was very helpful, he could not have stayed in hospital by himself. My sincere thanks to the manager and staff, we are very grateful."

The service had a clear complaints policy in place, and relatives we spoke with said they were confident that any issues could be resolved by speaking with the registered manager. No formal complaints had been raised since our last inspection. However, informal concerns had been raised, and we saw that these were recorded appropriately and measures put in place to address these. One relative said "I had a complaint, the manager emailed me, it was a communication mix-up. I think they took the right steps, it's always been spot on." Following a concern the service had agreed a protocol with each family on when and how they wanted to be informed of minor and major incidents concerning their relative. We saw that this protocol was clearly displayed in the staff room. One relative informed us "we weren't always told in the past, it's improved 100%."

Good

Is the service well-led?

Our findings

The registered manager had a presence in the service and a good rapport with people who used the service. Relatives we spoke with praised the registered manager, comments included "He's an excellent manager, he keeps us in the loop", "he communicates well", and "he's a nice guy."

We saw evidence of good leadership throughout the service. For example, staff responsibilities in areas such as keyworking, cleaning and the responsibilities for night staff were clearly defined and displayed in the staff room. We saw that audit tools were in place to ensure that staff were correctly completing their allocated tasks. The registered manager showed that he was able to work out strategic priorities for the service. For example, he explained that the main priority for the previous year was to prevent altercations and incidents between people who used the service, and "we can now focus on developing the service as a whole." The registered manager spoke of the importance of maintaining good relationships with families through good communication and being "candid and honest about where we are." This was reflected in what families told us of their experiences of the service.
The service was correctly completing statutory notifications to the Care Quality Commission (CQC). This included when significant incidents had occurred, or when the service had applied to deprive people of their liberty in line with the Deprivation of Liberty Safeguards (DoLS).

One staff member told us "it's an open culture here." We saw that team meetings were carried out regularly and were used as an opportunity to develop areas of practice such as communication, where staff were asked to practice Makaton and use a camera to capture activities to help people make choices. We saw that an agenda for the next staff meeting was in place, and staff were invited to add items to this list that they wanted discussed. Supervisions were carried out every three months, and were used to review training and discuss areas of concern. Supervisions were also used to develop staff skills by offering additional training in certain areas, and where staff had expressed an interest in developing their leadership skills, they were encouraged to take on extra responsibilities such as auditing of staff training. Staff told us "I feel supported by the manager, he helps us in all things."

The provider had extensive policies in place to cover areas such as person-centred support, anti-discriminatory practice and safeguarding. We saw that the provider had a detailed induction process in order to ensure all staff joining the organisation understood its culture and values, as well as using this process in order to ensure staff had the correct skills to carry out their roles.

The service had audit tools in place to ensure good quality care. For example, key documents such as support plans, behavioural support plans, health action plans and financial support plans were regularly updated, and the dates these had been reviewed and were next to be reviewed were clearly displayed in the staff room, and we saw that this tool was being used effectively. The registered manager maintained a register of risk assessments to ensure that these were regularly reviewed.