

Islington Social Services

Islington Social Services - 3 Wray Court

Inspection report

3 Wray Court
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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

3 Wray Court is a home providing residential care and support for eight people with learning disabilities. The service is run by Islington Council Social Services department. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. The service continues to be accredited with the National Autistic Society.

This inspection took place on 19 October 2018 and was unannounced. At our previous inspection on 26 February 2016 there was no registered manager in post and this had been the case for over six months. We imposed a requirement action regarding this breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009. This matter was resolved a few weeks after that inspection and a manager was registered with CQC.

At the last inspection on 26 February 2016 the overall rating was Good.

At this inspection we found the service remained Good.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The service is owned and run by the London Borough of Islington and adhered to the authority's safeguarding adults from abuse procedures. Staff were trained in using these procedures, which they confirmed when speaking with us. Staff had a sound understanding of how to keep people safe from harm.

Risk assessments were detailed, and were regularly reviewed. The instructions for staff described risks and risk reduction measures.

There were policies, procedures and information available in relation to the Mental Capacity Act 2005 [MCA] and the Deprivation of Liberty Safeguards [DoLS] to ensure that people who could not make decisions for themselves were protected. The service was applying MCA and DoLS safeguards appropriately.

People's health care needs were assessed and care was planned and delivered in a consistent way. Information and guidance was provided to staff about how best to support people which included how people's health and nutritional needs were met.

Individual support was provided for people to maximise their opportunities to engage in day to day life, recreational and social activities.

Care plans described how staff could maximise opportunities for people to make as many choices that they

were meaningfully able to make. People were treated with dignity and respect and we observed staff interacting with people in ways that demonstrated this.

The provider carried out audits and reviews of the service and regularly sought people's feedback on how well the service operated.

At this inspection we found that the service met all of the regulations that we looked at.

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 remains Good.

Is the service effective?

Good ●

The service remains Good.

Is the service caring?

Good ●

The service remains Good.

Is the service responsive?

Good ●

The service remains Good.

Is the service well-led?

Good ●

The service had improved and was well led. A registered manager was in post.

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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 was unannounced which meant the provider and staff did not know we were coming. The inspection took place on 19 October 2018 and was carried out by one inspector.

Before the inspection we looked at notifications that we had received and communications with people, their relatives and other professionals, such as the local authority safeguarding and commissioning teams as well as other health and social care professionals.

We used a number of different methods to help us understand the experiences of people using the service. The people using the service had complex needs and limited or no conversational communication which meant that not everyone was able to tell us their views. We gathered evidence of people's experiences of the service by observing interactions with staff and by reviewing communication that staff had with people's families, advocates and other care professionals. We also spoke with the registered manager and three members of the care staff team, the registered manager and the lead residential services manager for the provider. We made email contact with two relatives although no replies were received.

As part of this inspection we reviewed three people's care plans. We looked at the medicines management, training, appraisal and supervision records for the staff team. We reviewed other records such as complaints information, quality monitoring and audit information, maintenance, safety and fire records.

Is the service safe?

Our findings

An advocate that contacted us said, "I would say that yes people are safeguarded, that they [the staff team] provide good care which is often complex, that the care is well tailored and the staff seem to know each client very well."

A social care professional told us, "During my direct work with the service, I have no evidence to suggest that residents are not safeguarded from abuse."

The service had the provider's policy and procedure for protection of people from abuse. The service was owned and run by the London Borough of Islington and used the authority's borough wide safeguarding adult's procedures.

Staff had regular updated training about keeping people safe from harm or abuse. Our review of staff training records confirmed that staff training did occur. Staff we spoke with demonstrated a sound awareness of what protecting people meant and of their role in making sure this happened.

The authority had sound procedures for the safe recruitment of staff. These procedures included background checks, employment history, references and qualifications [where relevant] all having been verified. Verification of checks was also undertaken for temporary bank or agency staff when they were used. The staff rota and deployment of staff around the home showed there were suitable numbers of staff on duty to give people individual attention and meet their care and support needs, with one to one [sometimes two to one if needed] support being offered to each person.

People's needs were assessed taking into consideration general and specific risks. For example, we found risk assessments in people's care plan files that covered areas such as accessing the community [including the degree of staff support each person required], behaviour and techniques for minimising potential triggers and responses to signs of distress, specific activities that people participated in and possible health care needs for example people that lived with epilepsy. These assessments were tailored to each person. Risk assessments were being reviewed at regular intervals and all that we viewed had been updated recently.

We spoke with care staff about handling and administering medicine and they could tell us about the procedures. Medicines were prescribed by a local GP practice and when they were delivered they were checked by the senior person on duty at the time. Each person had their medicines stored separately on pre-packed monitored dosage cards [for tablet medicines] or in separate bottles labelled with their own name for liquid medicines. We looked at the medicines administration record [MAR] sheet for three people living at the home and these included each medicine, the dosage and any known allergies. Two medicines errors had been reported to CQC since our previous inspection in 2016. These were a missed medicine [May 2017] and an error in the amount of medicine left in stock suggesting a use of paracetamol that had not been recorded [January 2018]. Neither of these had resulted in any harm to people and as a result the provider who initiated a review of medicine management procedures. Action had been taken and at the time of this inspection medicines were managed safely, and no further errors have been reported to the

commission.

The provider had arrangements in place to deal with emergencies related to people's individual's needs, or common potential emergencies such as risk of fire or other environmental health and safety issues. Fire alarms were tested regularly and other safety checks, for example gas and electrical safety, were being carried out.

Is the service effective?

Our findings

A social care professional told us, "I think staff are meeting people's care needs. Staff have engaged with occupational therapy input when this has been structured by therapists. Staff have a growing and developing knowledge of how to support people who have very high sensory needs."

We looked at records which showed that staff received regular training, and supervision. The provider maintained effective systems to ensure that staff training was kept current and up to date. Where staff were about to, or had exceeded, the necessary timescale for refresher training this was flagged up by the provider's training department. This system worked well. A system to provide in house supervision for agency staff had recently been introduced as agency staff were previously supervised by their employing agency. This is a positive development as the service does use regular agency staff who support people either specifically for one to one support or as additional support on shifts that need to be covered.

One new member of permanent staff had been recruited since our previous inspection. This person had completed their induction in early 2017.

The staff we spoke with told us they had received effective training, which included more specialised training about caring for people with autism and other complex needs. They also told us they received supervision each month. When we looked at the frequency of staff supervision records for the whole staff team we found this was happening consistently for all staff, other than if people were on leave. The staff we spoke with thought they were well supported and trained for their work.

People who lacked mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this was in their best interests and legally authorised under the Mental Capacity Act 2005 [MCA]. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS].

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

All the staff we spoke with had a good knowledge of their responsibilities under the MCA and DoLS. Where DoLS decisions had been made these were recorded. DoLS authorisations were all within date and there was also a record of when these were due to expire and new applications needed to be made. The service had not notified CQC about recent approved decisions, which we clarified and the necessary notifications were subsequently supplied to CQC.

We found that best interests decisions, when made, were documented. Signed consent was obtained and was agreed by a relative or advocate for each person.

Breakfast and lunches were prepared by staff, involving people as much as they could be involved. People could choose before each meal what they wanted. People were often out during the day so lunch was often

taken at cafés or wherever a person was engaging in an activity.

The home continued to employ a chef from mid-afternoon each weekday to prepare evening meals. Choices of meals were tailored to people's preferences and took account of their dietary needs such as culturally or health related requirements. Nutritionist advice was available from the local health care services and was sought whenever necessary. People were also supported to maintain good health. Each person had a hospital passport that provided healthcare professionals with the necessary information about how to support people accessing healthcare services.

Is the service caring?

Our findings

A social care professional told us, "I have observed staff ensure people are given preferred and culturally appropriate meals in addition to supporting them to maintain relationships with family during home visits." Another told us, "Overall I would say yes [staff are caring]."

The interactions we observed between staff and people living at the home were sensitive, attentive and caring.

Staff could tell us about people's communication needs and all the methods used and were aware of how best to communicate with each person. We observed this throughout our visit.

The provider continued to use a technique called 'PROACT SCIP' [Positive Range of Options to Avoid Crisis and use Therapy Strategies for Crisis Intervention and Prevention]. This technique seeks to avoid the use of physical interventions and focus on recognising people's feelings and what may cause them distress. Staff told us they were very familiar with using this technique. No need for physical interventions was reported to us as staff knew people's personalities and how to minimise people experiencing serious distress, which was successful. Our observations showed that people were supported to be as involved in their care as they could meaningfully be.

An advocate that contacted us said, "As far as I'm aware all cultural identities are taken in to account when care planning." People's individual care plans included information about their cultural and religious heritage, daily activities, including leisure time activities and how best to communicate with people. The home had a largely longstanding staff team and all but one of the people living at the service had done so for a few years. Staff we spoke with evidently knew about people's unique heritage. Staff could readily tell us, without reference to care plans or other information, about what they did to respect and involve people in maintaining their individuality and beliefs.

Care plans demonstrated the degree of input that relatives had in care planning and sharing their views. The care planning process also showed how people using the service were involved as much as they were meaningfully able to be. Where people did not have family members who could do this an advocacy service was used.

People's independence was promoted. On the day of the inspection there were eight people using the service. Staff were engaging well with people to participate in the activities they had planned for their day. The service provided one to one support for people, each having this support regularly each week. During our inspection visit, one person was supported by two members of staff to visit a relative and this level of support was provided each time they made these visits. The service gave a high priority to enable people to maintain relationships with important people in their lives and gave careful consideration about how this could best be achieved.

Is the service responsive?

Our findings

Care plans encompassed personal, physical, social and emotional support needs. Care plans were updated at regular intervals, including monthly summaries of people's progress. This process helped to ensure that information remained accurate and reflected each person's current care and support needs.

The provider had clear policies and operated procedures that included due consideration of people's heritage and cultural needs, as well as anti-discriminatory practices and ensuring that protected characteristics were acknowledged and respected.

We asked staff what they did to ensure personalised care. We were told about people's needs in detail and staff demonstrated a clear knowledge of the people they supported and their goals and aspirations. People's individual care plans included information about their cultural and religious heritage, daily activities, including leisure time activities, communication and guidance about how personal care should be provided. One person had moved into the home since our previous inspection. Their move had been carefully planned, taking account their diverse needs and wishes of both the person and their family. This process had been given the time required to assure the person and their family that the service was able to meet their needs on both physical and emotional levels as well as support required to adhere to their cultural heritage. This success with which this introduction had been achieved received praise from the person's family who were assured the service could provide what was needed.

The service was accredited by the National Autistic Society and to maintain this accreditation, were required to show that it used best practice in supporting people with autism. The service was most recently reviewed by the National Autistic Society in April 2017. The report of their observations praised the service for being "a home" and that the staff team paid attention to detail in providing positive life experiences for people.

The care plans we viewed showed in detail how each person lived their day to day life and how staff should enable each person to be meaningfully involved. Staff we spoke with were proud that the national autistic society accreditation continued and acknowledged that this was not a reason to sit back and not strive to make more improvements. We noted that sensory experience for people was referred to as an ongoing piece of work at the service and this was continuing. Such experiences included audio and visual stimulation as well as tactile physical experiences.

The complaints system allowed people to make a complaint to anyone working at the home or to the provider directly. This was presented in picture as well as word formats. An independent advocacy service was also used to support people to make a complaint if they wished to. The complaints information gave details about what action would be taken to resolve a complaint, who would take the action and what people could do if they remained dissatisfied with how their complaint had been handled. People using the service had a range of different abilities. We were informed by the registered manager that no complaints had been received by the home in the last twelve months.

Is the service well-led?

Our findings

An advocate told us, "I've always had positive interactions with the management. They always seem to be aware of the myriad natures of their clients."

A social care professional told us, "Every time I call [the home] I am able to speak to someone in the office and arrange visits. Often I turn up for pre-arranged visits and find they are not expecting me or the person I am going to see is not there." The registered manager told us that on some occasions people may prefer to go out and not wait for an expected visitor. If people were unable to understand that they had a visitor coming and did not want to wait this may at times result in unnecessary anxiety and distress if people were focused on wanting to do something else. We were also informed that there had been occasions when visitors have requested to meet with key-workers at short notice. However, the registered manager told us that this did not result in meetings being cancelled. They told us there was always another colleague available who had suitable knowledge of the person's needs in order to facilitate these meetings if the person's keyworker was unable to be present. The registered manager told us that as a result of this feedback they would look at what else may be able to be done to minimise any possible recurrence. We were also told that on occasions some staff do not attend booked training sessions. We did not receive this feedback until after our inspection, however, we followed this up with the registered manager and were told that members of staff had missed training a few weeks ago due to unforeseen circumstances. We were told that an apology had been provided and attendance at training was considered important. Our review of training records showed that training was provided regularly and there was not an issue about frequent missed training.

At the time of our previous inspection there had not been a registered manager in post for over six months. This had been resolved shortly after that inspection and at this inspection a registered manager was in place at the home.

We asked staff about the leadership and management of the home and were told that staff worked well together and were supportive of each other. We were told, "We are noticing changes", "I think if I needed to raise anything it would be taken seriously" and "If I was concerned I would raise it with senior managers and even CQC."

There was a clear management structure in place for senior and junior staff at the home as well as the provider organisation and staff were aware of their roles and responsibilities.

There was clear communication among the staff team at the service. Staff meetings took place and views about how the service operated were listened to. Staff told us that there were regular team meetings, which we confirmed and people using the service were discussed as well as day to day operational matters.

The provider had a system for monitoring the quality of care. The home was required to submit regular reports to the provider about the day to day operation of the service. In addition to this there were monthly evaluations of direct care practice. This included care planning, keeping people safe from harm, activities

and engagement with families. We viewed the reports covering the last twelve months and these demonstrated that this system worked well at keeping up to date on the way care planning and people's needs, including changes to needs, was monitored.

We were informed by the registered manager that written feedback survey questionnaires were to be issued in November 2018, the most recent survey by the home had been in 2015. These were to be sent to families and a pictorial format questionnaire, we were told, was also being developed for people using the service who may be unable to reply to the questionnaire. However, an independent organisation was used to carry out an annual review of the service. As a part of that review the views of relatives were sought. The response to the most recent of these reviews in November 2017 from families included "staff are very good at understanding and communicating with people" and "staff are good at communicating and can call the office [at the home] whenever they need to speak to staff." Suggestions for improvement to in house activities was also made and this had been acted upon. The rating as a result of that review, for example, staff, life and taking part, the home and support described these and other areas as being either good or excellent.

The provider had an organisational governance procedure designed to keep the performance of the service under regular review and to learn from areas for improvement that were identified. We found that the service developed plans to address the matters raised and acted to implement changes and improvements. This demonstrated that the service listened to what people said and took action to respond.