The Brandon Trust

Brandon Trust Supported Living - Earlsfield

Inspection report

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10 April 2017
11 April 2017
20 April 2017

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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

This inspection took place on 6, 10, 11, 12 and 20 April 2017 and was announced. The provider was given 48 hours' notice because the location provides a supported living service; we needed to be sure that someone would be in.

At our previous inspection on 26, 27 and 28 April 2016 breaches of legal requirements were found. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to safe care and treatment and person-centred care.

We undertook this comprehensive inspection to check that they had followed their plan and to confirm that they now met the legal requirements in relation to the breaches found.

There was a registered manager at the service. 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.

Brandon Trust Supported Living – Earlsfield provides support to people with learning disabilities with a wide range of support needs. Support ranges from a couple of hours to 24 hours cover across services ranging from people's individual homes to shared group homes in the Southwark, Wandsworth and Croydon boroughs of London.

At the time of the inspection, the provider was supporting people living in 20 different supported living services. The landlords in most cases were housing associations. There were registered managers for the services, known as locality managers. They each managed a number of services between them.

At our previous inspection we found that care records were not always fully completed in the services that we visited. For example, some risks were not fully assessed, care and support plans were not always in place and key worker reports were not always completed. We also found that some people may have been at risk of not receiving their medicines in a safe manner as some medicine administration record (MAR) charts were not always completed.

At this inspection, we found that improvements had been made.

Risks to people were identified and assessed appropriately. Records were up to date and included ways in which the risk could be managed including steps that care workers could take. Care workers we spoke with were aware of the risks to people and how they would manage them.

Each person had a care plan in place which was up to date. Care plans contained person centred information and included ways in which people could be supported to lead independent lives. Each person

was assigned a key worker who met with them monthly. Monthly reports were available for each person, written by their keyworker documenting if people were happy with the support they received in relation to any complaints, housing issues, food and their general health. Keyworkers also completed more generalised yearly reports.

MAR charts were completed accurately and regular audits took place to try and minimise the occurrence of errors. Where specific concerns had been raised in relation to medicines management managers had implemented a number of changes to make improvements, including changes to staff shifts, improving care worker's medicines practice and requesting support from the dispending pharmacy.

People using the service told us they were happy with the care and support they received. They said staff were caring and supported them to lead independent lives. People were able to pursue interests and activities of their choice. They told us they had no concerns about the support they received in relation to food or their health.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). If there were concerns around peoples' capacity to make decisions in certain areas, formal capacity assessments took place in line with the MCA. If people lacked the capacity to make decisions, best interests meetings took place to ensure their rights were protected.

Robust recruitment procedures were in place which helped to ensure care workers were safe to work with people. The use of agency staff was closely monitored by managers. Care workers completed a comprehensive induction and ongoing training for employees was monitored and tracked by a learning and development coordinator.

Concerns and complaints were documented and responded to. Incident and accident monitoring took place and was overseen at management level. This meant that any root causes could be identified and action taken in response.

There was a formal quality assurance programme that had been put in place by the provider. This included measuring each service against CQC standards, risk assessments for each service and a health and safety audit to monitor incidents such as safeguarding, complaints and accidents. There was evidence that the provider acted on feedback from people using the service and other stakeholders.

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

We found that action had been taken to improve the safety of this service.

Care workers completed Medicine Administration record (MAR) charts and medicine audits took place.

Individual risk assessments were completed for people and guidelines were in place to minimise risk to people.

There were sufficient numbers of staff to meet people's needs. Recruitment procedures were robust.

People told us they felt safe and care workers were familiar with safeguarding procedures.

Is the service effective?

Good

The service was effective.

Care workers received a thorough induction based on the Care Certificate.

If there were concerns around peoples' capacity to make decisions, formal capacity assessments and best interests meetings took place in line with the Mental Capacity Act 2005 (MCA).

People's dietary and healthcare needs were managed appropriately.

Is the service caring?

Good

The service was caring.

People told us that care workers were nice and were happy with the support they received.

Care workers were aware of people's preferences and the things they enjoyed.

Care plans were person centred.

Is the service responsive?

Good

We found that action had been taken to improve the responsiveness of the service.

Care plans were up to date and completed fully.

People met their key worker on a monthly basis and these meetings were documented.

The provider acted upon complaints received.

Is the service well-led?

Good

The service was well-led.

Care workers were happy with the support they received from managers.

A formal quality assurance programme was in place to monitor quality within the organisation.

Feedback received from people was acted upon and learning from incidents and accidents took place.

Brandon Trust Supported Living - Earlsfield

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.

We undertook this comprehensive inspection on 6, 10, 11, 12 and 20 April 2017. The inspection 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.

This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our inspection on 26, 27 and 28 April 2016 had been made.

The inspection was carried out by one inspector.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During the inspection we spoke with seven people who used four different services, the transformation support manager, four locality managers, six care workers, a recruitment specialist and the learning and development coordinator. We looked at eight care records, staff records, training records, complaints and audits related to the management of the service.

Good

Is the service safe?

Our findings

At our previous inspection which took place on 26, 27 and 28 April 2016, we found that care workers were not always correctly recording medicines administration. We also found that although risk assessments were in place for each person, they were not always accurately completed.

At this inspection we found that improvements had been made.

One person told us, "The staff help me with medicines." We saw that where people were assessed as not having the capacity to manage their medicines, a best interests decision had been made in consultation with staff and family members where appropriate to support them to receive their medicines safely.

Where concerns had been identified with regards to a particular service and the relatively high number of medicine errors, we saw that the locality manager had taken action to try and reduce the frequency of errors. This included having meetings with care workers to try and understand why errors were occurring. The locality manager had also allocated two care workers to administer medicines at each medicines round so that peers could pick up on errors at the time of administration. We reviewed meeting minutes which showed that the locality manager had changed the shift times so that there were always two people on duty for the medicines round in the evening. We also reviewed MAR charts which showed two care workers signing them after this change. The locality manager had also decided to change the dispensing pharmacist to one who used more easy to use blister packs. The new pharmacy had been booked to deliver training to care workers on how to administer medicines safely. Care workers told us they felt this was a positive step and told us they found the new blister packs easier to use. The locality manager had reassessed care workers' competency and carried out observations of medicines practice; we reviewed these records during the inspection.

Care workers confirmed to us they had received medicines training. We spoke with the learning and development coordinator who told us medicines training was delivered at induction and then refreshed annually. New starters completed online and face to face medicines training and were then assessed for competency by their manager. They were reassessed every year. The transformation support manager told us that the medicines policy had been sent to all the services for care workers to familiarise themselves with.

People had medicine profiles in place which included a list of medicines they were taking and their uses. There were protocols in place for medicines which were given when required within prescribed limits (PRN), these provided guidance to staff about when they should offer people PRN medicine.

People using the service told us that staff helped them to take medicines. Medicine Administration Record (MAR) charts were completed correctly in all the records we saw. A record of staff signatures were retained, allowing for care workers to be identified. Liquid medicines were dated with the day they had been opened to ensure that they were not used after expiry.

Weekly medicines audits were completed, looking at whether MAR charts had been completed fully, expiry dates recorded, stock levels counted and delivery of new medicines recorded.

Care workers were familiar with the risks to people, one care worker said, "The main risks are falling due to mobility." We checked this against care records for the person. They also told us the steps they had taken to lower the risk which included involving professionals such as an occupational therapist, procuring equipment such as a walking stick and shower chair and doing regular exercises to keep the person's joints flexible. Another care worker told us, "[Person] is at risk of getting lost so we did travel training with them." Another gave an example where a person who was not fully aware in money matters and at possible risk of financial abuse had been enrolled in a numeracy and literacy life skills workshop.

Specific risk management guidelines were also in place for people that had epilepsy, dysphagia and those with indwelling catheters. Care workers were aware of the risk and of potential indicators of things that could go wrong. They told us they had received training on how to manage these things.

Risk assessments were in place for people and the level of risk was determined according to the likelihood and the consequence. The risk level was then recalculated with the control measures were in place to mitigate risks. Individual risk assessments were in place for people in relation to a number of areas including mobility, personal care and being out in the community.

Safety checks such as gas, electrical safety, emergency lighting, fire detection alarms and fire risk assessments were carried out by the landlord of each of the services. Records were retained in each service. These were current. Environmental risk assessments such as infection control, COSHH and electrical were carried out by the provider. Individual services completed annual health and safety self-assessment tools.

Identified actions were followed up. Where issues had been identified we saw that action had been taken. For example some of the fire detection alarm inspection reports and fire risk assessments had recommendations to be acted upon and these were done. People's personal emergency evacuation plans were also updated.

Staffing levels in the services we visited were sufficient to meet the needs of people. Team leaders told us that if extra staff were needed for activities then they were provided. We reviewed rotas in some of the services we visited and saw they were as described by the staff.

Some bank staff were utilised to cover for leave and vacancies but the reliance on agency staff had reduced. All locality managers were responsible for completing weekly agency forms and any agency staff use had to be authorised by the regional director. The management team monitored the reliance on and use of agency staff across the services on a weekly basis.

Recruitment of staff was managed by a recruitment team who received and reviewed all new applications. We spoke with a recruitment specialist who told us they contacted applicants to go over their applications and explain a little about the role they had applied for. The vetted applications were then forwarded onto the relevant locality managers who reviewed the applications and then carried out interviews, checking any gaps in employment history. Interviews were done by two managers and candidates were often invited to visit the service and spend some time with people using the service to gain an understanding of the support needs of people as part of the recruitment process.

If applicants were successful they were required to complete Disclosure and Barring Service (DBS) and occupational health (OH) checks. The DBS provides information on people's background, including

convictions, in order to help providers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. People were able to work while they were waiting for the DBS to be verified as the provider carried out risk assessments to ensure people were kept safe, this included ensuring they did not work unsupervised. New employees were not allowed to lone work until 12 weeks into their employment unless they had been risk assessed.

People using the service told us they felt safe living in their homes.

A care worker said, "Safeguarding is preventing abuse when you see something is not right and whistleblowing if you see poor practice." Care workers were aware of safeguarding procedures and who they could contact if they had concerns about people's safety.

Good

Is the service effective?

Our findings

People were supported by staff who were supported to meet their needs effectively.

Care worker training was overseen by the learning and development coordinator who was responsible for analysing the training needs within the services and to deliver and implement training.

They told us they aimed for all care workers to have a good understanding and training in the role once they start. People were enrolled onto the training programme when they started employment. There were two pathways for new employees, those that had no previous experience in care and those with at least six months paid experience. The training was specific to each group.

The learning and development coordinator also said that all existing employees regardless of their length of service were mapped to the standards of the Care Certificate and if gaps were found then they were put on the relevant pathway. This helped to ensure some level of standardisation in staff experience. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health.

Mandatory training for staff included corporate induction, moving and handling, life support/first aid, safeguarding, the Mental Capacity Act 2005 (MCA), medicines and positive behaviour support.

Up to date training records were available to all locality managers with details of what training had been completed or was outstanding for all care workers. Locality managers were responsible for ensuring care workers were up to date with their training. We were shown a record of training that had been booked for the upcoming month.

We reviewed supervision records for staff and saw that supervision was carried out approximately every six weeks. Care workers wellbeing, attendance, care plans, people who use the service and staff issues were topics of discussion.

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.

Records relating to how people made decisions referenced any mental capacity assessments that were in place for the person in relation to finances, personal care, medicines and other areas.

Capacity assessments were in place if there were concerns about people's ability to understand and

consent to decisions related to their care and treatment. For example, one person was assessed as not having capacity to make decisions related to holidays. A formal best interests meeting was convened in which care workers, team leaders and family members made a decision on behalf of the person. In another example, a best interests meeting had been held when a decision needed to be made regarding an operation. Care plans and other records were also completed for people in their best interests if they were unable to complete these.

A care worker told us, "We do a best interests meeting if there are concerns about capacity like finances or major medical issues." Another said, "People have the right to refuse, but we need to explain the benefits and if they continue speak to either the GP or social worker." And "Everyone has capacity unless proved otherwise." "We offer [person] choices and show them different foods to choose."

We saw one example where some restrictions were in place for a person so that risks in relation to epilepsy could be reduced. They had understood these restrictions were in place for their own safety and had agreed to them.

People told us, "Staff make me dinner, I get a choice", "I like pasta, they make it for me", "I don't need to ask, if I'm hungry I just take something from the kitchen", "They sort my meals out but I make my own breakfast", "Staff cook food, it's nice."

We observed some people eating lunch independently in some of the services we visited. They told us it was "nice". They were supported to eat independently with the aid of specialised cutlery. Fridge, freezer and food temperatures were recorded and in some services food diaries were kept, documenting what people had eaten. Where people needed support with eating, for example those with dysphagia, there were guidelines in place for how food was to be prepared. Care workers were aware of this. Prescribed food and fluid plans were in place for other people.

Menu plans were on display in some of the services we visited. In all of the services the kitchens were well stocked with food.

One person told us, "I go to the doctor if I'm not well."

Health profiles were in place for people. These covered a range of areas including important personal information, medical history, hospital passports, records of health appointments, and monitoring records. Records included details about allergies, emergency contacts and details of health professionals involved in supporting people and records relating to how people made decisions in relation to their health. They also included information in relation to health screening and details of immunisations and health checks. Health profiles were person centred, and written in clear English.

Other information related to people's health needs was retained, including discharge summaries from hospital and records of contact with health professionals.

There was evidence of input from healthcare professionals in people's care and support. For example, we saw exercise regimes on display in people's rooms from community physiotherapy teams that staff told us they used to support people. A care worker told us "We do the exercises for flexibility and mobility."

We also saw evidence of referrals for people to be screened for dementia, breast screening and for a referral to be made to professionals such as occupational therapists (OT).

Good

Is the service caring?

Our findings

People using the service told us that care workers were caring. Comments included, "[My key worker] is nice, s/he looks after me", "I like living here", "They are kind, look after me", "I'm happy, they care for me", "I'm happy, it's good", "Staff are lovely" and "The staff are alright."

People with varying levels of independence were supported from those who were able to access the community independently, to those that needed full staff support. This was documented in their care records. People lived independent, fulfilling lives. We spoke with people at length who were supported and encouraged to take up and maintain their interests. They spoke passionately about their interests and how staff supported them. One person who was interested in art was able to pursue his passion at an art studio. They showed us some of their paintings and was excited to tell us about an upcoming exhibition in which their artwork was to be displayed. Another person with an interest in trains was able to pursue this. They told us, "I usually go trainspotting every other day."

Staff supported people's independence and encouraged them to take part in daily living tasks. Comments from people included, "Sometimes they (staff) help me with laundry but I can manage it", "I try and do most things myself", "I lay the table, sometimes I peel potatoes", "I get help with medicines but I can dress and wash myself", "I like the independence", "I get travel buddies who help me go places I'm not sure about" and "I go to the pub on my own or sometimes with staff."

People were supported to maintain relationships. We saw some family members visiting people using the service on one day of the inspection and taking them out for the day. One person's partner came to stay with them regularly at the service and another person visited their partner. A care worker told us, "I take her to see her [family member]." People told us, "I'm friends with everyone here", "I go out and see my friends", "I speak to my [relative] on the phone", "I've got a [relative], I keep in touch with" and "I go see [my relative] every weekend." Care plans were in place for relationships and sexuality and where these were relevant to people, ways in which staff could support people to maintain relationships were included.

Care records were written in a person-centred manner and included information about people's lives, relevant history and things that were important to them such as important dates, people and activities. A section in the care plans called 'How I like to be supported' included what people's preferred names were, how they communicated, what positive interaction looked like and activities they enjoyed.

Care records included a person centred plan consisting of a one page profile detailing how people made decisions, how they liked to be supported, any risks and how they were involved in developing their plan. We asked care workers to tell us about some of the people they supported and they were confident in how they spoke about them, indicating they knew them and were able to support them effectively. The records reflected what care workers had told us.

Good

Is the service responsive?

Our findings

At our previous inspection which took place on 26, 27 and 28 April 2016, we found that although care records were comprehensive in scope, they were not always complete. Some support plans were non-existent or not up to date.

At this inspection we found that improvements had been made.

Comprehensive care plans were now in place for people. These were called 'plan for life.' The transformation support manager told us this had been a comprehensive piece of work and they had received a lot of support from the quality manager and compliance coordinators to help the services complete up to date care plans for people.

Plan for life documents were split into six sections that covered the assessment of people's needs, any risks, their care and support plans and any other relevant information.

There were 16 care plans in place for each person covering a number of areas including personal care, social networks, education and emotional health and wellbeing. They included information for staff on how they could support people in those areas, for example the communication support plan had information about how people communicated, if there was any specialist input required and how people expressed if they were not happy. They also included the tone of voice and type of speech to be used by staff. The eating and drinking support plan referenced people's level of independence and any specialist equipment or support needed. Care workers had signed and dated people's care plans indicating they had read and understood each one.

There were behaviour support plans in place for some people who had behaviour that challenged, these included guidelines for care workers when supporting people at home and in the community and techniques that care workers could use to support people.

The provider also utilised an 'enabling support plan' for people who were more independent and needed support with daily living skills.

Care records also included things that people wanted to achieve such as go on holiday, maintaining family relationships and attend day centres. Each outcome was broken down into steps to help people to achieve these goals. Reviews took place once a year as a minimum to ensure that people's care plans reflected their current needs.

Each person was assigned a keyworker. A keyworker told us "I'm responsible for his wellbeing, the day to day activities, booking appointments. We also meet every month."

Key workers completed 'my life in a month' which were monthly reviews that took place with people using the service. People were asked how they were feeling, if there were any housing or tenancy issues, asked

about their health, things that had gone well and not so well. We saw these were done regularly and action was taken when people raised issues or wanted support in a particular area.

They also completed yearly reviews which they told us were shared with social workers. These contained details about people's personal care needs, daily living, health, finances and communication.

People lived independent lives and were supported to take part in daily activities. In one service we visited, where there were four people living, three people were out either with their support worker or at college. Some people went to day centres and we saw good communication between day centre staff and the staff at the service. Some services had holiday pictures and other activities that people took part in such as parties. An allotment was available for people to utilise and once a month people were able to volunteer to help out. People told us, "I go to the garden and to the shops", "I go to the market on Monday, on Friday I go see [my relatives]" and "I do ceramics and needlework, I like it."

People who used the service held meetings in some of the services where they discussed their home environment, activities, menus and complaints. One person said, "We have meetings, they ask about holidays, how we are doing."

People told us they knew how to complain. One person said, "I would speak with [the team leader] or [key worker], they will listen." Easy read complaints information posters were on display in the services we visited.

We reviewed the complaints log for the service which included the date the complaint was raised, details of the complaint, details of the complainant, the investigation manager, and the dates that other parties such as the police, social service were informed. It also included the action taken, the date resolved and the outcome.

We saw evidence that investigations did take place, meetings were held and fact finding investigations took place in response to complaints if required. Where complaints were of a safeguarding nature, appropriate action was taken.

There were 22 recorded complaints during 2016, we saw a couple of examples where the outcome had not been documented. We went over these with the transformation support manager and saw they had been resolved.

Good

Is the service well-led?

Our findings

Care workers told us they liked their jobs and were supported by their colleagues and managers. A care worker told us "[The locality manager] is very encouraging, [she/he] visits us around once a week."

Team meetings took place within each service. Staff discussed issues relating to training, safeguarding, supporting people, health and safety and any feedback from managers or external professionals. Staff within a service were given an area of responsibility such as medicines or health and safety. Each service had a team leader and was managed by a locality manager who was responsible for a number of services.

There had been some changes to the management team since the previous inspection. The locality managers had also changed some of their services.

The provider had a good overview of each service as there was an effective system in place to monitor incidents. Incidents/accidents were recorded within each service and then reviewed by managers. Notifications to the CQC were completed as required. The transformation support manager was responsible for reviewing these. The provider notified the relevant parties when safeguarding allegations had been made and ensured these were investigated appropriately.

Making improvements and driving up quality were important aspects that the management team focussed on.

A new regional compliance coordinator had started in March 2017 to provide assurance that the quality policy was being consistently applied in all the services.

The transformation support manager told us they were conducting weekly catch-up meetings with the quality manager and the locality managers to do a quality assurance check covering a range of issues such as human resources related queries, complaints, safeguarding, health and safety, notifications and the quality assurance programme. She told us, "This helps us keep on top of everything."

A monthly health and safety report that was reviewed by the board was used to identify any trends or themes. This included any incidents of behaviour that challenged, medicines and slips and trips.
There was a performance log in place which consisted of weekly monitoring of long term sickness, vacancies within services, safeguarding, investigations, disciplinary, development plans, complaints and health and safety.

There was a quality assurance programme in place. A rolling annual programme had been started by the health and safety manager and every month two risk assessments were reviewed for each service. Services completed audits every two months checking each service against one of the standard CQC questions. The service being inspected produced evidence relating to how they were meeting the key lines of enquiry and a manager from another service would review the evidence to see if it was in place and correct.

There was a member's board with approximately 10 people using the service sitting on it. The board made decisions about events, guest speakers, managing budgets and allocating money. We reviewed minutes from a member's board meeting and saw they discussed upcoming events and fundraising. We also saw pictures from the last event that had been held at the local town hall.

There was evidence that the provider acted on feedback from people using the service and other stakeholders.

People and their relatives completed annual surveys to feedback anonymously about their views of the service. The main findings from this was that people did not always feel informed about news across the organisation. In response to this, the provider had developed 'video news for you'. This was available on DVD and distributed to each service. Videos were also available on YouTube.

We reviewed the 'driving up quality 2016' report in which the desired outcomes for the London team were to have a more meaningful involvement in the recruitment of staff, meaningful activities and connectivity, to receive support that focussed on a good quality of life, for individual cultural needs to be reviewed and people across services to be better connected. These outcomes were reviewed in February 2017 which helped to ensure they were being acted upon.