The Royal National Institute for Deaf People

RNID Action on Hearing Loss Brondesbury Road

Inspection report

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Date of inspection visit:
14 January 2016
15 January 2016

Date of publication:
19 February 2016

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 unannounced inspection took place on 14 & 15 January 2016. The service met all of the regulations we inspected against at our last inspection in October 2013.

RNID Action for Hearing Loss Brondesbury Road (RNID AfHL Brondesbury Road) is a service for six people who are hearing impaired, some people have additional sensory impairments and may also display behaviours which challenges the service. The service is spacious and provides accommodation on the first and second floor. RNID Action for Hearing Loss Brondesbury Road is located closely to Queens Park and Kilburn High Street; both areas provide good transport links and shopping facilities.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

There was a strong emphasis on continually striving to improve by finding innovative and creative ways to empower people and seek their view. In addition, a wide range of different quality assurance systems were used to ensure the quality of service was continuously monitored and also to make sure that improvements were implemented.

The service developed and created an inclusive communication environment for people who used the service, staff and visitors.

We found that RNID AfHL Brondesbury Road provided a highly personalised, person-centred service for people with hearing impairments and people who have additional loss of their vision. People were in control of their support and participated in decision-making for the service and organisation as a whole. People were encouraged and enabled to learn new skills and become more independent. People were provided with support that was outcome-focussed and there were systems to document this.

People consented to their support and staff and the registered manager of the service worked in partnerships with people and their relatives to support people in taking positive risks and make independent well informed decisions. Feedback about the service was encouraged and there were a range of mechanisms to support this.

Staff were aware of the requirements of their role and were vetted appropriately before starting work. Staff supported people safely and knew what to do to protect people from the risk of abuse.

Recruitment procedures ensured staff had the appropriate values when they were employed. We saw that staff gained skills and qualifications shortly after they started work. Ongoing training was provided and staff were encouraged to pass on their expertise to their colleagues in various aspects of service delivery through

workshops and team meetings.

People received their medicines in a safe manner and staff recorded and completed Medicine Administration Record (MAR) charts correctly.

People had access to healthcare services and received on-going healthcare support. Referrals were made to other professionals if the need arose. People met with their GP, psychiatrist, audiologist, optometrist and their behaviour was regularly reviewed with the involvement of the person's psychiatrist.

Risk assessments and care plans for people using the service were effective, individual and there was a strong focus on how to meet people's communication needs as well as any other needs. People were encouraged and supported in gaining greater independence by working together with social workers, British Sign Language (BSL) interpreters and relatives to achieve the best possible outcome.

People had the opportunity to comment on the service at regular meetings and were clear how and whom they would raise concerns with.

Quality assurance systems were in place to assess and monitor the service people received. The service worked well in partnership with other organisations such as SENSE; the UK deaf-blind charity, to ensure current practice was followed and a high quality service was provided to people.

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. Risks associated with people's support were assessed and managed with guidelines for staff.

There were sufficient staff deployed to meet people's needs safely and in a timely manner. Recruitment procedures ensured staff were suitable to work with people in need of support.

Medicines were managed safely and people were encouraged to take their own medicines whenever possible.

Is the service effective?

Good

The service was effective. Staff had the knowledge and skills necessary to support hearing impaired properly.

Staff understood the principles of the Mental Capacity Act 2005 and told us they would always presume a person could make their own decisions about their care and treatment.

Staff supported people to maintain good health and eat a balanced, healthy and nutritious diet. People received appropriate assistance to eat when needed.

People had good access to healthcare professionals such as doctors, dentists, chiropodists and opticians.

Is the service caring?

Good

The service was caring staff had a clear understanding of peoples individual communication skills and abilities and went often 'the extra mile' to look for alternative or additional forms of communication.

We observed staff treating people with respect and as individuals with different needs and preferences. Staff understood that people's diversity was important and something that needed to be upheld and valued.

Staff demonstrated a good understanding of people's likes and dislikes and their life history.

Is the service responsive?

Good

The service was responsive and people told us that the registered manager and staff listened to them and acted on their suggestions and wishes. They told us they were happy to raise any concerns they had with the staff and management of the home.

We saw that people were engaged in in-house and community based activities throughout the day of the inspection. We saw that these activities had a positive effect on people's well-being.

Is the service well-led?

Good

The service was well-led. The registered manager was well respected by staff. Staff told us they felt empowered and valued.

Great emphasis was placed on promoting staff who showed excellence.

Quality assurance audits were thorough and the service continuously looked at ways of improving the service based on feedback, audits or incidents.

RNID Action on Hearing Loss Brondesbury Road

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 14 & 15 January 2016 and was unannounced. The inspection was conducted by one inspector. However, on the first day the inspector was accompanied by a BSL interpreter.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service including people's feedback and notifications of events affecting the service.

We spoke with two people who used the service and two support workers with the help of a BSL interpreter. We also spoke with the registered manager and observed support workers interacting and supporting people who used the service.

We looked at three people's personal care and support records, personnel records for three staff and records relating to the management of the service such as staff training and supervision records, meeting minutes, records of checks and audits, action plans and safeguarding records.

Good

Is the service safe?

Our findings

People told us with the help of a BSL interpreter that the service provided was very good. One person told us, "The staff is very good and kind. They know what they are doing and always make sure that I am safe." Another person told us "Staff are always available and whenever I need them they are there to help me." Support workers also told us that people were safe and that there were systems in place to ensure people were protected. One of the hearing impaired support workers told us with the help of a BSL interpreter, "We have risk assessments. In the kitchen we make sure all the knives are put away and make sure the cooker is safe. We make sure the temperature of the food is okay for clients. If I were to see a hazard for clients I would report it immediately to the manager."

Staff confirmed that they had been trained in procedures to safeguard adults and knew the procedure to follow if they had concerns about a person. Support workers told us that they would immediately raise any safeguarding concerns with the registered manager and were confident that she would deal with them appropriately. The provider had a safeguarding and whistle blowing procedure which provided guidance to staff on their responsibilities to ensure that people were protected from abuse. Support workers knew about these policies and gave us practice examples of when they would use the guidance in these policies. For example, one support worker told us, "I would immediately contact the manager or one of the senior support workers if I notice anything unusual with one of the residents." Another support worker told us "I can call the police or the CQC if I think that nothing would be done."

One of the people displayed behaviours that challenged the service. A behaviour intervention care plan had been developed specifically to support this person pro-actively. The behaviour intervention plans provided information and guidance to staff which ensured that they managed and responded to behaviour that challenges consistently. The behaviour intervention plans were reviewed regularly and if behaviour deteriorated or changed, referrals were made to relevant specialists to ensure a more pro-active approach could be found. For example, the home was currently working closely with SENSE to support the staff team and develop with them additional communication strategies to reduce behaviours that challenged the service.

Staff told us that they had received MAPA training. MAPA is training for the Management of Actual or Potential Aggression. Staff told us that this training had helped them to recognise what could be the cause for people's behaviour to become challenging. This also taught them safe techniques to manage these behaviours.

People's personal care and support records showed that risks associated with people's support were assessed with guidelines in place for staff to reduce those risks. Each person's records contained a number of individual risk assessments including managing money, preparing meals, personal care, accessing the community and one off risk assessments such as people going on their annual summer holiday. There were also environmental risk assessments available which provided information for people who used the service and staff on safety in the home such as the location of gas stopcocks and emergency evacuation procedures. We saw these were up-to-date and reviewed regularly. Staff had been trained in health and

safety and other topics relevant to the support people received such as food hygiene and moving and handling.

Staff and people who used the service told us that there were sufficient care workers deployed to meet people's needs. One support worker told us, "Staffing levels are pretty good. We have three to four staff on shift in the morning and three staff on shift in the afternoon when things are a little quieter. We have enough staff to spend quality time with residents." The registered manager told us, "We are quite well resourced for the range of people we have here. However, we always have to demonstrate that the funding is needed to provide activities and a good quality of life for people" During both days of our inspection we saw that there were sufficient staff deployed to ensure people's needs were met. We saw that people went with staff for shopping, to the bank or see the doctor. All staff working at the home were trained to the minimum Level 1 in BSL and around 50% of support workers were deaf themselves.

The provider followed safe recruitment practices and ensured staff were appropriately vetted before working with people. The staff files we looked at included criminal record checks. We were not able to see if staff had two written references which were verified by the provider, interview records and an application form detailing the staff member's employment history. We were told that this information was held at the providers head office, which had been agreed with the CQC corporate provider's team.

The provider had a robust medicines administration procedure. Support workers told us, and records confirmed that they had received training for the administration of medicines. We observed that two staff administered medicines together, one to witness that the medicines had been given and the other to administer the medicines. After medicines had been successfully administered to one person both members of staff signed the Medicines Administration Record Sheet (MARS). We observed that the MARS and stock levels had been counted during each handover. We witnessed the daily medicine reconciliation and saw that MARS tallied with the stock levels. This ensured that any mistakes could be resolved as soon as possible. None of the people living at the service were able to self-medicate.

Where people had been prescribed medicines to be taken as needed (known as PRN medicines), staff had 'PRN protocol' guidelines for each medicine detailing the circumstances in which it was to be administered and how. These were correctly included and completed in each person's MAR sheets.

Good

Is the service effective?

Our findings

People spoke highly of the support provided from staff. One person told us "All the care staff know what they are doing and I find it easy to talk to them." and "I meet with my key worker often and we talk about planning holidays or how I feel, he is very good."

Training records showed that staff had received induction training prior to commencing work. The registered manager told us that all staff appointed since April 2014 who did not have experience in care, commenced the Care Certificate as part of their induction. Staff told us that the formal induction lasted about two weeks; this included learning about policies and procedures, systems and day to day responsibilities as well as shadowing opportunities and mandatory training. Informally one support worker told us that the induction was much longer and lasted for about three months and provided a wider range of training as well as more in-depth learning about people's likes, needs, wishes and dislikes.

Staff also attended mandatory training and training on other relevant topics including BSL various levels, learning disability, mental health, mental capacity, and end of life, epilepsy, and diabetes. Staff were very positive about the standard of training provided by the provider and confirmed that they received annual refresher training. They displayed a good understanding of how to support people in line with best practice particularly in promoting independence. Staff told us that they "feel supported" and confirmed that they had "regular, planned supervisions". Staff also told us that they were able to discuss with the registered manager if they required additional training to meet people's needs. For example, one support worker told us, "I have applied for a more in-depth sign and touch training with SENSE; this should help me to meet the needs of the two deafblind people living here better."

Staff team meetings were held on a monthly basis, covering a range of topics relevant to the service, to ensure that staff worked consistently with people. Staff members received individual bi-monthly supervision sessions with their line manager and regular annual performance reviews. Staff told us that prior to the appraisal meeting all staff were issued with a pre-appraisal self-reflection form. One staff member said, "This allows me to comment on my performance and discuss it with the manager during my appraisal." The service put extra focus on supporting staff to learn BSL, which was part of the induction. We observed that all staff working at the service were able to communicate with people using BSL. Some staff were also trained in using sign and touch to communicate with deafblind people.

People were in control of their support and make their own decisions where possible. For example, we saw people making their own breakfast or helped staff to prepare lunch and dinner. We observed staff asking people for permission when they provided care and support. For example, we observed staff discussing with one person if they needed help with washing their clothes. The home created an environment for inclusive communication. Inclusive communication means sharing information in a way that everybody can understand. For service providers, it means making sure that you recognise that people understand and express themselves in different ways. We saw that a wide range of policies were in pictorial format, staff rotas were pictures of staff, the TV had subtitles and menus were pictorial. All this was put into place with the view of enabling people to express their needs more easily, and also helped staff and visitors who lacked

the skill of BSL to communicate with people. For example at one point a person who used the service explained to us with the use of a rota what household chores he was doing each day.

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 had been trained in the requirements of the MCA 2005 and understood what that meant for the people they supported. People living at the service had the capacity to make their own decisions.

The registered manager told us that none of the people were subject to any Deprivation of Liberty Safeguards (DoLS). The DoLS are there to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and correct way.

The registered manager was aware of recent changes to case law relating to depriving people of their liberty for their own safety and had identified some people for whom this would be explored further.

Staff supported people to shop and prepare meals of their choice. The menu was discussed regularly during residents meetings, which were held monthly. The pictorial menu was displayed on a notice board in the kitchen. People's dietary needs had been recorded in their care plan as well as information if they required assistance to eat. We observed breakfast and lunch time and saw that people were provided with the support they required and were able to choose what they wanted to eat. We saw in the menu that people were able to order take away meals and culturally appropriate meals such as Indian or Caribbean meals.

Staff supported people to maintain good health and access health services when required and when this was part of their support. Records documented appointments people had with health professionals and outcomes and actions for staff. We saw that staff sought support from health professionals quickly when they were concerned about a person's health. People said they had good access to other healthcare professionals such as dentists, chiropodists and opticians. People were able to choose their own health care professional.

Good

Is the service caring?

Our findings

People who used the service told us, "The staff are very good; they do care and are very helpful if I need them." " Another person told us, "I like living here and the staff is good, they do help me when I need them." Care staff told us, "People are given the same dignity and respect I expect for me"; "If I provide personal care the door must be shut. I treat clients as an individual, giving choice and provide ways of working that reflects that" and "I always knock on the door and don't go in unless I am granted entry. I call clients by their name and treat them as adults".

Staff knew people well and built positive, caring relationships with the people they supported. Each person's care and support records included their background and history as well as information relating to their current support needs. We also viewed one page profiles, which provided information on people likes, needs, wishes and aspirations. Staff told us these records helped them to get to know the person. However, they said that this was not a replacement for getting to know the person individually. One support worker told us, "You have to tailor the support to the person – each person has different needs and their own life and history and what makes them who they are. They get to know you too." The same support worker also told us that staff and volunteers were matched to people with common interests to facilitate a positive working relationship. For example "[Persons name] has a volunteer who goes swimming with him and another person has a volunteer to do gardening in the summer. We match volunteers to people's needs and people are consulted if they like their volunteer."

We observed staff respecting people's privacy and dignity when supporting them. We saw that staff closed the door when people used the bathroom and staff discussed personal issues with people in private.

We found that people directed their own support which was delivered according to their preferences. For example during lunchtime we observed one person being able to choose the member of staff to provide support. We observed people were in control of their support, for example we saw staff asking one person to go to the bank, but the person decided to wait a little as he had something else he wanted to do. We observed staff respecting the person's decision and giving the person additional time to get ready in their own time.

Staff told us they enjoyed supporting people and we observed staff treating people with respect and as individuals with different needs and preferences. Staff understood that people's diversity was important and something that needed to be upheld and valued. They gave us examples of how they respected people's diverse needs. For example, by making sure people's cultural and religious preferences were still maintained when they moved into the home. Due to around 50% of staff having hearing loss themselves, we saw that there was very good understanding of the obstacles people who used the service could experience and we saw that discussions had taken place during key worker meeting of how to overcome some of these barriers.

Staff demonstrated that they knew what providing a caring environment meant. One support worker told us, "You need to understand the people you are caring for. You need to discuss with them what they want

because it is their home. We come and go, but this is their home. If people are not happy we will know. If they are happy it is a good environment." Another support worker told us, "Clients need to be involved and their needs must be met".

Staff were able to give us examples of how they maintained people's dignity and privacy not just in relation to personal care but also in relation to sharing personal information. Staff understood that personal information about people should not be shared with others and that maintaining people's privacy when giving personal care was vital in protecting people's dignity.

Good

Is the service responsive?

Our findings

People who used the service told us that they knew about their care plans and met their key worker regularly. One person told us "My key worker arranges to meet me once a month, but can see him more often if needs be." Another person talked to us about his activities, "I like to go shopping and will go out later to purchase some items." People also talked to us about making a complaint. One person told us, "If anything is wrong I would talk to my key worker or to the manager; they will help me to sort it out."

We looked at people's care plans which were comprehensive and based on information obtained during the assessment on admission or during the stay in the home. Care plans and staff were realistic about the group of people they were working with and the potential limitations of their intervention. People's care plans recorded the best possible approach for working with individuals to support them appropriately and safely. Care plans were reviewed every six month and people who used the service, outside professionals and staff were involved in the review process. We noted that care plans were available in formats suitable to people's needs and level of understanding and had been signed by people to demonstrate that they had been involved in the care planning process.

Care plans were sufficiently detailed and personalised to provide guidance to staff about how to meet people's assessed needs. For example, one person's care plan identified the person could become verbally and physically aggressive and provided information about how to respond to the person consistently when displaying this behaviour.

People told us that they accessed various activities in-house or community based. People went regularly to the gym, local daycentres, swimming, pub, cinema or stay at home to watch TV, DVDs or videos. All people undertook different household chores during the week, such as laundering their clothes, cleaning their room or helping with cooking. One of the people explained to us using the pictorial timetable in the kitchen what chores he was doing each day and we observed staff encouraging people during both days of our inspection to take part in household chores.

The registered manager and staff told us that since last year the provider changed the way annual holidays were facilitated. Previously people went on group holidays, but since last year people had more choice in where and with whom they wanted to go on their holiday. One person told us that he enjoyed his holiday last year to the Canary Islands and another person told us that he was planning to go to America this year.

One formal written complaint had been received in the past 12 months. We saw that this complaint had been well documented and records showed that actions had been taken to resolve the complaint to the satisfaction of the complainant. People who used the service told us they felt confident in raising concerns with the registered manager and told us she would deal with any concerns and complaints made. The complaints procedure was available on the notice board and accessible to people who used the service and staff. Staff spoken with told us they took complaints seriously and would always raise them with the manager. However, staff told us that formal complaints were rare. The majority of times people had small disagreements which were easily resolved informally, by staff mediating and supporting people to find

solutions for their disagreements.

Good

Is the service well-led?

Our findings

Staff told us they thought the service had an open and inclusive atmosphere and they found the manager to be approachable and supportive. One member of staff said, "[The manager] is fantastic. I don't have a problem with going to her about anything. She is very supportive." Another member of staff told us, "When I came here the manager explained everything and said to go to her if any problems" and "The staff are very helpful, we work well as a team."

One of the very good features were that the service continually strived to improve the quality of care provided to people. The registered manager and staff recognised and promoted regular quality assurance monitoring systems, which allowed the service to reflect on the provision of service and how to improve this. The registered manager told us the service had various mechanisms for gaining the views of staff. These included one to one meetings with staff, monthly staff meetings, and daily hand over meetings, informal discussions between management and staff, and annual surveys on staff and people using the service. This included an annual survey to gain the views of people that used the service and staff. We saw the results of a survey that was completed in 2014. The feedback received was very positive an action plan was formulated following the survey to work on shortfalls. The action plan was regularly reviewed by the line manager of the registered manager during supervisions and any further action and completion of actions were documented. For example during the previous staff survey staff asked to have greater input in drafting policies and procedures and we viewed an e-mail sent by the CEO, that this will be implemented in 2016. The registered manager told us that the survey for 2015 had been completed, but the head office was currently in the process of analysing the results.

Regular and robust monitoring and audit systems were in place, which ensured that shortfalls were dealt with and the quality of care was improved. The system in place included regular fire checks, individual fire risk assessments for all people who used the service, regular health and safety checks, which were carried out weekly, monthly or quarterly. First Aid boxes and panic alarms were checked weekly, annual Health and Safety audits and building audits carried out by the landlord annually. The service had implemented a national framework for quality management which is ISO 9001, this meant that quality assurance assessment information was monitored regularly and any shortfalls were responded too. This led to further improvements to the service and the quality of life for people who used the service.

The service had an experienced registered manager and a clear management structure in place. This included a deputy manager, senior care workers, residential support workers and volunteers. Staff we spoke with were clear about their lines of accountability and who they should report to in the first instance.

Staff said they felt listened to by senior staff and senior staff acted upon their concerns. One staff member told us they had problems which they discussed with the registered manager who was empathic and supported the staff member to resolve the problems. The member of staff told us "I can't thank the manager enough, she was so helpful." This demonstrated that the views of staff were welcomed and acted upon if appropriate. The registered manager told us that she felt well supported by her line manager who was approachable and available for advice if required.

Staff told us that the service had regular staff meetings where staff were able to raise issues of importance to them. Staff also told us that the manager initiated discussions during staff meetings about important subjects, including cleanliness in the service and safeguarding adults. We saw minutes of a staff meeting from December 2015 where discussions lead by care workers were clearly recorded.

We saw that the service had close partnerships with key organisations and health care professionals such as the GP from the local surgery that had been involved in the health care of people using the service. We also saw close links with local mental health support groups, cultural groups, SENSE and the wider local community.

Staff completed incident forms following each episode of behaviour which challenged the service. The record addressed what had happened before, during and after the incident. This information was used to work with people more pro-actively, but also supported staff and the registered manager during debriefing sessions to look at better ways of working with people. This meant the service ensured that learning from incidences was paramount to improving people's lives.

The service had identified areas and priorities for improvements over the next 12 months in the PIR submitted prior to our inspection. These included review of the positive behaviour policy, finding better ways of engaging people and gathering their views, recruit more volunteers, have people who used the service lead residents meetings and appoint a member of staff as a person centred champion for the home. We saw that some of the planned improvements had already been implemented; these included the person centre champion and the recruitment of more volunteers. This showed the service was able to identify shortfalls and work to make improvements.