Octavia Housing

Octavia Housing - Miranda House

Inspection report

Miranda House
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14 July 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 13 and 14 July 2017 and was unannounced on the first day. At our last inspection in June 2015 we rated this service "good". At this inspection we found the service remained "good."

Miranda House provides an extra care service for up to 20 older people who live in self-contained flats over three floors within the building with a single secure entrance. Each flat contains a lounge, bedroom, kitchen and walk-in shower. There are also shared bathrooms on each floor, and the ground floor contains a staff office and a shared lounge with a kitchen. There is a small courtyard outside. At the time of our inspection there were 16 people living in the service and four flats were vacant.

The service had a registered manager. 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.

At our previous inspection we made a recommendation about how the provider developed policies and procedures around mental capacity. At this inspection we found the provider had acted on our recommendation to improve policies and training relating to mental capacity, but had highlighted the need to provide better evidence that people had consented to their care and support when they were unable to write. We have made a recommendation about this. Staff continued to receive suitable training and supervision to carry out their roles.

The provider had measures in place to monitor people's views of the service and had acted on these. For example implementing a more detailed programme of activities included a weekly Sunday roast. People spoke of being treated well by care workers and commented positively on the cleanliness of the building.

People's care was planned and delivered in a way that met their needs, and people received additional support as required. We saw that people received support to maintain good health and people's weights were monitored, with action taken to address weight loss. People's plans contained extensive information about peoples' life histories and preferences, and regular reviews and keyworking sessions were used to ensure that people's needs were still met.

The provider had systems in place to address and manage risks to people, in areas such as mobility and social isolation. The building was kept secure, and staffing levels were suitable to meet people's needs. People were able to call for assistance from staff who were available 24 hours a day.

People received support where required to receive their medicines safely, and the provider had systems in place to detect possible errors or issues with medicines. The provider had suitable safeguarding measures in place to protect people from abuse and to investigate where allegations had taken place.

Managers carried out checks to ensure that standards of care remained good, and were working with local organisations to improve the service people received.

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 was effective.

The provider had reviewed their mental capacity policy and provided staff training in this area but the provider recognised that they needed to take further steps to ensure that they were able to document people's consent to their care when they were unable to physically sign documents.

Care workers received supervision and training to enable them to carry out their roles effectively.

The provider had measures in place to monitor people's weight and provide access to dietician services and health services.

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 remains good.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 13 and 14 July 2017 and was unannounced on the first day. On the second day the provider knew that we would be returning.

Prior to carrying out this inspection we reviewed information we held about the service, including the previous inspection report and notifications of significant events that the provider is required to tell us about. We also contacted a contract monitoring officer from the local authority, but did not receive a response. We asked the provider to complete a Provider Information Return (PIR). This is a document where the provider tells us what the service is doing well and how they seek to improve the service.

The inspection was carried out by a single inspector. We spoke with three people who used the service. We reviewed records of care and support relating to six people who used the service, records of medicines administration and audit for five people. We reviewed records of finance checks for three people, staff rotas, records of staff training and records relating to incidents and accidents, safeguarding and health and safety checks. We looked at records of supervision and recruitment for five staff members. During the inspection we spoke with the scheme manager, who was the registered manager, the scheme co-ordinator, three support workers and a member of the domestic team. After the inspection we made calls to four relatives of people who used the service.

Good

Is the service safe?

Our findings

At this inspection, we found that the service remained safe. People who used the service and their relatives told us they felt the service was a safe place to live. Comments from people included "Yes I am safe here" and "I've had no trouble here."

The provider maintained suitable safeguarding measures. Staff had received training in safeguarding adults, were able to describe possible signs that a person may have been abused and were clear about their responsibilities to report this. Comments from care workers included "If I see something that's not right, I'll tell the senior and the manager" and "Yes it will be taken seriously, [the manager] is very spot on, very professional." Where abuse was suspected, the provider had met its responsibilities to inform the local authority and CQC, and had carried out an investigation.

There were measures in place to ensure the building was safe. There were pull cords in people's flats and communal areas, which people could use to communicate with staff if they required help. Staff carried a portable handset so that they could hear alarms, and people told us staff responded quickly to these. Additionally, where one person was at risk of falling, care workers used sensors to alert them when the person had got out of their bed or chair. There were also systems of health and safety checks, which included nightly checks of the building and monthly audits which verified that staff health and safety training was up to date and that communal areas and corridors were safe and kept clear. There were also temperature checks of fridge freezers in communal areas, and up to date checks of portable electrical appliances, emergency lights, gas systems and fire alarms and extinguishers. Checks were carried out yearly on hoists, although these were not currently in use. The front door of the building was kept secure and the entrance was overlooked by the staff office. Visitors to the building were asked to sign in and out. Communal areas of the building had been provided with non-slip flooring on floors where people had requested this. People using the service and their relatives observed that the building was kept clean.

There were clear fire safety instructions for people who used the building, which was to remain in their flats and await evacuation in the event of fire. Each person had a personal evacuation plan, which included information on the support and equipment people needed to evacuate. Staff received a fire safety induction before they started work.

The provider maintained risk assessments where risks had been identified to individuals, which were reviewed every six months. These contained details of the severity of the risk and brief personalised plans to manage the risks. For example where a person was at risk of anxiety, particularly when their schedule was disrupted, there was a plan in place for how staff could most effectively communicate with the person and inform them in advance of any changes to their schedule. Where people were at risk of falling, there were plans in place, including encouraging people to use equipment and to keep passages clear of hazards, which we observed was taking place. The provider recorded when incidents and accidents such as falls had occurred, and recorded what steps had been taken in response such as seeking medical help and reviewing risk assessments. Therefore the provider was taking appropriate steps to protect people from avoidable harm.

People using the service and their relatives told us there were enough staff around to meet their needs safely. Comments included "There's always staff around" and "There's plenty of staff, definitely." The provider told us they maintained three care workers in the morning and evening, and two waking night members of staff, but due to reduced occupancy this may reduce to two staff in the afternoon if cover was not available. We reviewed three weeks of rotas and staff signing in sheets and verified that this staffing level was maintained. A relative told us "It's been the same staff most of the year, which is good."

Prior to starting work, the provider had obtained photographic identification, evidence of the right to work in the UK, a complete work history and two references from previous employers where appropriate. We saw that the provider had carried out checks with the Disclosure and Barring Service (DBS) on all staff. The DBS provides information on people's backgrounds, including convictions, in order to help providers make safer recruitment decisions. The provider told us that all staff were now subscribed to the update service, which meant that the provider would be informed of any changes to care worker's suitability for their roles.

We saw that medicines were safely managed by staff. All staff had received up to date training on managing medicines. The provider had carried out a medicines assessment for people who used the service, which included determining which medicines people took and why, whether they had any difficulties managing their medicines and the level of assistance required. For the majority of care plans we looked at, people had been assessed as requiring prompting with medicines, however the registered manager told us that in many cases staff took medicines out of the packaging and gave this to people, which would be considered as administering these medicines.

We reviewed medicines administration record charts (MAR charts) for five people, we saw that care workers checked medicines had been correctly delivered and completed these charts correctly. When discrepancies had occurred, these had been noted promptly and followed up by managers. Where medicines were taken as required (PRN), there was a clear protocol for when these were to be administered, and care workers recorded the reasons why these were given. Additionally, where people were supported with topical creams, the provider completed a chart to illustrate how and where this should be applied on the person's body. A senior staff member also carried out a weekly audit of medicines, which included checking recording, storage and stocks of medicines. Where issues were identified, such as medicines storage cupboards requiring cleaning, there were clear actions for staff to follow which had been carried out. Where an individual had regularly refused medicines, the provider had addressed this with the person's GP and sought advice.

Good

Is the service effective?

Our findings

At our previous inspection we made a recommendation that the provider develop its policies and procedures in line with the Mental Capacity Act (2005) (MCA). The Act 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. We found that the provider had a policy in place to support staff to act in line with the MCA if a person lacked the capacity to make a decision for themselves. Staff told us that they had received training in mental capacity, and there was information about the principles of the MCA displayed in staff areas. In the June 2017 staff meeting the registered manager discussed that when people were unable to sign documents due to deterioration in their cognition, frailty or memory staff should ensure that they had read the contents to the person and then state on the form what they had done to inform the person of the contents and the reason they could not sign.

The provider told us that at the time of the inspection there was nobody using the service who lacked the capacity to make decisions relating to their care, which was reflected in people's care plans. However, we observed that in some cases the provider had not obtained suitable consent from people to their care plans. For example, two people's plans stated that they were unable to sign due to their disabilities; the provider had documented conversations with the people to demonstrate their engagement in care planning but had not documented their consent to their most recent plans.

We recommend the provider take advice from a reputable source on how best to demonstrate that they are meeting the requirements of the Mental Capacity Act 2005.

Care workers were complimentary about the training they received. Comments included "We're always going on training. They've come up with new training [concerning meeting the needs of people living with dementia] it puts me in their position, I found it very useful", "We've all got access to a training system, the admin are very good and if it's due it's on the board" and "They're very useful, you get to know new things that have come up." One care worker told us "They came up with a new training course; it's about looking after yourself so you can look after others. You realise you need to be well in yourself, it opened my eyes."

Training records showed that staff received annual training in medicines and moving and handling, two-yearly training in fire safety and three-yearly training in first aid, food hygiene, health and safety and conflict management.

The provider had recently recruited two new staff members, who were undertaking the Care Certificate as part of their inductions. 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. We observed a training session being carried out with the new staff; the trainer reviewed key principles in the care and support of people living with dementia, and this in a way which encouraged staff to put themselves in the position of the person they were caring for and to think of the

ways in which diet, stimulation and hydration can affect people's wellbeing. Staff received a probation review after six months in post to assess their suitability.

Staff received a quarterly supervision with the registered manager, which was used to discuss any issues relating to the people they were supporting, and to review staff's performance, development objectives and training needs. Additionally, the registered manager carried out observations of the care that care workers provided, assessing whether staff demonstrated patience, respect for the person's dignity, followed appropriate infection control measures and recorded whether this observation had identified any development needs for staff. Staff also received an annual appraisal, which tracked staff performance against the key areas of reliability, respect and responsiveness, and identified learning and development needs for staff.

The provider had measures in place to ensure people received appropriate nutrition. The provider told us that at the time of our inspection no one using the service had additional nutritional needs, although some people had been referred to dietitian services for reasons of weight loss or diabetes. There was a dedicated weighing area in the building, and people's weights were recorded monthly by care workers; who recorded whether a person had gained or lost weight and whether further action was required. Where one person was losing weight, staff had referred them to a dietitian, this had been effective at reducing the rate of weight loss.

We saw that the provider had measures in place to support people to maintain their health. People's care files had records of when they had been supported to attend appointments, including with their GP or with specialist health services for diagnosed conditions. There was evidence too that care workers had taken action to contact health services where they had concerns about people. For example, an incident report showed that care workers had become concerned about one person who had developed a rash; staff were concerned that this indicated a serious health condition and sought medical attention promptly. Where a person was at risk of deterioration in their oral health, the provider had an oral health action plan in place for the person which detailed measures care workers needed to take to improve their health.

Good

Is the service caring?

Our findings

People using the service and their relatives told us that they felt staff were kind and treated people with respect. Comments included "Staff are really nice and helpful", "We're very happy with how they're looking after [my relative], the main thing is they care." "They all seem very caring…when I ask how my relative is they tell me the amusing bits too." One relative told us "The carers are really lovely, they all know me by first name, and they greet me and [my relative], who is very comfortable with them."

Staff told us of the measures they took in order to promote people's dignity and to engage with people effective. These included making sure doors and curtains were closed when providing personal care and addressing people by their preferred names. One care worker told us "We always knock before we go in and I introduce myself. I picked up that I shouldn't say 'it's me'". We observed several respectful interactions between people and their care workers. For example, one person approached a member of staff requesting directions to a particular area of London. Staff offered advice, and then asked further questions to determine why the person needed to go there and then offered support with this task. People were referred to by their chosen names and we observed good natured and positive interactions between people and the staff team.

The provider told us that they provided a laundry service to people who used the service, and that people had specific days allocated to do their washing, this was recorded in people's care logs. We noted the provider had measures in place to prevent people's laundry being mixed up, and that staff displayed attention to detail in how they handled and presented clean laundry to people.

People's care plans began with a detailed description of the person and their life stories. These included information on their personalities, family background, past occupations, interests and preferences, and showed considerable knowledge and insight into the person and what was important to them. In addition, there was a more detailed booklet which had been completed with people about their lives, which included further information on their families, childhood memories and places that they had visited. There was information displayed in communal areas on how to access advocacy services; the provider told us that at present two people had advocates working with them. Where one person had disagreed with the outcome of an assessment carried out by a social worker they had annotated their assessment with their concerns; the provider recorded that they had raised these concerns with the social worker. People's care plans clearly indicated whether they had made a will, whether they wanted to be resuscitated and what their wishes were for after their deaths.

The provider had a system of keyworking in place, with a list of which keyworker was allocated to each person, including one person who had declined to have a keyworker. Keyworking sessions took place monthly, and records were kept of these discussions. Areas discussed included staying well and safe, keeping in touch, feeling positive, being treated with dignity and finances. We saw that the content of these varied each month, which indicated that they reflected genuine discussions that had taken place. This included support people had received to attend appointments and to go on outings, and there was evidence of support being offered to people in line with their interests. For example, one person liked to

watch sport on TV, and their keyworker offered them support to attend a match.

Staff understood the communication needs of people they provided care to. Where applicable, the provider used pictorial formats to convey information to people, such as a weekly diary with personalised photographs. Risk assessments highlighted the risk of people becoming de-skilled, and contained clear information to care workers on the need to engage people in tasks in order to prevent this. Where a risk of isolation was identified, the risk assessment contained information for staff on effective communication strategies for the individual in order to help prevent this.

Good

Is the service responsive?

Our findings

People using the service and their relatives told us that they received care that met their needs. Comments included "They were helpful when moving in and giving advice, and they sorted out electricity and gas too", and "[My relative] is getting the help she needs and is independent as well."

People's care plans included a one page summary sheet, which gave basic information on people's support needs, medicines, allergies, phobias and contact details. Support plans had been reviewed within the last six months, and were organised around people's specific needs, with information on what people wanted to stay the same, who they worked with and what they did with them. This was useful when people received support from additional care workers or regular support from friends and family members. Plans included information on the support people received in areas such as maintaining effective communication, continence, personal care and support to access the community. When plans were reviewed, they included an outcome based document which rated whether people had reached their preferred outcomes in areas such as staying well, feeling positive and managing money. A care worker who had recently joined the service said, "When I look at the plans I feel that it's good."

Plans also included a summary of people's scheduled visits, including their allocated support hours and the tasks that needed to be carried out at these times, such as providing support with bathing, changing pads and preparing meals. Logs were checked by managers to ensure that people were receiving their allocated hours. We saw that people received the support as planned, but sometimes timings varied, for example one person's plan stated that they were to receive a welfare check, support with personal care and breakfast in a single visit, but in practice this happened consistently over several morning calls which appeared to better meet people's needs. The provider told us that they were unable to change timings on plans as these were set by the local authority. One person's plan stated that they were supported by their own care workers during the day, and that care workers from the provider provided support with welfare and continence overnight, and logs showed that this was taking place as planned. In addition, the provider recorded when people had requested additional support from staff, for example when they had pulled their emergency call bells as they were not feeling well.

Where people displayed behaviour which may challenge the service, the provider had worked with the Community Mental Health Team in order to develop an appropriate response. For example, where a person had a diagnosis of a condition relating to their mental health, a psychologist had provided specialist training for the team and had recorded "Since diagnosis, staff have had training and are now able to understand things from [the person's] point of view." These interventions had been effective in preventing further incidents from occurring.

The provider told us that they were in the process of developing an activities programme in response to feedback from people who used the service. The registered manager said "We're not so much communal living but this is what people wanted to see in house." People were given a copy of the activity programme each month, this included activities such as a move night, book club, nail spa, sing a long and a weekly Sunday roast. Some of these activities were run by staff and some were run by local community groups such

as Age UK. A care worker told us "At weekends they have their roast and it was great. They loved it, and we all talked together which was brilliant."

We saw the provider had extensive records of compliments they had received from family members and visitors to the service. The provider had a complaints policy, and people we spoke with told us they knew to speak to the manager if they had a complaint. For example, one relative told us "I've had no cause to complain, I know who I'd have to speak to." The provider told us they had not received any formal complaints, and we saw no evidence of formal complaints that had not been recorded. However, there was evidence of concerns which were raised informally being followed up by managers. For example, one person had recorded in a keyworking session that they were unhappy that some staff did not knock on their door before entering, Managers had noted this and had recorded a discussion with all care workers about the importance of knocking on doors before entering.

Good

Is the service well-led?

Our findings

People who used the service and their relatives were positive about the quality of management. Comments included "It seems to us a very well run place with a very nice manager" and "They seem a good team, they all seem to get on well." Comments from care workers included, "We get enough support, we're not a big team and I can contact the manager at any time" and "It's so friendly, everyone's helpful. We all chip in to help each other. The communication is very good and our manager is very supportive."

Managers had measures in place to monitor the performance of the service. For example, they worked with the local authority to carry out an independent meeting with relatives in order to look at people's satisfaction with the quality of care, staffing, housing, safety and activities. Comments in this meeting were very positive. Additionally, managers held monthly tenant's meetings, which were used to discuss issues relating to the service such as health and safety and activities. Minutes of previous meetings were displayed in communal areas.

A service manager had carried out an external audit of the service in February 2016, this involved speaking with a number of people who used the service and reviewing records. This had identified some areas for development, such as ensuring plans highlighted people's preferences clearly and obtaining specialised psychology input for one person, and we saw that these points had been addressed by the service. Managers checked people's logs of support to ensure that they received the correct care, and had implemented a system of medicines champions who were responsible for carrying out checks.

Team meetings took place monthly, and were used to discuss individual people's needs and wellbeing, and to share important information such as that relating to health and safety, training, activities and mental capacity. Managers used team meetings to clarify staff responsibilities, such as to check whether people had out of date food and were using their pendant alarms.

The provider also worked with other organisations to improve the service. For example, at the time of our inspection they were working with the local health service to participate in a falls prevention pilot scheme. This included providing training to staff and to train trainers, so that this could continue if funding was no longer available. We saw correspondence from the local health team outlining plans to implement this with the service, such as providing monthly visits to the service and to implement a multidisciplinary team meeting to address concerns about people promptly.

The provider was meeting its responsibilities to display its ratings from their previous inspection report, and were notifying CQC of significant events as required.