MacIntyre Care

Southview Close

Inspection report

1 Southview Close
Rectory Lane, Tooting
London
SW17 9TU
Tel: 020 8682 3312
Website: www.macintyrecharity.org

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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?	Requires improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 7 January 2016 and was unannounced. At our previous inspection on 25 September 2014 we found the provider was meeting the regulations we inspected.

Southview Close provides care for up to 12 adults with a range of learning disabilities. The service is arranged as four flats, two on the ground floor and two on the top floor, each with three bedrooms. There were 12 people using the service at the time of our inspection, eight male and four female.

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.

People using the service told us they felt safe living at the service and would speak to the manager if they were not happy. They told us that staff treated them kindly and looked after them. Staff demonstrated a caring and kind

Summary of findings

attitude towards people. Some of the staff had been working at the service for a long time which had enabled them to get to know people and build good relationships with them. This was clear to see in our observations during the inspection. Staff were knowledgeable about people's needs and the atmosphere in the service was warm and informal.

People were supported to take their medicines and had their healthcare needs met. They were registered with a local GP and staff made appointments for them when needed. Healthcare professionals told us they were kept informed by staff of any changes to the support needs of people using the service.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had received training in MCA and DoLS. There was evidence that best interests meetings were held for people who did not have capacity to make specific decisions and the provider placed restrictions on people where necessary to ensure their safety after seeking legal authorisation.

The majority of people spent time at community day centres during the week. There was a lack of structured activities within the service for those that stayed at home. Although people were assigned as link workers, regular meetings did not always take place.

The care plans were in the process of being reviewed and developed into new person-centred plans. We saw some examples of the new plans and they were easy to follow and written in a way that was easy to understand. Due to the overhaul of the care plans, some information was difficult to find meaning we had to rely on staff to show us where certain records were kept.

Staff recruitment checks were robust and staff levels at the service were sufficient to meet people's needs. Staff told us they felt supported and enjoyed working for the organisation. They praised the registered manager, saying she listened to them and had an open door policy. They told us they were happy with the training and formal supervision they received at the service.

The values and culture of the organisation were on display in the staff room and staff received training in how they could showcase these values during their day to day job.

A number of audits, both internal and external, were carried out which the provider used to monitor and improve the quality of service. An area manager visited the service every month which helped to ensure that any identified issues were picked up and resolved.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People told us they felt safe living at the service. Staff had received training in safeguarding and were able to identify tell-tale signs of abuse.

Risk assessments were thorough and clearly identified the risk and what measures were needed to manage the risk.

Staffing levels at the service were adequate and recruitment checks were thorough.

People received their medicines from trained staff and regular audits took place.

Good

Is the service effective?
The service was effective.

Staff were happy with the training, support and supervision that they received.

Staff understood the Mental Capacity Act 2005 (MCA) and when the Deprivation of Liberty Safeguards (DoLS) were to be used. The provider followed accepted guidelines and held best interests meetings for people that did not have capacity and only placed restrictions on people after seeking legal authorisation.

People told us they enjoyed the food at the service.

People had their healthcare needs met and we received positive feedback from healthcare professionals about the service.

Good

Is the service caring?
The service was caring.

People told us that they were happy and staff looked after them.

Staff demonstrated a good understanding of people's needs and we saw some good examples of a caring attitude from staff towards people using the service.

Care plans were being developed into person centred plans.

Good

Is the service responsive?
The service was not responsive in some aspects.

Care plans were in the process of being updated and some information was difficult to locate. Link worker meetings did not always take place on a regular basis.

The majority of people spent time at day centres during the day but there was a lack of structured activities within the service.

Requires improvement

Summary of findings

People were given accessible information on how to raise complaints.

Is the service well-led?

Good

The service was well-led. Staff were aware of the culture and values of the service and demonstrated these values during the inspection.

The registered manager was praised by both staff and healthcare professionals for her openness and ability to listen.

Quality assurance checks were carried out in the form of incident monitoring, feedback surveys, internal and external audits and monthly checks were carried out by an area manager.

Southview Close

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 7 January 2016 and was unannounced. This unannounced inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses services like this.

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

During the inspection, we spoke with four people using the service and observed staff supporting other people. We spoke with five care workers and the registered manager.

We looked at four care records, four staff files and other records related to the management of the service including training records, audits and quality assurance records.

After the inspection, we contacted 32 health and social care professionals to gather their views of the service and received a response from six.

Good

Is the service safe?

Our findings

People replied "Yes" when we asked them if they felt safe. One person said they would tell the "named manager" if they did not feel safe. When asked if they thought people were safe using the service, one staff member said "very much so". Another said that "Safeguarding is about abuse; financial, verbal or physical, anything that hurts people" and "We have to make sure this does not happen, I would tell the head of service." Staff were able to identify the signs of abuse, saying "they could be withdrawn, marks, swelling, could be crying." However, one staff member was not clear on the correct safeguarding procedures to follow saying, "I would make an emergency appointment to see the GP as not part of their normal behaviour" and they said they would "go with what [the] GP has said" when asked when they would make a safeguarding alert.

Robust financial checks took place which helped to ensure people were safeguarded against financial abuse. Checks on petty cash were carried out at every handover by two staff. Only the registered manager and three senior workers had access to the bank book, no debit cards were kept in order to minimise the risk of financial abuse. Receipts were retained for any items bought and any money spent was audited by both the registered and area manager.

We found that there were enough staff to meet the needs of people using the service. Staffing levels were based on the needs of people using the service, with more staff assigned to flats where people had greater support needs. There were seven staff on duty between the hours of 07:00 and 21:30 working across all the flats and three waking night and one sleep in staff on duty during the night. Staff that we spoke with did not raise any concerns about staffing levels across the service.

We reviewed the staff rota for December and saw that staffing levels were consistent throughout the month. The registered manger told us there some vacancies at the service and some of the shifts were being covered by offering existing staff overtime.

Staff recruitment was robust and the provider carried out appropriate checks which helped to ensure that people were kept safe. Each staff file contained a list with details of the documents that staff had produced when they were first recruited. These included proof of address, identity, criminal records checks and certificates relating to any relevant qualifications. Original documents were kept at the head office.

Risk assessments were comprehensive in their scope and specific to people's individual circumstances. They clearly identified the risk, existing control measures to manage the risk and any extra action needed to further mitigate against the risk. A risk rating was then calculated according to severity and likelihood, with and without the control measures. This meant that it was clear to see the benefits of having the control measures and how having these in place made people safer. Risk assessments were signed off by the registered manager and the area manager. Staff were also required to sign them to indicate they had read and understood them.

The areas that were risk assessed included personal care, physical support, medical and health needs, safeguarding, relationships and behaviour, finance, accessing the community and domestic life skills. Healthcare professionals told us staff were able to identify potential risks and implement appropriate risk reduction strategies.

A number of environmental checks took place, which helped to ensure that people lived in a safe home. These included a 'premises hazards checklist' dated June 2015, weekly water and individual bath temperature checks and daily fridge and freezer temperature checks. A thermometer calibration test was also completed to ensure that the thermometer was working to the correct temperature. Equipment such as wheelchairs and profiling beds were checked weekly to ensure there were no defects. Portable electrical appliance testing had taken place in March 2015.

Each person had a personal emergency evacuation plan (PEEP) that had been reviewed in July 2015. Fire checks took place every month and fire drills were conducted every six months, the most recent one was in December 2015. Individual risk assessments were also completed for areas of the home including the kitchen, bedrooms, hazardous materials and electrical sockets. The provider kept a fire risk assessment file which contained a fire control and a fire prevention risk assessment dated June 2015. An emergency lighting inspection took place in March 2015, we saw that it stated that a further inspection needed to take place 'not more than six months from this date'

Good

Is the service safe?

however a more recent one was not available. We raised this with the registered manager who said she would get in touch with the company responsible for carrying out the checks.

Medicines were managed in a safe manner. A record of staff signatures was kept to help identify staff that administered medicines. Guidelines for administering medicines were kept in each flat. Each staff member had received training in medicines administration which consisted of completing an e-learning module and observation completed by the registered manager. They also underwent an annual review of medicines administration competency.

Medicines were stored securely and accurate records kept of medicine administration. Medicines with a use within date were labelled with the date they were opened and medicines that were administered as required were regularly checked to verify their quantities remaining in stock.

Each person had a medicines profile containing details of the medicines taken, how they were administered and how often and what the medicines were for. It also contained details of where the medicines were kept, the level of support the person required and whether the person consented to take their medicines. We saw in one example, an out of date medicines profile for a person which contained the incorrect dose for one medicine. We pointed this out to the registered manager during the inspection and this was immediately rectified.

Good

Is the service effective?

Our findings

People received care and support from staff who had the skills and knowledge to meet their needs. Although no new care workers had been employed recently, the registered manager was aware of the 'Care Certificate' induction training for new care workers. This is an agreed set of standards that health and social care workers adhere to in their daily working life, to provide the introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Training was a mixture of e-learning and classroom based training. A wide range of training was available to people, both mandatory and specific training to meet the needs of particular people using the service. Mandatory training included safeguarding, infection control, fire safety, mental capacity, moving and handling and food hygiene. The registered manager was qualified to deliver manual handling training herself. The registered manager told us "If any training becomes available then I will put people forward." Some of the training that was available to staff included positive behaviour support, dysphagia, autism, epilepsy and diabetes. We reviewed a calendar of the planned training for 2016 which demonstrated that the provider had considered the future training requirements of staff.

Staff told us they were satisfied with the training that they received. One staff said "They have a lot of training which helps you to do your job properly."

The registered manager told us she was working on a central training matrix that would enable her to see when staff training was due for renewal. At the time of our inspection, we saw that this was underway but had not been fully completed.

Staff told us they had regular supervision which was confirmed from the supervision records that we saw. Supervisions took place every eight weeks and were documented. Each supervision record had progress against agreed objectives, any actions from their last supervision and any new actions. Staff were able to discuss their learning and developmental needs. All the records that we saw were signed by the staff member and their supervisor.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us that 10 people using the service had DoLS authorisations in place. The records in the service confirmed this and we had received statutory notifications from the provider in relation to these applications as required.

Staff had received training in the MCA and DoLS. They were able to explain aspects of the Act including best interests meetings and the requirement for capacity assessments and DoLS. Staff were aware of the need to hold best interests meetings for people where they did not have the capacity to understand decisions that needed to be made. One staff member said, "Mental Capacity is used when a resident cannot decide, they have to be offered a choice and we have to involve their family member."

Healthcare professionals confirmed they were involved in best interests meetings when making decisions for people who did not have capacity to decide the most appropriate care and treatment for themselves.

Peoples care plans contained a section called 'Choice and Control'. This gave staff information about decisions people could make for themselves, decisions that they needed some support with and decisions that required full support. One staff member told us they "read his file, we support him to what is required personal care, medications" when we asked them how they supported people with complex needs. They were aware that people communicated in different ways, for example verbal and non-verbal communication such as Makaton or using objects of reference. One staff member said, "[We] look at body language or his response, if [we are] offering a drink, we touch him and show him a cup." They said that they had received training in Makaton and that people were

Good

Is the service effective?

supported to make their decisions. One staff member told us "They may choose how they want to be supported, [we] include them at all times and don't assume that they can't make a choice. They can through picture and objects."

Staff told us they respected people's choices and if people refused support they would respect their choice or offer them alternatives, for example if someone didn't have a bath for an extended period. "We can offer a different choice like a wash and maybe a bath once a month" and encourage them by offering them a choice like a shower."

Each flat had its own kitchen. The kitchens were clean and well stocked with food. We observed staff preparing food for lunch and also the evening meal. Appropriate preparation boards were used. One person told us they had "roast chicken and roast potatoes" for dinner on Sunday. People said the food at the service was nice.

Pictorial menus were on display in the flats which were used to offer people choices during mealtimes. However, we found that food that was prepared did not necessarily follow the menus. We asked staff about this, they told us that although people made choices at the beginning of the week, on a particular day they often changed their mind and chose something else. They also said that some people using the service liked to change the pictures on display themselves.

A food hygiene inspection and rating report had taken place in March 2015, there were no concerns identified and the service received the highest rating of 5. Safe cooking instructions and other useful information such as tips for managing diabetes, choking risks and food and fluid plans from the dysphagia community team were on display to inform staff of special requirements for people using the service. We asked a staff member what they would do if someone was losing weight or lost their appetite. They told us they would, "make an appointment with the GP and ask the dietitian to visit who may prescribe [a nutritional supplement drink]."

We found that people's healthcare needs were met by the service. People told us they had regular medical appointments with their GP, dentist and optician.

All the people using the service were registered with a GP who provided general check-ups as well as yearly medicines reviews. There was evidence in the care files that people were supported by other healthcare professionals, for example we saw correspondence from the community learning disability health team including a consultant psychiatrist and other professionals such as occupational therapists and physiotherapists. Records of health appointments were kept by the provider and we saw that the provider was proactive in reviewing people's health needs, for example by supporting people to have bowel cancer and dementia screening.

Feedback that we received from healthcare professionals was positive. They commented that staff were proactive in notifying them of any changes in health or support needs. People had up to date hospital passports which people brought to appointments so that medical staff were aware of their individual needs if they were unable to communicate these.

Good

Is the service caring?

Our findings

One person told us, "I'm fine, staff are nice." Another person told us staff were kind and they were happy at the home. People also told us that staff had time to sit and talk with them.

People said they got up on their own and went to bed when they wanted to. Staff told us they always encouraged people to be as independent as possible. One staff member said, "We help them to lead independent lives, some take their own breakfast." They gave us examples where they helped people with some aspects of their personal care but encouraged them to do others by themselves, for example one person needed help with shaving but staff told us "We encourage [them] to brush their teeth, we prompt them." People were also encouraged to tidy their rooms if they were able to.

Staff that we spoke with had all worked at the service for a number of years, some as long as15 years. They said this really helped them to get to know people and befriend them. They were familiar with people's likes and dislikes and how they liked to spend their day. People were supported to maintain contact with family and friends. Some people spent time with their families over Christmas and others spent weekends with their families every two weeks. Family and friends were welcome to visit people at the service. One staff member said, "We always say to the family you don't have to make an appointment just pop in." Some people that did not have any family involved in their care and did not always understand decisions related to their care had an independent mental capacity advocate (IMCA) who acted in their best interests.

We saw some good examples of staff demonstrating a caring attitude. One person was going out for the day and was supported to make themselves a packed lunch and a snack. They were prompted and supported to carry out this task with constant reassurances. Another person who was non-verbal was offered an orange as a snack. Staff peeled the orange into segments, placed it into a bowl and the person got sensory pleasure out of squeezing and eating the orange, they were smiling throughout. Staff did not step in and try to clean them up before they had finished eating. This was done in a way which was person centred and not task centred.

Staff had received training in 'facilitation skills' which taught them about the importance of interacting with people in a person centred manner. These included eye contact, listening, touch, observation, warmth and positioning.

Care plans were written in a person centred manner and included guidance on the best ways of communicating with people, for example using Makaton or objects of reference. Communication profiles had been recently reviewed and had details about how staff could understand people, how people communicated, how they expressed their liking or disliking of certain things. People's preferred afternoon and evening routines were recorded which helped staff to support them appropriately. Care plans also contained preferences related to breakfast and mealtimes including how they liked their tea, what type of food they enjoyed and what their preferred times for eating were.

Staff respected people's cultural and religious needs. They gave an example of one person with specific dietary requirements. Staff told us, "We buy meat from the halal shop and it is cooked separately from everyone else." Other people were supported to go to church. One staff member said, "We have two individuals who go to church, so we take one of them to mass to light their candles and pray and we take the other individual to her church."

We looked at a few bedrooms during the inspection and saw that they were all personalised and individual to each person using the service. They were kept clean and people were able to furnish them as they wished. Some people had single beds, others had requested larger beds and their wishes were respected. We saw staff meeting minutes that showed people were offered a choice of bed.

Requires improvement

Is the service responsive?

Our findings

Before people came to use the service, the registered manager completed a pre-admission assessment of people's support needs. People and their families were also encouraged to come to the service, for a day visit or an overnight or weekend stay to get to know the service and the staff.

People were given a service user agreement when they came to the service, this was written in an easy read format and gave people a range of information related to their residency including house rules, their rights, responsibilities, safeguarding information, how to raise complaints and information on the people that would be supporting them.

Staff told us they found out about people and what was important to them "by looking and observing them, we speak to their family and check their life history", "listening to them, reading their communication profile" and "body language, eye contact, behaviours, how they interact; that's how you can tell if they are happy or not happy."

One person who had just returned from a day centre told us, "I played bingo, I enjoyed it." The majority of people attended various day centres throughout the week. On the day of our inspection we saw two people waiting for a bus to collect them and they looked happy and excited about going. We spoke with some professionals who supported people at some of the day centres and they told us they did a range of activities including massage, music based activities, and community days out. There were many pictures displayed in the individual flats of activities that people had taken part in and we also saw some of the items that people had made in their bedrooms, including ceramic work and sewing. Some people went to Center Parcs every year and we saw that activities and days out were discussed in link worker and tenant meetings.

There appeared to be no structured activities within the service for people who did not go out into the community. We went into three flats and they all had the televisions on, although staff sat down and engaged with people there was little in the way of structured activities to meet people's social and leisure needs. We also found that link worker meetings were not always taking place on a regular basis which meant that people may have been missing out on some intensive, structured time with their assigned link worker.

At the time of our inspection, the service was going through a process of reviewing and reorganising their care records. The registered manager showed us some examples of the new care plans they were introducing for each person. The new care plans, known as 'The One Plan' was a single file, written in a person centred way containing all the important information related to a person. The registered manager said that previously care plans were written in different records and the One Plan was a way of bringing all the disparate information into a single record that was accessible to staff and written in a manner that was easy to understand. The One Plan was split into different sections, including a section 'About Me' containing information about important people in people's lives, how they communicate, religious needs and things that were important to the person. There was a second section called, 'How to Support Me' which had information related to general support needs and more specific needs with respect to day and night routines, personal care support, medicines, health needs, leisure activities, and behavioural support.

We saw some examples of this new support plan and information had started to be transferred into these, although they were not fully complete. Due to the changes taking place with respect to the care records, other information was sometime difficult to find and we had to ask staff to locate some records for us. For example, although hospital passports were available for each person some of these were stored in individual care records whilst others were in a separate folder.

Details of how to raise concerns or complaints were available to people in an accessible format. Some flats had a pictorial noticeboard, giving people details of what to do if they were not happy. People also had easy read 'service user guides' which contained this information. Tenant meetings were held in which a standing agenda item was asking people if they were unhappy about anything. Some people had link worker meetings during which they were given a chance to raise concerns.

Requires improvement

Is the service responsive?

The provider kept a record of any complaints that had been raised, we saw that none had been raised in the past year. However, we saw that complaints raised prior to that were assigned to a manager to investigate and complainants were responded to in a timely manner.

Good

Is the service well-led?

Our findings

People told us they enjoyed working at the service and were familiar with the culture and values of the organisation. One staff member said, "It is an open and honest culture, here to support each other and offer encouragement" and the values were "Treating others with respect and dignity and value the individual."

Staff praised the registered manager for her openness and willingness to listen. Comments included, "I can't fault her, she will support you 100%", "I like working here, we help each other" and "If I have a concern I would call her up and she will be very honest." They told us they would not hesitate to raise any concerns about the practice of their colleagues and one care worker gave an example of when they had done this previously, with a positive outcome. One care worker said, "If you see something happen you do something about it straight away…always best to report something when you see it."

Healthcare professionals commented on the professional and positive relationship they had with the registered manager and care workers. They said that they were kept up to date with any changes to people's support needs and the provider was open in inviting them to multidisciplinary meetings.

The values of the organisation were on display in the home for staff to refer to. The values contained a list of promises and expectations made to people using the service and staff. Promises included keeping people safe and healthy, to listen, be kind, friendly and fun, get to know people, learn new things and make things better if people were unhappy.

Monthly team meetings took place, these looked at a number of issues including a review of the previous month's minutes, staffing issues, health and safety and also a discussion about each person using the service and any important updates regarding their support needs.

The provider kept an accurate record of any incidents and accidents. In the past year, there had been 20 recorded events. We reviewed these and saw that accurate records were kept, including follow up actions and people that had been contacted as a result. These were signed off by the registered manager. These events were then uploaded onto an online reporting system so that the area manager could review and monitor these.

Various audits were carried out, by both the registered and area manager. The registered manager conducted a monthly medicines audit during which she checked that all medicines records had been signed, any medicines received had been recorded, stock levels were checked and if medicines were within their expiry date. Other audits included checking that financial records and money held for people at the service were audited and receipts retained by staff. An area manager visited the service every month to provider further auditing of these areas.

External audits also took place, for example a health and safety audit had taken place in October 2015. We saw that there were 12 minor actions that the registered manager needed to rectify as a result of this and that she had begun to work through the identified issues.

Questionnaires that were written in an accessible format had been sent to people using the service to gather their views of the service in December 2015. Sufficient time had not passed to enable the results of these to be analysed at the time of our inspection.