The Westminster Society For People With Learning Disabilities

Kingsbridge Road

Inspection report

20 Kingsbridge Road
London
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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 27 and 28 September 2017 and was unannounced on the first day. Kingsbridge Road provides a respite service for up to 11 people with learning disabilities or autistic spectrum conditions across three ground floor flats with a shared garden. Each flat contains a shared lounge, bathroom and shower and kitchen. Two of these flats provide an unplanned respite service, and one flat provides a planned respite service. At the time of our inspection there were 10 people using the service.

We last carried out a comprehensive inspection in May 2016 where we found breaches of regulations relating to the safety of the premises and consent to care and rated the service "Requires Improvement". We carried out a focussed inspection in November 2016 where we found the provider was now meeting these regulations and changed their rating to "Good". At this inspection we found the service remained "Good".

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.

Since our last inspection visit, we found that the service was supporting more people with complex, mental health needs. We saw that the provider had suitable measures in place to manage this, including working with other professionals to plan people's support and managing risks in a way which protected and promoted people's rights. There were measures in place to manage times when people's behaviour could challenge. Incidents and accidents were monitored and measures put in place in response to these. Staffing levels varied in order to meet the needs of who was using the service at the time. The provider maintained safer recruitment measures and included people who used the service in interviewing and assessing a candidate. There were suitable systems in place to safeguard people from abuse.

We brought this planned inspection forward as the provider had reported a number of medicines incidents. We saw that an action plan was in place to address this, however some of the checks carried out on medicines were not always being applied effectively in a way which would detect mistakes. We have made a recommendation about this. We found that people's medicines were checked in and out of the system and there were clear medicines support plans, including medicines which were given as needed.

The service was able to respond to people's changing needs, through support planning and review. Circle of Support meetings took place as needed, and were used to review people's support and ensure that decisions were made in people's best interests when necessary. The provider had assessed people's capacity to make decisions and worked to promote people's rights.

People were supported to speak up through keyworking and everyday interactions and the provider maintained communication passports and other tools to promote this. People continued to have personalised programmes of activities. Managers had clear tools in place to ensure that people's needs were

met throughout the day, including shift plans and regular handovers between shifts.

The building remained in a poor condition in places and had not been designed for its current purpose, which the provider worked with the building's owners to address. Although the condition was poor, the building was not unsafe and the provider had worked to promote a more homely environment. We found that sometimes health and safety checks were not overseen in a way which meant that issues of concern could be addressed promptly, however these were audited by managers. There were measures in place to promote fire safety, including tests of fire equipment and personal evacuation plans.

Managers were visible in the service and people's relatives were positive about the way the service was led. Managers had checks in place to ensure that staff received training in line with the provider's requirements, and staff received regular supervisions with their line managers. People were confident they could speak to managers if they had a concern, and there were measures in place to monitor and investigate complaints. A new system of audit had been introduced which identified clear areas for improvements, but it was too early to judge its effectiveness.

We have made one recommendation about how the provider monitors people's medicines.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

The provider had action plans in place to address medicines errors, although these were not fully implemented and audit procedures regarding medicines were not operated in a way which could prevent and detect errors.

The provider had measures in place to safeguard people from abuse and managed risks to people in a way which upheld their rights.

Staffing levels varied in order to meet the needs of people who used the service. There were safer recruitment measures in place.

Is the service effective?

Good

The service was effective.

The provider was working in line with the Mental Capacity Act to assess people's ability to make decisions and to demonstrate they were working in line with their best interests.

People were supported to eat and drink as required and there were measures to promote good health. Staff received suitable training to carry out their roles and were adequately supervised by their line managers.

The building was not designed to meet the needs of the service and required maintenance work, but there was evidence the provider was working with the landlord to meet this and had taken steps to make the environment more homely.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Good

The service remained good.

Is the service well-led?

Good

The service remained good.

Kingsbridge 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 27 and 28 September 2017 and was unannounced on the first day; on the second day the provider knew we would be returning. The inspection was carried out by one inspector. We brought this inspection forward as the provider had informed us that they had had several incidents relating to medicines errors.

Prior to carrying out this inspection we reviewed information we held on the service, including notifications of serious incidents that the provider is required by law to tell us about. In carrying out this inspection we spoke with four people who used the service and made contact with six relatives. We reviewed records of care relating to four people who used the service and records of medicines management relating to five people. We looked at the personnel files of six care workers and records relating to the management of the service such as shift plans and records of health and safety checks, incidents, accidents and complaints. We spoke with the registered manager, unit manager, two team managers and four support workers, and spoke with a social worker and a commissioner from the local authority.

Requires Improvement

Is the service safe?

Our findings

We found that the provider had measures in place to promote people's safety, but in some areas these required more oversight to be effective.

People who used the service and their relatives told us they felt safe using the service, although some people told us that there were sometimes incidents with other people who used the service, which the provider had addressed. One relative told us "There was an incident, but they were doing everything to make sure [my relative] was safe and that I felt OK about leaving [him/her] there." Staff we spoke with told us they had received training in safeguarding adults and were confident in recognising and reporting signs of abuse. Comments from support workers included "There's no-one mistreating anyone" and "I've not witnessed any abuse, but I'm confident about knowing how to deal with it based on our training." One support worker said "They show us videos about abuse; unless you're trained to pick up on it you may not know how to do so." Where allegations had been made about suspected abuse, managers had taken appropriate measures to safeguard people and investigate the incident accordingly. All staff we spoke with told us they were confident that managers took safeguarding people seriously.

There had been a number of incidents relating to people going missing from the service. The provider told us that they were supporting people with more complex mental health needs, who appeared to have capacity to leave the service when they chose to do so, even though this may not be safe. The provider told us they had worked with staff in order to manage these risks and also to avoid restrictive practice. We saw that the provider had clear risk assessments for addressing these situations, and had missing persons procedures, which were agreed with people's care managers. There was a procedure for each person, which contained a recent photograph, a physical description of the person and an agreed timescale for reporting the person missing. People were given cards to carry with their identification and contact details for the service. A care manager we spoke with told us "They've done a great job, they've done all they can."

The provider carried out checks to ensure that the premises were safe. This included outlining clear responsibilities on shift plans for carrying out nightly checks of fire safety and security. The provider had carried out Personal Emergency Evacuation Plans for people who may need support to leave the building safely, these outlined people's mobility, sensory and behavioural needs and had an agreed evacuation strategy. Evacuation documents for people currently using the service were stored in a prominent red grab bag on the noticeboard in the main living area. Fire extinguishers and emergency lighting were serviced regularly and support workers carried out weekly checks of these and the call points and fire alarm. The fire alarm was displaying an error at the time of our visit, but the provider arranged for an engineer to visit urgently, who verified that the alarm was still functioning. Support workers and people who used the service received a fire induction when they started at the service, and we saw records of regular fire drills taking place.

Support workers were carrying out daily checks of fridge and freezer temperature checks. However we saw that at times fridge temperatures were sometimes slightly higher than those recommended by the provider's guidelines, but these were not routinely followed up or checked by managers to ensure storage

temperatures were suitable. We saw that food was stored in the fridges in a safe manner, with containers labelled with opening dates. There was accessible information on maintaining food hygiene and hand washing displayed in the kitchen and colour coded chopping boards for preparing different types of food, although some of these were worn and were in need of replacement.

There were suitable checks of gas and electrical safety being carried out, including Portable Appliance (PAT) Testing. An electrical safety check in April 2016 had identified some non-urgent issues which required attention, there was a record the provider had asked the landlord to rectify these but this had not yet taken place. The provider told us that they had an ongoing issue with water temperatures which they were addressing with the landlord; these were checked monthly in all rooms and were sometimes higher than those recommended to prevent the growth of legionella bacteria and some kitchen taps were far hotter than the provider's guidelines to prevent scalding; however we saw that the landlord had arranged a monthly visit from a contractor to test and adjust temperature valves to address this. However, although maintenance logs showed times when this was reported to the landlord there was not a record of immediate follow up when temperatures were too high and managers did not check these records regularly. Staff carried out weekly flushing of disused outlets in line with the provider's legionella risk assessment.

People who used the service told us about measures that the provider had taken to promote their safety, such as keeping their money in a locked tin. There was a check-in process for when people arrived at the service which included a list of possessions, these were checked out when people stopped living at the service. The provider maintained risk assessments and management plans where people may be at risk, these included areas such as risks which may occur at night-time, eating and drinking, physical activity, leaving the building without support, finances, personal care and relationships and sexuality. These assessments were reviewed regularly and monitored by managers. The provider also carried out a "first month" risk assessment when people began to use the service, which could be used to highlight areas such as anxiety from attending a new service or health needs not being met. Care plans contained information on how best to support people to manage risks to their wellbeing, including behaviour which may challenge, and directed staff to the appropriate risk assessment. There were also behavioural support plans, which contained information on how staff may recognise a person was becoming more agitated, possible triggers and de-escalation strategies. The provider kept chronologies of serious incidents such as when people went missing and maintained Antecedent-Behaviour-Consequence (ABC) charts for monitoring when people had displayed behaviour which may challenge. Records of serious incidents were maintained and checked by managers.

We saw that staffing needs varied considerably on a day to day basis depending on who was using the service and their support needs. We saw that rotas were arranged based on who was staying in each flat at any time, and shift plans showed that support workers were allocated to carry out support to people to safely meet their needs, including on a one-to-one basis. Relatives told us they had no concerns about staffing levels. Comments from support workers included "There's enough staff; you'll get the odd time when there's staff sick but we get it covered" and "They always make sure they put staff in depending on service user's needs…here the rota can change from day to day."

The provider had safer recruitment measures in place, including obtaining proof of identification and address for staff members and evidence of satisfactory conduct in previous employment. Staff were required to provide a full work history, and where there were gaps in this these had been explored before an offer of work was made. All staff had obtained a satisfactory check with the Disclosure and Barring Service (DBS) before starting work. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. The provider maintained a record of dates of DBS checks to ensure that these were repeated when due. All care workers attended an assessment centre and

were signed off by a manager before an offer of employment was made.

The provider had measures in place to check people's medicines when they arrived at the service, and checked that medicines were in a suitable labelled container and that the person had a medicines profile in place. Medicines profiles included information on the reasons people took medicines and what the possible side effects were. We saw that medicines were clearly labelled and stored safely in a locked cabinet. Medicines administration recording (MAR) charts contained clear information on people's prescribed medicines, including dose, frequency and times, and there was evidence of the provider contacting a person's GP to ensure that they had up to date information on medicines. Where people were prescribed medicines to be taken as needed (PRN), for example due to anxiety and agitation, the provider had clear protocols for their administration, including the need to seek authorisation from a manager before administering these. We saw logs of the on call management service which showed that this was taking place.

The provider had told us that they had experienced a number of medicines errors in June and July this year, and had contacted us with their action plan to prevent recurrence. Some investigations had identified the cause of the error, including the checking in of medicines and the need for regular checks, and these had been addressed by the provider, however some investigations were not yet complete. Some of these errors had been identified by medicines sweeps, where shift leaders were responsible for checking medicines had been administered, which formed part of the shift plans and were to be carried out at least twice daily. However, we saw that at times these had not been recorded as having taken place, and we saw that for two people there were gaps on people's medicines administration recording (MAR) charts which had not been identified by these checks. The provider showed us logs which showed that the medicines had been administered, however we were not satisfied that the measures the provider had put in place were sufficient to identify an error promptly once it had occurred. We recommend the provider take advice from a reputable source to ensure that medicines procedures operate in accordance with the NICE guidelines on managing medicines in care homes.

Good

Is the service effective?

Our findings

The provider had measures in place to ensure that it was working 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 worked with the local authority to assess people's capacity in complex situations, in doing so we saw that managers had demonstrated a good understanding of the requirements and nuance of the Act. This included recording what steps had been taken to aid the person in their understanding of the decision and, where applicable, why the provider felt the person lacked capacity.

The provider showed us evidence that they had advocated for the rights of others, for example when they were asked to carry out restrictive practice or use restraint and had explained why they were unable to do this. Care plans were clear about areas in which people had capacity to make decisions, and which areas people lacked capacity. Where people lacked capacity, there was evidence of best interests meetings being arranged and held, with records of these kept on file, however we found sometimes managers could demonstrate the meeting had taken place but lacked evidence of the details as they were awaiting minutes from other professionals.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). When people started to use the service, the provider carried out a risk assessment with regards to DoLS in order to assess whether they were likely to be deprived of their liberty, whether there were any potentially restrictive movements and whether an application to the local authority may be required, where this was the case. There was one person subject to a DoLS authorisation and the provider had fulfilled their responsibilities to submit this and to notify the Care Quality Commission of this. The door to the building was kept locked, however people we spoke with told us they didn't feel restricted and could leave at any time and there was evidence people had done so. One person told us "I go into town, but sometimes brand new staff don't know that I can."

Managers maintained a training needs analysis which allowed them to check that support workers and managers had received essential training within the provider's requirements. This included three yearly training on first aid, fire marshal training and food safety, two yearly moving and handling training, annual training on safeguarding adults, fire safety and medicines management. This showed that staff maintained their training in line with these requirements, although some support workers needed to carry out refresher training on food safety. Comments from care workers included "We get training every six months or so based on the expiration date" and "We get a lot of support with [training], they've been very helpful whenever we've requested any." Support workers typically received supervision every two months; the provider maintained a system to monitor this, but this needed updating at the time of our visit. Support workers had an allocated supervisor who maintained records of these discussions. Supervision sessions were used to discuss the staff member's wellbeing and issues relating to health and safety and any concerns that staff

members had, as well as reviewing the provider's policies and values and discussing how these could be put into the practice.

There was information on people's care plans about people's dietary needs and the support they required to eat and drink, including specialist diets and measures to manage diabetes. People were free to access the kitchen at any time and we observed people doing so throughout our visit. Kitchens included accessible information about healthy eating. Care plans contained information about people's preferred foods and drinks, and support workers recorded what people had eaten on a daily basis. People who used the service had health action plans in place which were reviewed regularly. People also had hospital passports, which are documents designed to communicate important information about a person's needs to hospital staff in the event of admission. Care plans contained detailed information on how to support people with their needs relating to certain conditions. We saw evidence that people were supported to attend GP or health appointments when required, including when people were unwell.

The building was in very poor condition, but there was no evidence that it was unsafe and was kept in a clean condition. For example, at the time of our inspection one shower was out of order and the provider told us at one point they had been down to one working shower. In many corridors we saw that paint and plaster were missing from walls and some kitchen cabinets were broken. In one bathroom the flooring was coming lose from the walls and there were many missing tiles. We noted that some doors did not have hold-open systems, which could benefit people who were unable to open doors for themselves. Comments from people and their families included "I think this place needs a little surgery" and "I'd say it needs a lick of paint." There were extensive records of the provider reporting maintenance issues to the landlord. A commissioning officer told us "They're relentless when it comes to that sort of thing" and added "They have done everything they can to make it a more homely environment." Measures in place to adapt the environment included comfortable furniture, personalised decorations on doors to people's rooms, photographs of activities and artwork that people had made and a sensory room with projectors and lights which were in working order. There were accessible notices in place where required and an easy to access garden which was shared between the three flats.

Good

Is the service caring?

Our findings

People and their relatives told us that the service was caring. Quotes from people included "I do like coming here" and "The staff are magnificent, they're out of this world." Relatives told us "They're so obliging, so good" and "They're really committed."

People we spoke with told us they had keyworkers and were able to speak with them regularly to make decisions about how they spent their time. People had a one page profile, which contained a brief overview of important information such as how they liked to be supported and what people liked and admired about them. There was also key information such as the preferred gender of their support workers and daily routine, information about how people communicated and also information about any behaviour the person had which may challenge and possible triggers for this.

There was more detailed information about how to support people to speak up in communication passports, this included how people demonstrated their feelings, whether people used Makaton and whether people had sensory needs including wearing glasses. There was information for support workers on the most effective ways to talk to people, including examples of clear, unambiguous sentences and examples of strategies which had been shown to be ineffective. The provider had also sought out specialist advice, for example working with an external service in order to support a person who was deaf and had complex mental health needs.

We saw examples of these being applied to support people to speak up, this included giving a lot of reassurance to people and support workers and managers encouraging people to move to quieter areas of the building in order to have a conversation. We noted that on several occasions people who used the service asked members of staff to come into the room when speaking to Inspectors in order to provide support and reassurance. We observed many instances of respectful and friendly interactions between people who used the service and care workers. One person told us that they were involved in interviewing candidates for the staff team, and said "When they recruit people they call me up and I interview staff."

Good

Is the service responsive?

Our findings

The provider demonstrated that they were able to respond to meeting the needs of a changing group of people who used the service. This included working with the local authority and specialist agencies in providing support to people with more complex mental health needs and providing emergency placements for people whose placements had broken down. The registered manager told us "The client group we're working with have more acute mental health needs, I think it shows the faith social services have in us that we can support people with these needs."

Comments from relatives about the responsiveness of the service included "They're really good; they will bend over backwards to help you" and "They're quite willing if [my relative] wants to do something to support them to do it."

Support plans were detailed and person centred with clear outcomes, and outlined the support people required in areas such as daily living, community and leisure, education and employment, housing, communication and keeping in contact with friends and family. Each section of the plan was organised in three parts; a plan outlining what needed to be done, a "do" section which detailed who would support the person and how often and a section headed "check", which outlined what the desired outcome was and how often it would be reviewed.

People had regular reviews through a Circle of Support system, which included the person, their support workers, families and other professionals. We saw that these were organised in a way which responded to people's needs; for people whose placements were stable these were yearly, but for people with less stable placements and more complex needs these could be as often as fortnightly.

The unit manager told us "Previously we talked about fantastic activities, unfortunately these wouldn't be safe with some people." However, there was still evidence of varied activities taking place where possible. For example, people's care plans had information on preferred outings and journeys, including using journey planners with clear walking routes for people and preferred places to stop for lunch. People who used the service regularly had activity timetables in place, including checklists for support workers to make sure people had everything they needed on them such as bus and activity passes, lunch and money. Where appropriate, people's days were broken down to the hour, outlining what the person required support with and how this should be done by support workers. At the time of our inspection one person had returned from a day trip in London which they told us they had enjoyed. Records of daily support showed that people were supported to attend activities which met their needs. A support worker said "When they first sign up we will ask them what you enjoy doing and is there anything you'd like to be a part of."

People who used the service told us they got to choose what they did. One person told us "Anything I want to do they will do it, they are very supportive." A relative told us "They try to encourage [my relative] to do other stuff, they've got a Playstation which the younger people like. They really try and get [him/her] to go down to the gym, they're really good that way."

The provider had measures in place to monitor and address complaints. Records were kept of the nature of the complaint and measures that managers had taken to investigate and respond to these. These were overseen and discussed at board level.

People we spoke with and their relatives told us they were confident with raising complaints. Comments included "I'd talk to my keyworker", "If I have any complaints they put it right" and "I feel if I was any way worried they would take notice."

Good

Is the service well-led?

Our findings

We saw that managers remained visible in the service, with a manager allocated to each of the two units who were overseen by a unit manager. Managers appeared to have a clear vision for what they wanted to achieve in the service, and spoke of the measures they had taken to put this in place. The registered manager told us "We've been stronger about saying we cannot support certain people, when the impact on others was not acceptable." There were clear guidelines displayed for shift leaders responsibilities and a 24 hour on call service for support staff to contact, with clear criteria for when this should be used. Managers showed us records of the on call system which showed that this was being used appropriately.

Relatives of people who used the service were positive about the way the service was led. Comments included "It wasn't managed well, but since Westminster took over it's much better run" and "I think Westminster Society is much better than anybody else; it's the best one I think."

Support workers told us they felt well supported. Comments included "The people I work with are easy to talk to if any problems; that's both staff and managers", "If we have any issues the managers are always on hand", and "On a daily basis they'll come and check on us and see if there's anything you'd like to talk about." One support worker told us "I'm proud to be able to say I'm part of Westminster Society."

We saw that handovers took place three times a day, and included all staff on shift . Extensive notes were taken of these meetings, which were used to discuss people's needs, current health status and their plans for the day, and managers were responsible for bringing these notes to support workers who were unable to attend the meeting. Managers also compiled a clear plan for each shift, including each person's needs and activities for the day, and which health and safety checks needed to be carried out each day, which was then reviewed by the appropriate manager in handover.

Managers had systems in place for monitoring risk. This included maintaining a risk register for each person using the service, which listed which risk assessments were currently active and when they were due for review. The provider maintained a review of complaints, incidents and accidents, which were compiled into a report which was discussed at board level, so that these could be monitored externally.

We found that the provider had introduced a new system of audit, which was to be carried out twice yearly. Managers had rated their service's performance in a number of areas, and following this the unit manager carried out a validation visit to identify areas for improvement with a brief description of their findings in areas such as support, health and safety and team management. The final stage of the audit was for this to be assessed by an external quality check. The audit had identified areas for development but it was too early in the implementation of this system to say whether this had led to direct improvements.