London Care Partnership Limited

London Care Partnership Limited - 185 Arabella Drive

Inspection report

185 Arabella Drive
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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

London Care Partnership – 185 Arabella Drive is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides care and accommodation for up to nine people with learning disabilities. It is located in the Barnes area. At the time of the inspection, the home was fully occupied. Eight people were living in single bedrooms, and one person was living in a one bedroom self-contained flat.

At the last inspection, the service was rated Outstanding.

At this inspection we found the service was Good.

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 told us they felt safe living at Arabella Drive. Relatives told us they were very happy with how the service looked after their family members and had no concerns about their safety. Risks to people had been assessed and steps were in place to manage these so that people could live a fulfilling life in a safe environment. Positive behaviour support plans and behaviour monitoring charts were used by staff to provide the appropriate level of support. Staff records showed that support workers received training in safeguarding and proactive methods for managing behaviour that challenges.

There was a homely atmosphere at the service and it was clear from our observations that support workers had built up close relationships with people using the service. This was reflected in comments we received from relatives of people using the service and the conversations we had with staff.

Relatives told us their family member's wishes were respected and they were offered a choice. This was reflected in our observations and also through their care planning. People had communication profiles in place which helped staff to communicate with them effectively. People were supported to maintain their independence and each person had short and long term targets to help them achieve this. The registered manager said these targets were reviewed by key workers every three months, however we found these meetings were not always taking place.

There was evidence in the care plans that decisions related to people's care and treatment were taken in consultation with health professionals and other stakeholders in people's best interests. All but one of the people using the service were subject to a Deprivation of Liberty Safeguards (DoLS) where they were deprived of their liberty to ensure their safety.

People were supported to take their medicines by support workers with the appropriate training. Each person had a medicines plan with details of the medicines they were prescribed, their uses and possible side effects. Medicines guidelines were on display for staff to refer to if needed.

Relatives told us the provider managed the health care needs of their family members well. Records of correspondence and referrals from the provider to health care professionals were seen. People had support plans in place to manage their healthcare needs. We saw correspondence from healthcare professionals praising staff for the positive impact they had on people using the service.

Staff recruitment was a robust and new support workers received a thorough induction which helped them to integrate well into the service. This included training based on the Care Certificate and an opportunity to visit the home prior to confirming their employment to observe existing staff members. They were also provided with an introduction to each of the residents. Existing staff received a range of training which enabled them to support people effectively. They also had an opportunity to reflect on their work through reflective practice meetings with their supervisor.

There had been no formal complaints received and it was evident due to the open culture of the service that if people had concerns they were free to raise them. Feedback was sought from people and their relatives which was acted upon.

Relatives told us the service was very well led and they praised the open culture of the service. Staff told us they really enjoyed working at the service and felt valued by the management team.

The provider demonstrated its commitment to ensuring they were a good employer and striving for excellence through accreditation from Investors in People (IIP). It continued its practice of internal promotion through its management academy which identified 'top talent' within the company. It had also maintained their autism accreditation by the National Autistic Society. In order to achieve and retain accreditation, the provider demonstrated its expertise in the understanding of autism.

Quality assurance and governance systems were effective and used to drive improvement. A Quality Action Group (QAG) chaired by the provider's quality of life lead and attended by the registered managers and team leaders met every two months.

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 remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service was Good.

Care records were comprehensive in scope and were based around people's individual needs.

A positive behaviour support (PBS) analyst was responsible for assessing each person and producing behaviour support plans.

People's independence was encouraged through long and short term target planning.

Is the service well-led?

Good

The service was Good.

Relatives and health professionals praised the open culture of the service.

Staff morale within the service was high which was reflected in the Investors in People report. The service continued its practice of internal promotion through its management academy.

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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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection and took place on 9 and 11 January 2018.

The inspection was unannounced. The inspection was carried out by one inspector.

Before the inspection, we reviewed the information we held about the service. This included notifications sent to us by the provider and other information we held on our database about the service such as the Provider Information Return (PIR). Statutory notifications include information about important events which the provider is required to send us by law. A PIR is a form that requires providers to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan the inspection.

During the inspection we spoke with the registered manager, area manager, the director, operations director, head of resources, quality of life lead, a positive behaviour support consultant, an aroma therapist and three support workers.

We checked records related to the management of the service. These included three care plans, three staff files, training records and audits.

During the inspection we spoke with two people using the service and one relative. People who live at Arabella Drive have significant communication needs so more were not able to tell us of their experiences. We observed their interactions with staff in communal areas. After the inspection, we contacted relatives of

three people using the service. We also contacted 12 health and social care professionals involved with people who use the service and we received feedback from five of them.

Good

Is the service safe?

Our findings

People told us they liked living at the home and were happy. Relatives also told us they felt their family members were safe and well looked after. Training records showed that staff received safeguarding training and support workers we spoke with demonstrated a good understanding of safeguarding reporting procedures if they suspected a person was at risk of abuse. One staff member told us "Safeguarding is making sure clients are safe and protected from harm."

There were enough staff employed to meet people's needs. On the first day of the inspection there were seven support workers for nine people using the service. The registered manager told us these were the usual staffing levels during the day. At night there was one waking night and one sleep in worker on shift. Relatives told us there were always sufficient staff on duty when they visited the service. The provider had a policy to not use agency staff but relied on familiar trained bank and full-time staff overtime which helped to ensure consistency in the support provided to people using the service.

The service used an online HR tool to manage their HR function and to monitor DBS status, sickness and annual leave of staff. Each staff member had a current Disclosure and Barring Service (DBS) check. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

Individual assessments were completed for people to manage any areas of identified risk. Each area assessed was given a risk rating based on the severity of the risk and the probability of it occurring. The risk rating was calculated alongside the control measures needed to minimise the risk. The guidelines stated that if the risk rating score after the initial control measures was greater than 12 then additional control measures were needed to reduce the risk further. We saw some examples where the risk was not calculated. We raised this with the registered manager who demonstrated that the additional control measures were in place and the risk to the person had been reduced. She also said that they were looking into reviewing their risk assessments and these would change in future to not include risk scores but with more focus on control measures.

There was evidence that the provider acted upon incidents and used these as a learning opportunity. One person using the service had experienced a seizure, this had been recorded in the incidents form along with the action taken to prevent further occurrences. An appointment had been booked with the neurologist and their seizure care plan had been updated. The staff team had also been briefed following the incident. The incident report flowchart was on display in the staff office alongside the procedure if a person using the service absconded.

People were supported to receive their medicines in a safe manner. We observed staff supporting a person to take their medicines and they did this well, asking the person for their consent and checking the right medicines were being given and completing the Medicine Administration Record (MAR) charts after observing the person take their medicines. MAR charts were completed correctly.

The provider had a system where two support workers administered medicines, with one support worker

observing and signing a separate MAR chart as a witness. This helped to minimise potential errors.

One person using the service was able to self-medicate, the rest needed staff support. People had a 'my medicines plan' with details of the medicines they were prescribed, their uses and possible side effects. Medicines guidelines were on display for staff to refer to if needed.

There were checklists in place for keeping the service clean, these included night cleaning duties and cleaning schedules for bathrooms and sanitising cleaning tools such as mop heads. Cross contamination guidelines were on display in the kitchen and food items were labelled with the date they had been opened and when they were to be used by.

Current certificates were seen for gas safety, electrical safety, emergency lighting and fire alarms. Fire risk assessments had been completed for bedrooms and communal areas. Fire alarms and emergency lighting were tested on a regular basis and food temperature checks and water temperature checks were completed as and when required.

Good

Is the service effective?

Our findings

People using the service were supported by staff who received regular training to enable them to meet people's needs effectively.

Relatives told us that staff were appropriately trained to support their family members. One relative said, "All the staff are trained, they are great." Another said, "At 185 all new staff are given a thorough induction so that they understand the needs of each resident. This induction includes shadowing staff with [my family member] before they work with them alone. This has proved to be very effective."

Staff told us, "Induction was good, part of it was reading care plans, the communication profiles and shadowing. I was invited to visit before the induction" and "The training is good, we get an email reminding us to update the training."

New staff completed the Care Certificate as part of their induction. The Care Certificate is an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new support workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. Before being offered work, support workers visited the service which helped to ensure they had a good understanding of the role and the people they would potentially be supporting.

The registered manager showed us an induction folder that was given to new starters. This included a guide to the service, their principles, an introduction sheet for all of the people and their learning disability diagnosis, its impact and important strategies to support people and their known behaviours. It also contained details of their personal care and meal time support needs.

We spoke with the provider organisation's head of resources who explained that training was a mixture of training, e-learning, case studies and classroom based training. The provider had an effective system for monitoring training for staff which helped to ensure they were all current. All staff had received training that enabled them to meet people's needs , this included mandatory training in safeguarding, medicines and first aid and more specialised training in epilepsy awareness and proactive methods for managing behaviour that challenges.

Supervision sessions were called reflective practice meetings, these focussed on progress on actions from previous meetings, line manager's reflection and evaluation, team working, health and wellbeing.

There was evidence that the provider worked within and across organisations to deliver effective support. A health professional said, "They assess service users based on need and consider their current vacancies they have with the mix of service users and their needs in that service."
A Positive Behaviour Support (PBS) analyst worked with the service to develop positive behaviour support plans for people. A quality of life lead worked closely with the PBS analyst focussing on people's quality of life and how this could be enhanced. There was also a group manager for the provider organisation who

was responsible for overseeing four services and coordinating best practice and ideas across services.

A thorough assessment process was in place when people first came to use the service. This included reviewing the person's previous placement reports. The PBS analyst and the Head of Operations were heavily involved in this process, visiting people in their existing home and completing detailed reports. Thorough assessments were completed by the Head of Operations and the positive behaviour support consultant prior to people moving in. Detailed informative reports were produced around people's behaviour which was observed in the placements, discussions took place with relevant people including family members and healthcare professionals. The assessment included a behaviour functional assessment, communications, race, culture, religion, learning disability, mental health, daily living skills and social skills.

We asked people and their relatives if they received appropriate support with meals. One person said, "Staff help me [to prepare food]." A relative told us, "They always cook fresh food." Another relative gave an example where their family member was supported by the service to lose some weight and maintain a healthy lifestyle through the input of a dietitian and a healthy diet. Staff supported this person by helping them to maintain healthy eating habits and producing a healthy meals options menu.

People's likes and dislikes were on display in the staff office along with menu choices. The kitchen was well stocked with food and snacks. We observed staff supporting people with their meals and snacks throughout the inspection in an engaging manner.

There was evidence in care plans of appointments that people had in relation to their health and correspondence with health professionals and discharge reports. Staff were aware of people's disability and their health care needs. A health professional feedback that the provider "Has a good understanding of mental health and how to manage this, we have a very good relationship with them."

People using the service had epilepsy care plans in place with descriptions of their seizures. A relative said, "Their understanding of our [family member's] medical needs is very good indeed. Very detailed records are kept regarding [their] seizures and behaviour, both of which interlink."

People that needed them had crisis plans which documented what they were like when they were feeling well, signs that things were breaking down and a crisis was looming and symptoms indicating that they were in crisis. This helped staff to support them through crises and respond in appropriate, consistent ways.

People had shared care plans or health action plans in place which had details about their health and how they were to be supported. In one of the records we saw, although the registered manager told us this person's family managed their health needs, the person did not have a shared care plan or a health action plan in place. Their hospital passport had last been reviewed in January 2015. We fed this back to the registered manager on the day of the inspection.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

All but one of the people using the service were subject to a DoLS due to restrictions on their access to the

community and because they were assessed as not having the capacity to consent to their care. One person who was deemed to have capacity lived in a separate flat with their own door key. Staff demonstrated that they understood the purpose of the MCA, telling us "The MCA is used to support residents and help them to make decisions if they don't have capacity" and "We always give them a choice." One support worker gave an example of where a person using the service was supported by an advocate when their family was not available.

There was evidence in the care plans that decisions related to people's care and treatment were taken in consultation with health professionals and other stakeholders in people's best interests.

Good

Is the service caring?

Our findings

People told us that staff were caring and friendly. Comments included, "I like it here, everyone is nice to me", "I do enjoy it here" and "They staff are friendly and talkative." Relatives also told us they were happy with the staff and the service. Comments included, "[My family member] is very happy, you can always tell", "[My relative] is very happy", "The staff here are always very accommodating", "Staff are fantastic" and "Can't fault them." We saw comments in quality assurance feedback from relatives that they felt people were treated with kindness and compassion.

There was a homely atmosphere at the service and it was clear from our observations that support workers had built up close relationships with people using the service. This was reflected in comments we received from relatives of people using the service. They told us, "[My Family member] has two homes", "Happier here that when [they're] at home" and "When we pick [family member] up - [they] want to go back there which says it all." Staff demonstrated a detailed knowledge of people's likes and dislikes and how they liked to spend their day. When people came to the office or spent time with staff in the communal areas, we observed support workers acting respectfully towards them, speaking to them in a polite and easy going manner.

Support workers respected people's choices and supported them to make informed choices. People had communication profiles in place with details of how they communicated, what they could understand and how staff could help them to communicate. Support workers demonstrated that they could put these into practice and we saw them communicating with people effectively, speaking to them in a way that they understood. We also observed the registered manager communicating with a person using Makaton. Staff were aware of people's behaviour patterns and how they expressed themselves when they were happy or not.

The service respected people's culture and religion. People's religious and cultural needs were documented in their care records and there was evidence that this took place in practice. The provider stored and cooked food separately for one person using the service to ensure their religious rights were respected.

People were supported to express their views and be involved in decisions related to their care.
People were offered a choice in menu planning, some people had a visual timetable of activities enabling them to pick and choose their activities of choice.

The provider promoted people's independence. One person using the service told us, "I do my own laundry, sometimes I need help to hoover my flat." Relatives said, "[My family member] has improved greatly, [they] dress [themselves] which [they] never used to do before." People had long and short term targets and session plans which were used to promote people's independence and daily living skills.

Good

Is the service responsive?

Our findings

People using the service said, "I do card making", "I'm meeting my friend for lunch", "I'm going DJ'ing on Thursday", "I like it here" and "I go out shopping." Relatives said, "[My relative] is learning all the time", "[My relative] leads a very active lifestyle" and "[My relative] has a full plan of activities."

Individual activity charts were on display for each person using the service, support workers had AM and PM weekly planners with details of people they would be supporting that week. Staff were aware of people's preferences and how they liked to spend their day. We observed staff supporting people to take part in activities of daily living. The provider was proactive in looking at a variety of activities to suit people's individual needs. It had arranged autism friendly film screenings specifically for people across all their services at Shepperton studios.

One health professional said, "We have a very positive relationship with all the staff teams we work with. LCP support some of our most challenging young people in extremely high quality and responsive services." Another said, "Thank you for all your teams' efforts in supported an extremely challenging young [person] through a very difficult period. You and your staff have gone above and beyond to try and ensure that they have had the best chance at living and being supported in the community."

Care records were comprehensive in scope and included a working file, communication profiles, daily records, behavioural, accident/incident file and personal goal monitoring. Care plans had been reviewed recently and were based around people's individual needs. Each support plan had details of the support needed and what actions were to be taken to meet the support needs.

A positive behaviour support (PBS) analyst was responsible for assessing each person and producing Person-Centred Positive Behaviour Support Plans. These support plans included a description of behaviours, why the behaviours occurred, antecedents, triggers and proactive and reactive strategies for staff to support the person to manage the behaviours. Each person was given a rating of blue, green, amber or red based on the frequency and severity of their behaviours' patterns. The blue category was for people in transition or with frequently changing needs. They were given additional support from the PBS analyst or the 'quality of life' lead based on their rating. Behaviour monitoring charts were completed by staff and the data shared with the PBS analyst to monitor their behaviour and provide the appropriate level of support. For example, we saw an example where a person was referred to a psychiatrist as a result of their behaviour monitoring. A health professional praised the service for the quality of their behaviour monitoring records and said the data received from the service allowed them to monitor behaviour effectively which in turn meant that people's quality of life had improved.

The registered manager showed us some 'impact cards' which showed the significant improvement in people's quality of life and their level of engagement since they moved into the service. Having read these, they clearly demonstrated the improvement in people's lives since they moved into the service. For example, one person had spent Christmas Eve and Christmas Day with their family without staff support for the first time since he moved into Arabella Drive seven years ago. Another person had just set up their own

enterprise of baking and selling shortbread biscuits with support from the staff.

The registered manager explained that people had long and short term targets which were based on an initial Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis when someone first moved into the service and covered aspects of a person's life in the following areas: domestic, personal care, community and social and fun. They said they were reviewed by the keyworkers in three monthly keyworker meetings. However, we saw that on occasion the key worker meetings were not taking place with that regularity. One person had a key worker review in December 2017 but the one prior to that was June 2015. In another person's file the long and short term targets had been reviewed in February 2017 and their key worker meetings dates had taken place on 6 January 2016, 2 September 2016, 29 November 2016, 22 February 2017 and 25 October 2017. We recommend the provider looks at reviewing its key work sessions to make them appropriate to meet the needs of people using the service.

The registered manager said session plans were used to teach any gaps in skills and were used to work towards the targets. Session plans were also in place for people, these were tasks for people to focus on to maximise their independence, for example to dress independently. Some of these were not reviewed, in one care plan these were last completed in January 2015.

As part of the provider's skill development and session planning process, two people from Arabella drive were selected for a trial 'skill development workshop'. The sessions were created and run by an experienced staff member with a personal passion for autism and a background as an activity coordinator in day centres. This skills workshop was designed for people with particular skill deficits in communication and social understanding and the aims were to develop interpersonal skills including and build positive relationships with peers, staff and the wider community. Following the success of the trial, the provider agreed to implement it as a permanent service based provision starting in spring 2018.

The provider identified and met the information and communication needs of people with a disability or sensory loss. A sensory assessment tool was completed for people covering a range of areas such as smell, taste, vision, sounds, touch and movement. This was then used to create a sensory profile with guidance for staff on how they could support people in these areas proactively.

'The Quality Action Group (QA) chaired by the quality of life lead was responsible for identifying and acting upon service-wide needs and had been involved recently in the development and roll out of a relationships and sexual education training package to meet the needs of people using the service.'

People and their relatives told us they had never raised a formal complaint but were sure the provider would listen and act on any concerns raised. A relative said, "Any issues you can approach the managers."

The principles of good complaint handling from The Parliamentary and Health Service Ombudsman and Local Government Ombudsman were included in the complaints folder.

The provider maintained a comments and complaints log. There had been no formal complaints, but we saw evidence where a relative had raised concerns regarding their family members support the provider took action to the satisfaction of the complainant.

Good

Is the service well-led?

Our findings

Relatives praised the open culture of the service, telling us that they were able to voice their opinions which they felt were valued. They told us, "They set a high standard", "Always open to new ideas", "They communicate all the time", "Very open", "They have been brilliant", "We consider the leadership and management provided by LCP to be outstanding", and "We have a high opinion of the staff at LCP, starting right at the top with [The Director] and moving down through all levels in head office and at 185 Arabella Drive."

The provider continued to demonstrate its commitment to ensuring the staff team were happy and well supported. Staff told us they really enjoyed working at the service and felt valued by the management team. The core values of the service were CARE - collaboration, accountability, responsiveness and excellence. The provider organisation's head of resources emphasised that staff were recruited based on these values using a 'values based recruitment' approach which evaluates the applicant's core values rather than their experiences. New employees had to demonstrate these values within the interview process.

London Care Partnership had achieved 'silver' status from Investors in People (IIP) since our last inspection of Arabella Drive. The IIP Standard is the benchmark of good people management practice. Organisations are assessed on how closely they meet three criteria through a performance model of progression. Some of the feedback in the IIP report included, "The owners and leadership team are committed to people development and to embedding a people-oriented culture throughout head office and the homes." The report also said, "The organisation tries hard to 'live out' its values and people culture and be portrayed as a good place to work, and overall there is an honest and open relationship culture operating throughout."

The service continued its practice of internal promotion through its management academy which identified 'top talent' within the company. The registered manager of the service had worked in the service for a number of years and was a team leader before being promoted to registered manager. Staff were given the opportunity to progress within the company. New positions had been created as the provider organisation had grown, the quality of life lead position had been created as a result of the expansion in remit of the scope of the previous quality lead. This position was created to focus on improving outcomes for people to ensure they continued to lead a fulfilling life.

Staff meeting agendas were on display in the staff room, staff were given the opportunity to write down and points of discussion on the agenda prior to the meeting. Staff told us, "We discuss general topics, they ask for your opinion." We observed a handover between morning and evening shift, discussions took place about each individual person and upcoming events. Exit interviews were held with staff when they left with the aim of improving in future including improving the induction for new staff.

We saw correspondence from healthcare professionals praising staff for following their guidance and the positive impact this had on people using the service. One health professional said, "We have commissioned many placements from LCP over the years and my experience with them is always positive."

The service had maintained their autism accreditation by the National Autistic Society. Autism Accreditation is an internationally recognised process of support and development for all those providing services to autistic people. In order to achieve accreditation, the provider demonstrated its expertise in the understanding of autism.

Quality assurance and governance systems used to drive improvement. However, they did not always identify some deficiencies in recording, for example the gaps we found in the frequency of keyworker reviews and session reviews.

A Quality Action Group (QAG) chaired by the quality of life lead and attended by the registered managers and team leaders met every two months. We reviewed the minutes from the meeting and saw a wide range of issues had been discussed including Positive Behaviour Support plans, activities, session planning. The group's recent focus had been on supporting people to meet their sexual needs. This was set up due to the relatively young client group for whom relationships and sexuality were key areas.

A waking night quality assurance visit was completed in October 2017. Monthly general documentation auditing took place looking at health and safety checks, cleaning checklist, health and safety certificates, medication, training and rotas.

The quality of life coordinator and the Head of Operations were due to start doing some more auditing of groups of homes to draw out improvements that could be implemented across services. In addition, quarterly audits continued to take place. Audits were due to start around the key questions that CQC looks at during inspections.

Relatives were asked to feedback about the service in a format based on the five key questions of CQC methodology. We reviewed some of these forms and saw the feedback was overwhelmingly positive.

The provider organisation was one of the participating members of the Outstanding Society where outstanding providers meet to share their good practice. They also attended learning disability provider forums.