Sense

SENSE - Hyde Close Flats

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement

Overall summary

We carried out an unannounced inspection of this service on the 19 November 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements for breaches of Regulations 12 and Regulation18 of the Health and Social Care Act (Regulated Activities) Regulation 2014 in respect of risk assessment and staff training.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hyde Close Flats on our website at www.cqc.org.uk

Hyde Close Flats provides accommodation with personal care for up to 20 people who have physical and complex learning disabilities and sensory impairment. At the time of our inspection there were 14 people living at the home. The service is situated in High Barnet, in a residential area, close to shops and other local amenities. The service consists of four flats, three with five bedrooms and a bedsit for one person.

At the time of our inspection the service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in March/April 2015 we found the provider had made several improvements to the service. However, we found breaches relating to staff training and understanding in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and risk assessments

Summary of findings

were required for people at risk of self-harm. Staff training in areas such as Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLS) had not taken place for most staff for more than five years. Staff had limited knowledge of the MCA and DoLS and the impact of this on the people they cared for. We made recommendations about the management of and learning from incidents and Health Action Plans (HAPs).

We asked the provider to take action to make improvements. We received an action plan from the provider stating that these actions would be completed by end of July 2015. We saw that most of these actions had been completed.

During this inspection we found that the provider had made some improvements as outlined in their action plan. We saw that a number of changes had been made in response to DoLS. The main door entry system had been replaced with an automatic door system, enabling peoples' independence when entering and leaving the building, unit doors were no longer kept locked and people were encouraged to freely walk around the home with staff support. Health action plans and hospital passports were in place for everyone living at the home and most staff had received refresher training in the MCA and DoLS.

We made recommendations about assessing adults at risk of self-harm and assessing fire risk.

Some staff had not received supervision for seven months. Staff told us that this was due to some of the changes required to improve the service.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see at the back of this report what action we asked the provider to take.

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. We found that action had been taken to improve safety. Systems were in place for recording incidents and accidents. However, the outcomes and learning from these had not been recorded.

We could not improve the rating for 'Is the service safe?' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Requires improvement

Is the service effective?

We found that action had been taken to improve effectiveness. We found the provider had implemented Health Action Plans and Hospital Passports for people living at the home. However, some staff had not received supervision since April 2015 due to the changes in management.

Changes were made to the environment to make it safe for people to freely move around with minimal restrictions. Staff understood the MCA and DoLS most staff had received refresher training in this area.

We could not improve the rating for 'Is the service effective?' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Requires improvement

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Detailed findings

Background to this inspection

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

We undertook unannounced focused inspection of Hyde Close Flats on 19 November 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our April 2015 comprehensive inspection had been made.

The inspection was undertaken by an inspector. We inspected the service against two of the five questions we asked about the service: Is the service safe? and Is the service effective?

Prior to the inspection we gathered and reviewed information we held about the service, this included notifications received by the service and other information of concern, including safeguarding notifications.

We spoke with five staff, including the care manager, support workers and service administrator. We also contacted the local authority who informed us that they had been working with the service to develop their Health Action Plans and hospital passports. We reviewed care records for seven people using the service. This included records relating to peoples' health, including Health Action Plans and hospital passports.

Requires improvement

Is the service safe?

Our findings

At our last inspection in May 2015 we found risk assessments had not been carried out for two people who were prone to self-harm. Therefore this put people at risk of receiving care that was inappropriate and did not meet their needs. The registered manager for the service at the time told us that this was an area for improvement which was on their list of areas to be addressed by the service. Seven out of the eight care records reviewed did not have hospital passports. Therefore, this put people at risk of not receiving the appropriate care and treatment in the event of an emergency or hospital admission. There was no centralised system for recording incidents and we were unable to identify any learning taking place. We made recommendations that the service seek advice and guidance from a reputable source, about the management of and learning from incidents.

During this inspection we found the provider had made some improvements. We saw that hospital passports were in place for people using the service. These were kept in separate red folders for each person and provided staff with immediate access to information in the event of an emergency. Staff told us that having the information available made it easier for them to provide the information needed when supporting people to attend hospital.

Incident forms were centralised and kept in the office accessible to staff. The care manager told us these were recorded using the organisation's online system and a paper copy kept on the file. We were shown a sample of incidents and accidents forms which included, steps taken to prevent recurrence and investigating managers comments. We found that these sections were not completed therefore we were unable to confirm whether there was any learning from incidents. The care manager told us that this is an area where further improvements, including the need to analyse incidents where repeated patterns had been noted.

The provider action plan stated that risk assessments for people at risk of self-harm would be completed by end of July 2015 and reviewed in a further six months. At this inspection we found that these risk assessments were not in place. We were shown behavioural guidelines for one person which was dated 2014. Following our inspection the registered manager confirmed that a new risk assessment had been completed for one person identified by the service as being at risk of self-harm. We saw that a fire risk assessment had been completed by the landlord in May 2015 had identified a number of actions to be completed. All these actions had been assessed as being high risk. We saw that some of these actions had been completed, but some actions were yet to be completed. During our inspection we were provided with a copy of an email sent to the relevant department to request an update.

We recommend that the service review best practice guidance on assessing risk, particularly around adults who self-harm and assessing fire risk.

Requires improvement

Is the service effective?

Our findings

At our last inspection in May 2015 we found that although the manager and some staff had a good understanding and knowledge about the Mental Capacity Act 2005 (MCA), we found most staff did not have an understanding about the implications of the MCA and DoLS for the people living at the service. Most staff had last received MCA training between 2008 and 2012. All staff expressed a need for refresher training in the MCA and DoLS. The manager at the time of our inspection told us that this had been identified as a gap and would be seeking further training in this area. Supervision had not taken place for some staff in 2014. Doors were kept locked and people were not able to freely move around the service. We made recommendations that the service consider Department of Health guidance on the use of Health Action Plans (HAPs).

During this inspection we found that the provider had made improvements to the environment to enable independence and allow people to freely move around the service. This included changes made to the main front door which had been replaced with an automatic door entry system. The care manager told us that these changes meant that people could be encouraged to use the new door entry system when entering and leaving the building with support from staff. In one unit were people were not able to access their rooms due to one person, the service had introduced a key system to allow people to access their rooms when they wanted to. Other options were being explored by the provider, which included a fob system.

We saw that HAPs were in place for people using the service. This information was kept in a separate file and was accessible to all staff. This ensured that staff had access to up to date information about people's health needs. We noted that although the files contained information about people's health needs follow up information regarding appointments attended or planned were documented in different sections within people's HAP. The care manager who was present at the time told us that this would be addressed with staff to ensure consistency across the service.

We were provided with an up to date staff training matrix. Staff had completed training in the MCA and DoLS. All had completed on-line training and some had attended a two day MCA training course, with some due to attend the next training course. Staff confirmed that they had completed a questionnaire in MCA and DoLS as part of their training. Staff told us that the training had helped them to better understand people's needs in relation to capacity and decision making. We saw that the care manager had made reference to MCA and DoLS in a July 2015 team meeting. During our visit we spoke with the practice consultant for deaf and blindness who told us that she had developed a modular training pack for staff focusing on person centred active support. This covered areas such as, what person centred support looks like and values. Staff in one unit confirmed that they had attended this training and completed some of the modules.

During this inspection we also reviewed staff supervision and found a number of gaps. We reviewed supervision matrix provided by the care manager. This showed that some staff had not received supervision since April 2015. Staff told us that although there had been improvements since the current manager started, supervision had not been regularly undertaken due to all the changes taking place at the service. Therefore staff may not have received appropriate support to enable them to effectively perform their duties. The care manager told us that supervision should take place two monthly and they had not taken place for some staff due to staff absence and the service having to concentrate on other aspects of service improvements. Following our inspection we spoke with the registered manager who told us that supervision for other staff had taken place.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person failed to ensure that staff received appropriate supervision as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (1) (a)