The Westminster Society For People With Learning Disabilities

Kingsbridge Road

Inspection report

20 Kingsbridge Road
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Ratings

Overall rating for this service	Good

Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 24 and 27 May 2016. Breaches of legal requirements were found regarding safe care and treatment and consent. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

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 Kingsbridge Road on our website at www.cqc.org.uk.

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.

At our previous inspection we found that the provider was not carrying out satisfactory health and safety checks and was failing to assess people's capacity to make decisions about their care. We found that the provider was now meeting these requirements. Health and safety checks were taking place regularly with clear guidelines for staff and oversight by managers. Where checks had highlighted issues, these were followed up by the registered manager. The provider had taken steps to ensure that these took place by including these in shift plans, carrying out monthly and quarterly audits and clarifying responsibilities amongst staff.

The provider was acting in line with the Mental Capacity Act (2005) by carrying out assessments of people's capacity to consent to their care. A new support plan had been devised which would help to ensure that everyone's capacity was considered, but this was not in place for everyone who used the service. Where people could not sign their plans, the provider recorded discussions which had taken place with people to support them to understand decisions and to consent to their care. Where people were not able to consent to their care, the provider held meetings to ensure that they were working in people's best interests.

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 was safe. We found that action had been taken to improve health and safety checks and ensure these were carried out regularly.

The provider was carrying out regular checks on fridge and freezer temperatures and regular maintenance on the water supply.

Is the service effective?

Requires Improvement

We found that action had been taken to improve effectiveness. The provider had taken appropriate measures to assess people's capacity to make decisions in line with the Mental Capacity Act (2005).

We could not improve the rating for effective from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Kingsbridge Road

Detailed findings

Background to this inspection

We undertook an announced focused inspection of Kingsbridge Road on 7 November 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection on 24 and 27 May 2016 had been made. We inspected the service against two of the five questions we ask about services: Is the service safe and is the service effective? This is because the service was not meeting some legal requirements.

The inspection was undertaken by a single inspector. During our inspection we spoke with the Registered Manager, the service manager, two team managers and a person who used the service. We carried out observations of care and of the building and looked at records relating to health and safety. We reviewed the care records relating to capacity and consent of six people.

Good

Is the service safe?

Our findings

At our last inspection in May 2016 we found that checks to ensure the building was safe were not adequate. This was because the provider was not safely storing food or undertaking regular checks of fridge and freezer temperatures. We also found that the provider was not regularly checking that the water supply was safe.

At this inspection we found that improvements had been made.

We reviewed all checks carried out in this area since our last inspection. Fridges were clean with clear 'fridge rules' displayed on the front. Food was stored in appropriate containers that were labelled with the date they had been opened to ensure that staff knew when food was no longer safe to eat. There were guidelines displayed for staff on safe fridge and freezer temperature ranges, and these were checked on a daily basis by staff. Where temperatures were outside of these acceptable ranges, these had been reported to managers and appropriate action taken, such as replacing the thermometer.

Water temperature checks were being carried out weekly with clear guidelines for staff to follow which were particular to the type of outlet they were checking. Guidance on what were safe temperatures was available. Where temperatures were recorded as being outside of this range, staff had taken appropriate action such as reporting these to the building maintenance team. There was also guidance for staff on how to flush disused water outlets in order to manage the risk of legionella, and this was taking place regularly.

Records of these actions were checked by team leaders, and any anomalous readings were marked with appropriate action taken.

Systems were in place to ensure that these checks were carried out, for example fridge freezer temperature checks and cleaning were recorded in the daily shift plan, and staff responsibilities in this area had been discussed and clearly set out in team meetings. The provider arranged for external audits which took place quarterly, and these had noted that there was a clear improvement in this area.

We have improved the rating for this question from requires improvement to good because we found that concerns had been addressed and sustained over a period of time.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in May 2016 we found that the provider had not taken adequate steps to assess people's capacity to make decisions under the Mental Capacity Act (2005).

At this inspection, we saw that the provider was now meeting this requirement.

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.

All files we reviewed showed evidence that people's capacity to make decisions about their care had been considered and assessed. In some cases the provider had worked with other professionals such as social workers to do this. The provider had also recorded discussions with people about their ability to make decisions about sharing information about them. These recorded the steps staff had taken to support the person to understand the decision and whether this had helped the person. However, we found that in some cases these had been copied and pasted from discussions with other people who used the service and these discussions did not extend to other areas of their care, meaning that these were not always sufficient to evidence people's capacity.

In one case, a person with capacity was not able to sign their support plan due to a physical disability, and staff had recorded that they had discussed the plan with the person in order to obtain their consent. This showed that appropriate steps had been taken to obtain their consent. Where people did not have capacity to make decisions about their care, the provider had taken steps to ensure that they were working in the person's best interests, for example by recording best interests meetings with family and other professionals and through regular "Circle of Support" meetings, where aspects of the person's care were discussed between the person, staff and family members.

The registered manager told us that assessing and recording people's capacity was "a work in progress." We saw a new support plan for one person which showed detailed information of a person's ability to make decisions in certain areas, but this had not yet been put in place for everybody.

Although we found that concerns had been addressed, work was still in progress and sufficient time had not passed to assure us that these improvements could be sustained. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained.