

Islington Social Services

Islington Social Services - 28a King Henry Walk

Inspection report

Islington Council Housing and Adult Social Services
Department
28a King Henry Walk
London
N1 4PB

Tel: 02075278843

Website: www.islington.gov.uk

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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

28a King Henry Walk is a home providing respite residential care and support for up to 10 people with learning disabilities and other complex needs. Over 50 people use the service for short stays, although in emergencies two of the home's ten beds are kept available to offer urgent placements. The service is run by Islington Council social services department.

This inspection took place on 31 March 2016 and was unannounced. At our previous inspection on 19 May 2014 we found that the service was meeting the regulations we looked at.

At the time of our inspection a registered manager was not employed at the service, the previous registered manager having left in August 2015. However, the current acting manager informed us that they have begun the application to register and were compiling additional information required for the application. 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.

The service is owned and run by the London Borough of Islington and used the authority's borough wide safeguarding vulnerable adults from abuse procedures. The five members of care staff we spoke with said that they had training about protecting people from abuse. Training records we looked at also confirmed this. We found that staff had a good understanding of how to keep people safe from harm and recognised potential harm issues related to people's unique needs.

We saw that risks assessments concerning people's day to day support needs healthcare conditions and risks associated with daily living and activities were detailed, and were regularly reviewed. The instructions for staff were clear. These instructions informed staff about actions to be taken to reduce these risks and how to respond if new risks emerged.

There were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected. The service was applying MCA and DoLS safeguards appropriately and making the necessary applications for assessments when these were required and informing the CQC when DoLS approvals had been granted.

We found that people's health care needs were assessed. Care was planned and delivered in a consistent way and the service had good procedures in place to plan for every stay that people had at the service. We found that the information and guidance provided to staff was clear.

The care plans we looked at showed that staff had developed methods of communication best suited to people's needs. The care plans described how they could ascertain each person's wishes to maximise

opportunities for people to make as many choices that they were meaningfully able to make. We saw that staff were respectful towards people and knew how best to interact with each person.

The service complied with the provider's requirement to carry out regular audits of all aspects of the service. The provider carried out regular reviews of the service and sought people's feedback on how the service operated.

At this inspection we found that the service met all of the regulations we looked at.

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. People's personal safety and any risks associated with their care were identified and reviewed.

The local authority that operated the service had systems in place to ensure that recruitment of staff was safe.

Where temporary staff were used, the service verified that they were safe before permitting them to work with people.

Is the service effective?

Good ●

The service was effective. Staff received regular training and supervision as well as appraisals.

There was clear knowledge about how to assess and monitor people's capacity to make decisions about their own care and support.

People were provided with a healthy and balanced diet which took account of their own preferences and allowed for choice.

Healthcare needs were responded to with any changes to each person's health being identified and acted upon.

Is the service caring?

Good ●

The service was caring. Staff were observed interacting with people in a way that showed they treated each person as individuals and they demonstrated concern for people's well-being.

Staff had a good knowledge of people's unique characters and personalities, as well as their understanding of how to communicate and ascertain people's wants and needs.

Is the service responsive?

Good ●

The service was responsive. We found that people were actively engaged in making as many decisions about their care as far as they were able to. This included the involvement of relatives and other professionals where people needed this to happen.

Complaints and concerns were listened to and acted upon.

Is the service well-led?

Good ●

The service was well led. Many of the staff team had worked at the home for a number of years and those we spoke with felt that the service was well managed and organised.

The provider had a system for monitoring the quality of care. The service sought feedback from people using the service where possible, families and health and social care professionals and acted on this feedback.

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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.

This inspection was unannounced which meant the provider and staff did not know we were coming. The inspection took place on 31 March 2016 and was carried out by one inspector.

Before the inspection we looked at notifications that we had received and communications with people, their relatives and other professionals, such as the local authority safeguarding and commissioning teams as well as other health and social care professionals.

We used a number of different methods to help us understand the experiences of people using the service. The people using the service had complex needs and for some people there was limited or no conversational communication which meant that not everyone was able to tell us their views. We gathered evidence of people's experiences by talking with two people and by observing interactions with staff and by reviewing communication that staff had with people's families, advocates and other care professionals. We also spoke with the acting manager, deputy manager, care co-ordinator and five members of the staff team.

As part of this inspection we reviewed four people's care plans. We looked at the medicines management, training, appraisal and supervision records for the staff team. We reviewed other records such as complaints information, quality monitoring and audit information, maintenance, safety and fire records.

Is the service safe?

Our findings

The five members of care staff we spoke with said that they had training about protecting vulnerable adults from abuse and were able to describe the action that they would take if a concern arose. It was the policy of the provider to ensure that staff had initial safeguarding induction training when they started to work at the service, which was then followed up with periodic refresher training. Our review of staff training for the whole staff team confirmed that this training did occur.

The service had access to the organisational policy and procedure for protection of people from abuse. The service was owned and run by the London Borough of Islington and used the authority's borough wide safeguarding procedures.

The authority had procedures for the safe recruitment of staff. These procedures included background checks, employment history, references and qualifications (where relevant) all having been verified. The acting manager showed us confirmation that these checks had occurred and the authority had a procedure for renewing these checks for criminal records every three years.

Our review of the staff rota and deployment of staff around the home showed there were enough staff on duty to give people individual attention and meet their care and support needs, with one to one support being offered to some people. Apart from the permanent staff team there were bank and agency staff also used depending on who was staying at the service on any given day. This showed that support was provided flexibly in response to people's needs.

People's needs were assessed taking into consideration general and specific risks. For example, we found risk assessments in people's care plan files that covered areas such as physical condition (including epilepsy), activities and signs that show that someone may be becoming unwell. We saw clear and detailed examples of how these assessments were tailored to each person as well as risks that were common for all people, for example people's daily activities in the home or outside and using facilities in the community. We found risk assessments were being reviewed yearly but were also discussed and updated as necessary when planning for people's stay.

We spoke with one member of staff regarding the process for handling and administering medicine and they were able to tell us in detail about the procedures. Staff were seen to verify what people's current medicine needs were at the time that people came to stay at the service. All prescribed medicines were available at the home on the day of our inspection visit. We found no gaps in the recording of when medicines were given to people. Staff signed the records by way of using their initials to show who had administered people's medicines. Two staff were always required to administer medicines as this was a safeguard used by the service to minimise any potential errors and subsequent risk.

Guidance was available to staff about medicines policy, procedure and practice. Guidelines were also available for each person who may require emergency medication, for example if suffering from repeated epileptic seizures.

The provider had arrangements in place to deal with emergencies related to people's individual's needs, or common potential emergencies such as risk of fire or other environmental health and safety issues. Fire alarms were tested regularly and other safety checks, for example gas and electrical safety, were being carried out.

Is the service effective?

Our findings

The service kept records that showed which training courses staff had completed, and when they did them. We looked at these records and saw that staff attended regular training updates which included refresher training on standard core skills that staff were required to have. The five care staff we spoke with had a positive view of the way in which they were trained and supported to do their work. They told us, "I have supervision every four to six weeks", "I think we talk about issues well", "I think we make a good difference to people's lives" and "I have had an appraisal and the process is fair."

The provider had systems in place to ensure that staff training was kept current and up to date. Where staff were about to, or had exceeded, the necessary timescale for refresher training this was flagged up by the provider's training department and action was taken to ensure that staff attended the required courses. We found that this system worked well.

When we asked staff about supervision meetings staff all said they happened roughly every four to six weeks. Records we looked at confirmed this and also that an annual appraisal system was in place.

We attended the afternoon staff shift handover. We found that staff shared relevant information about what support had been provided to people on the early shift, who would be using the service for the rest of the day and overnight and planned how the support would be managed. This showed that staff planned their work and tailored this to the needs of each person who used the service, which changed daily.

We found that there was evidence of the home obtaining people's signed consent where possible which we saw on care plans we viewed, or more usually consent agreed by a relative or advocate.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

All of the staff we spoke with had a good knowledge of their responsibilities under the Mental Capacity Act (MCA) 2005. Staff were also aware of the Deprivation of Liberty Safeguards (DoLS). The staff we spoke with were able to tell us what this meant in terms of their day to day care and support for people. Where DoLS decisions had been made the records reflected this and included the authorisation that had been granted to restrict a person's liberty and when these authorisations were due to be reviewed and reapplied for if

required.

Breakfast and lunches were prepared by staff. People could choose before each meal what they wanted. People were often out during the day at day centre's or colleges so lunch was often taken elsewhere.

A chef worked from mid-afternoon most weekdays and prepared the evening meal. The chef offered evening meal choices each day and the menus were based on who would be staying each evening and their preferences and dietary needs.

People were supported to maintain good health. As a part of the booking procedure for short stays, people's health care needs were discussed in case there had been any changes which the service needed to be aware of. Where required, the home also had health action plans for people and not least where they had complex physical healthcare support needs. The community nursing service also visited to attend to people that required any nursing procedure to be carried out or to administer specific medicines that were necessary, for example, medicines needing to be administered via a peg (this is a feeding tube that is used for people who have swallowing difficulties).

Is the service caring?

Our findings

The two people who spoke with us told us about their activities and what they had been doing during the day and what they had planned for the evening. People were unable to answer complex questions, however, we also saw that they had no hesitation when approaching staff and engaging with them. Our observations of other people with limited or no verbal communication showed that staff used different approaches with each person and were able to tailor their interactions which recognised people's unique personality.

Staff were able to tell us about people's communication needs and all the methods used and were aware of how best to communicate with each person. We observed this on different occasions and saw that staff communicated well with people and understood what each person's responses meant.

The provider had organised training in 'PROACT SCIP' (Positive Range of Options to Avoid Crisis and use Therapy Strategies for Crisis Intervention and Prevention). Our observations and conversations with staff showed that people were supported to be as much involved in their care as they could meaningfully be and were meaningfully able to do.

People's individual care plans included information about their cultural and religious heritage, daily activities, including leisure time activities, communication and guidance about how personal care should be provided. We found that staff knew about people's unique heritage and had care plan's which described what should be done to respect and involve people in maintaining their individuality and beliefs. An agency member of staff, when informed of who they would be allocated to work with, was asked if they knew the person and the confirmed that they did. This showed that the service considered who was best able to provide support.

We found, by looking at care plans that relatives, where they were involved, had been included in their family member's decision making as had associated professionals. Where people did not have family members who could do this an advocacy service was used.

People's independence was promoted. On the day of the inspection there were ten people using the service. We saw that staff were engaging well with people to welcome them to the home whether they had just arrived to stay or had already been staying the previous day and to plan for the evening.

Is the service responsive?

Our findings

Care plans covered personal, physical, social and emotional support needs. Care plans were checked and updated if necessary before each person's planned stay to ensure that information remained accurate and reflected each person's current care and support needs. This meant that staff on different shifts had this information readily available and could plan the support they provided to meet each person's needs.

We asked staff what they did to ensure personalised care. Staff were able to tell us about their knowledge of people who had been staying or were about to arrive for their stay and how they organised staff support for them. We observed a lot of conversation between staff about what they were doing and who needed what support and when. We asked specific questions about individual people and staff demonstrated a clear knowledge of how to provide focused support to meet their needs. This meant that people's needs were assessed and their care was planned and delivered in line with their individual care plan.

The vast majority of the people who used the service lived with family members. Staff were able to demonstrate how the service supported people to maintain relationships even during their stay and regular communication was made with families as and when necessary. During our visit we saw that a relative had come with someone being admitted for their short stay and worked with care staff to ensure the person was settled in.

The complaints system allowed people to make a complaint to anyone working at the home or to the provider directly. The complaints information gave details about what action would be taken to resolve a complaint, who would take the action and what people could do if they remained dissatisfied with how their complaint had been handled. We looked at the complaints record for the last four months and the two that had been made were resolved. The provider monitors the complaints received in order to identify any trends that may emerge and learning points to be taken forward. There were no current concerning trends from the complaints received and it was positive to note that a mechanism for monitoring any trends was in place.

Is the service well-led?

Our findings

The current acting manager at the home had stepped into this position having formally been the deputy manager at the service. This person told us that they are applying to register with the CQC.

We asked staff about the leadership and management of the home and were told that the staff team working was effective and this helped when responding to people's needs and the volume of people who were using the service. Staff believed they worked well together and were supportive of each other.

There was a clear management structure in place and staff were aware of their roles and responsibilities. Staff told us they felt comfortable to approach senior staff.

We found that there was clear communication between the staff team at the service. Staff views about how the service operated were positive and we saw that the staff team was well co-ordinated. Staff told us that there were regular team meetings, which we confirmed by looking at the minutes of the most recent four staff meetings, where staff had the opportunity to discuss care at the home, developments at the service and other topics.

The provider had a system for monitoring the quality of care. This was regular by ways of seeking feedback after each person's stay at the home, quarterly coffee mornings and using an independent organisation that carried out surveys and visits to the service.

We looked at examples of the feedback from comments that had been received and in many cases written comments from people using the service, minutes from last two quarterly coffee morning evens and the survey carried out in February 2016. Most people were usually very satisfied with the service and where suggestions were made these were listened to and acted upon. The service placed a good deal of emphasis on maximising people's opportunities to provide their views and this demonstrated an inclusive approach.

The home's management team were required to submit monthly monitoring reports to the provider about the day to day operation of the service.

The provider had an organisational governance procedure which was designed to keep the performance of the service under regular review and to learn from areas for improvement that were identified. We found that the service developed plans to address the matters raised and took action to implement changes and improvements.