Support for Living Limited

Support for Living Limited - 37 Barlby Road

Inspection report

37 Barlby Road
London
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This comprehensive inspection was announced at short notice and took place on 30 October 2017. When we last inspected the service in July 2016 we found that the service was meeting all of the regulations we checked. We rated the service requires improvement overall.

Support for Living - 37 Barlby Road provides care and support for up to four people living with complex learning disabilities and physical disabilities. People have their own rooms and share bathroom facilities. People shared bathroom facilities and hoisting equipment was available when needed. At the time of this inspection four adults were receiving care and support from the service.

There was a manager in post who was registered with the Care Quality Commission (CQC). 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.

CQC is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report upon our findings. DoLS are in place to protect people where they do not have capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others. These safeguards are there to make sure that people receiving support are looked after in a way that does not inappropriately restrict their freedom. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and correct way.

Staff had received training on (DoLS) and the (MCA) and in theory understood what to do if people could not make decisions about their care needs in line with the MCA.

Staff developed caring relationships with people using the service. However, staff were not always adopting a creative and meaningful approach to maximising people's quality of life in terms of the range of activities people were able to access.

People's cultural preferences were documented in their care and support plans. However, we saw little evidence that these preferences were being promoted and provided for in relation to meal choices.

Safeguarding training was completed by all staff and refreshed when needed. Staff were trained to protect people from abuse and harm and knew how to refer to the local authority and others if they had any concerns.

Risk assessments were centred on the needs of the individual and were up to date and being reviewed in line with the provider's policies and procedures. Each risk assessment included clear measures to reduce

identified risks and guidance for staff to follow and to make sure people were protected from harm.

Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

There were enough appropriately skilled and experienced staff deployed to the service. Staff had completed the necessary training to equip them with the skills and knowledge to carry out their duties.

There were suitable arrangements in place for the safe storage and disposal of medicines and all medicines were administered by staff who had received the appropriate training to be assessed as competent to carry out these duties.

Staff supported people to attend healthcare appointments as required and liaised with people's family members, GPs and other healthcare professionals to ensure people's needs were met appropriately. Advocates and family members (where appropriate) were involved in reviews of people's care and support.

The provider had implemented and was operating effective systems to audit different aspects of the service; these included the administration of medicines, care records and reviews, fire safety procedures and health and safety checks.

During our visit we were unable to review people's proof of identity, right to work status and references as this information was not held at the service. We requested and received information from the provider relating to staff recruitment demonstrating that criminal record checks and other relevant checks were undertaken before staff commenced working with people.

We have made two recommendations in relation to the development of people's activity programmes and meal planning and preparation.

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.

Risk management plans were in place to reduce risks to people who used the service and were kept up to date.

Staffing levels were sufficient to meet people's needs and staff were recruited in line with safer recruitment processes.

Medicines were managed, stored and administered safely.

Is the service effective?

Requires Improvement

Some aspects of the service were not always effective.

People were not always being supported to have a varied and balanced diet, which included diets that reflected their cultural preferences.

Staff were not always adopting a creative approach to activities that ensured people's quality of life was being maximised.

The provider was meeting its responsibility in line with the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

There were processes in place to ensure good health outcomes for people.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion, dignity and respect.

Staff responded to people's needs promptly.

Staff encouraged people to be as independent as possible and involved in the daily life of the home.

Is the service responsive?

Good

The service was responsive.

People's care was planned in response to their needs and health action plans had been completed and reviewed.

There were processes in place for reporting accidents and incidents and any other concerns.

People using the service had access to speech and language therapists, dietitians, opticians, dentists and GPs when needed and attended hospital appointments when invited to do so.

Is the service well-led?

Good

The service was well-led.

Staff were positive about the registered manager and senior team members who they considered supportive, kind and good role models for their own conduct.

The provider monitored the performance of staff through regular supervision and staff appraisal.

The service was organised in a way that promoted safe care through effective record keeping and quality monitoring and emphasis was placed by the management team on continuous improvement of the service.

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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 inspection took place on 30 October 2017 and was carried out by one inspector. The inspection was announced. The provider was given 48 hours' notice because the location is a small care home for adults who may have been out during the day; we needed to be sure that someone would be in.

Before the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law. The provider completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we used a number of different methods to help us understand the experiences of people supported by the service. We were not able to ask people about their direct experience of using the service as they were unable to express themselves verbally. We observed staff interacting with people using the service, spoke with the service manager and two support staff on duty. We looked at people's care records, five staff files, as well as records relating to the management of the service.

Good

Is the service safe?

Our findings

People were protected from avoidable harm as staff completed a set of individualised risk assessments for each person using the service. These identified risks in relation to mobility, personal care needs, safety in the community and individual activities. Assessments provided clear instructions to staff on how to reduce any known or potential risks and were updated as and when risks or significant changes occurred in line with the provider's policies and procedures. Management plans were in place for people whose behaviour may challenge the service, and these contained suitable information on possible triggers for this type of behaviour. Staff we spoke with knew people well and were aware of the risks to individuals and how these could be managed.

Staff were clear about the action required to keep people safe. Staff told us, "[People using the service] can't speak for themselves. It's been made really clear to us how to protect people," and "It's important we know how to protect people, to prevent and report." The service had policies and procedures in place for safeguarding adults and whistleblowing which were available and accessible to members of staff. Staff completed safeguarding training as part of their induction and this training was refreshed as required. Staff told us they would report any concerns they may have to managers, local authority representatives, the Care Quality Commission and the police if this was required.

People's medicines were managed, stored and administered safely. Staff completed appropriate medicines training and competency assessments before carrying out medicines related tasks. Individual medicine administration records (MAR) for each person using the service were in place and were up to date. Where people were prescribed 'as and when' (PRN) medicines, we saw that sufficient protocols were in place. Medicines records showed that people received their medicines when they needed them and we found no anomalies in the recording of this task. Auditing systems were in place in regards to these matters and audits were being carried out on a regular basis.

References were taken up and verified before staff started work, and the provider obtained sufficient proof of identification and carried out a Disclosure and Barring (DBS) check. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. These checks were due to be renewed every three years in line with the provider's policy, and a list was maintained of the dates of these which showed the provider was working in line with this requirement. This helped to ensure that staff were suitable to work with the people using the service.

The service was staffed 24 hours a day. A minimum of three staff members were on duty during the day and a 'waking night' staff member covered the night shift. Staff rotas confirmed that staffing levels were sufficient to meet people's needs and on the day of our inspection four members of staff (including the registered manager) were on duty. On call arrangements ensured staff always had access to support and advice from a senior staff member out of normal working hours.

The home was clean and free from odours. Infection control measures were in place and staff had access to disposable gloves and aprons. The building was secure and we were asked to identify ourselves on arrival

and sign in and out of the building accordingly. We were also informed of the location of fire exits and assembly points. Health and safety checks were carried out regularly and were sufficient to ensure the building was safe. Checks were also carried out to address maintenance issues and environmental issues such as the condition of doors, windows and furniture.

A copy of the most recent report from CQC was on display at the service and accessible through the provider's website. This meant any current, or prospective users of the service, their family members, other professionals and the public could easily access the most current assessments of the provider's performance.

Requires Improvement

Is the service effective?

Our findings

People's rights were protected in relation to consent as the service was working in line with the Mental Capacity Act (MCA) 2005. 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. Staff had received training in mental capacity and Deprivation of Liberty Safeguards (DoLS) and understood their responsibilities in this area. Where people were unable to indicate that they had consented to care and support, the provider had taken steps to reach decisions in this regard through discussion and consultation with family members, advocates and health and social care professionals involved in people's lives.

Care and support plans documented these decisions and provided detailed information around people's likes and dislikes, preferences, wishes and desires. However, it wasn't always evident that staff were promoting these preferences in relation to people's diet. For example, staff told us they supported people to eat and drink what and when they wanted to and that each person had their own food cupboard containing their preferred food items. We checked people's cupboards to see what range of food was available. One person's cupboard was completely empty and the others contained just one or two items. We asked staff about this and were told that one person was fairly new to the service and they weren't yet sure what types of food they enjoyed. We noted that this person spent the morning helping themselves to slices of bread stored almost out of reach on top of a fridge unit. One person's care records indicated that they liked Caribbean food and beer. We noted that general food stocks were low and items such as rice, spices, herbs, sauces, vegetables, meat and ingredients for creating curries and/or Egyptian, Indian and Caribbean meals (meal choices that appeared as food preferences in people's support plans) were conspicuous by their absence.

We recommend that the provider implements more efficient systems to ensure people using the service have access to a more imaginative, varied and culturally appropriate range of preferred, snacks, drinks and other main food items at all times.

Whilst we acknowledge the effort staff are making to promote people's activity levels, we can not be assured that improvements in this area have been consistent. We were told that one person attended groups, went shopping and out to cafés and took part in a voluntary work programme for which they had recently won an achievement award. On the day of our visit we observed one person playing with plastic toys and another person leaving the building to go to the shops. We were told that other people using the service went out for long walks and journeys on public transport.

We recommend the provider takes timely action in conjunction with the appropriate agencies, organisations, health and social care professionals (where this may be required) to develop a more creative and consistent approach to maximising people's quality of life through the introduction of meaningful and stimulating activities.

Staff told us that they were happy with the level of training they received and described a recent learning session in relation to community, connection and preventing social isolation as "really good", "useful" and "interesting." Records showed that staff had up to date training in essential areas such as health and safety, equality and diversity, infection control, mental health legislation and first aid. The provider had systems in place to ensure this training was kept up to date, and any further training needs were reviewed in supervision sessions. New staff were required to complete a 12 week induction and were provided with a workbook and directed to complete e-learning, access the provider's intranet for sources of information, observe, discuss and reflect on their learning experience.

People's health and well-being was being promoted. Staff completed records detailing people's healthcare appointments. There were systems in place that ensured people were seen by the appropriate healthcare professionals at the appropriate time. People's care and support plans contained adequate information relating to their healthcare needs and included relevant guidelines in relation to specific areas such as, positive behaviour support and dietary requirements. Where people had complex healthcare needs staff told us they sought relevant guidance from people's GPs and district nurses. Staff were aware of who to contact in a medical emergency.

Good

Is the service caring?

Our findings

We saw evidence of caring relationships between staff and people using the service. Staff encouraged people to be as independent as possible and involved in the daily life of the home. For example, people were encouraged to tidy their rooms, and do daily chores where they were able.

People were treated with dignity and respect. People had their own bedrooms and were able (with support) to decorate them as they wished. Some rooms were maintained with minimal decoration where people's individual behaviours made this a necessity. People shared bathroom facilities and hoisting equipment was available when needed. People had access to a large kitchen, sitting room and small garden area. They could, if they chose to, spend their time in the privacy of their own room or with each other and staff members in the communal areas.

We saw people being supported by confident and compassionate staff members who were aware of the need to obtain people's consent before supporting people where this was possible. Staff understood how to maintain people's privacy. We observed staff asking people's permission, letting people know what they were going to do and making sure doors were shut whilst people were being supported with their personal care.

Communication passports were detailed and comprehensive in scope. Staff used pictorial aids, objects of reference, simple language, touch and signing to interact and engage with the people they supported. When required, the service worked with advocates to review people's care and support. Advocates work on a person's behalf to explain information and ensure the person receiving support is placed at the centre of the care planning process. This supported the best interests decision making process when important decisions needed to be made about people's healthcare needs.

Staff took time to engage with people using the service and were managing challenging situations calmly and professionally. We observed staff responding to incidents in a sensitive and caring way. Staff reacted calmly to people displaying behaviour that challenged, responding with patience and offering reassurance.

Staff organised consultation meetings with people using the service to explain upcoming visits and appointments or when changes to the home environment were planned. Records of these meetings demonstrated how decisions had been reached, what communication methods had been adopted and what choices people had been supported to make.

Records in respect of each person using the service were being well maintained, completed accurately and reviewed in line with the provider's policies and procedures. People's care records were stored securely which meant people could be assured that their personal information remained confidential.

Good

Is the service responsive?

Our findings

Before people moved into the service an assessment of their needs was completed by staff, family members (where appropriate) and care managers from learning disability teams to confirm that the service was suited to their needs.

Individual care and support plans had been developed for each person using the service and contained a good level of detail around people's individual needs, life histories and personal preferences. Any potential risks to people and/or others had been identified and management guidelines were in place to ensure people were supported in a safe and appropriate manner.

People were assigned a dedicated key worker who aimed to develop a consistent and supportive relationship with the people they supported. Key workers are responsible for overseeing all aspects of the care and support provided and ensuring people's health and well-being needs are being met and promoted. Key workers produced monthly summaries which provided a good account of how people were feeling, what they had been doing and what they had achieved or wished to achieve in the future.

People's care plans contained adequate information relating to their healthcare needs and included relevant guidelines in relation to specific areas such as, positive behaviour support and dietary requirements. Staff were made aware of any changes to people's health and welfare at handover meetings and through the use of daily notes.

Health action plans had been completed and were reviewed on an annual basis. Appointment logs and records of correspondence showed that people using the service were seen by speech and language therapists, dietitians, opticians, dentists and GPs when needed and attended hospital appointments when invited to do so. When changes occurred, care plans were reviewed and revised accordingly. Staff were aware of who to contact in a medical emergency.

We saw that accidents and incidents were monitored and reviewed by healthcare professionals and the provider's communication and behaviour support team (where required). Staff told us that incidents and accidents were discussed at team meetings and in supervision sessions with a view to promoting learning.

There was a policy for managing and responding to complaints. Staff understood that the people they supported were not always able to verbally complain. Staff compensated for this by being aware of any changes in people's mood, routines, behaviours or health. There was regular contact between people using the service and the management team to monitor people's welfare. The provider had not received any formal complaints since our last inspection in July 2016.

Good

Is the service well-led?

Our findings

The service had a registered manager in post who was supported by a deputy 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.

Members of the management team played an effective part in the running of the service and were aware of their responsibilities to comply with the Care Quality Commission registration requirements including notifying us of any serious incidents and safeguarding concerns that had occurred within the home. We have received one notification from the provider since our last inspection took place in relation to an incident of behaviour that challenged the service. This was managed appropriately by the provider.

Staff were very positive about the registered manager and senior staff members. We were told, "[The registered manager] is kind, he's interested in me, he's very hands on and knows what he's talking about", and "[The registered manager] always has time for you and there's nothing you can't ask him, if you're sick, he'll call, he cares and I don't have a bad word to say about him." One staff member told us, "I chose this job because of people like [the registered manager] and [senior member of staff]. It's an amazing team."

People were supported by staff who were able to express their views and input ideas as to how the service should be run. Staff records confirmed that supervision and annual appraisal sessions were delivered by the management team in line with the provider's policies and procedures. Records of supervision sessions we looked at were supportive and a positive approach towards staff and their needs was evident. Sessions focused on staff well-being, what was working well, training needs and updates and achievements.

Staff told us the registered manager and senior team members were supportive, kind and good role models for their own conduct. Team meetings took place every six weeks and provided opportunities for staff to discuss people's welfare, suggest ideas and discuss any concerns. The provider's policies and operating procedures were appropriate for the type of service and clearly summarised, to help staff when they needed to refer to them. They were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance.

People's experience of using the service was assessed and monitored on a regular basis. We looked at records of quality assurance checks, quality observation visits, auditing of care records, medicines records and health and safety environmental checks. All of these were completed diligently and provided a good overview of how the service was performing, where improvements were required and what action was needed.