London Borough of Barking & Dagenham

Millicent Preston House

Inspection report

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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

The inspection took place on the 4 and 5 May 2016 and was unannounced on the first day. The service was last inspected on the 22 September 2014 and was meeting all the legal requirements we looked at.

Millicent Preston House provides extra care housing and has 34 flats. The service provided accommodation and daytime support. Evening support was provided by an external service. People who were assessed as needing support with personal care and/or medicines had staff support.

Each flat had its own bedroom, living room, kitchen and bathroom area. Some people had their own garden on the ground floor. There were communal areas where people could sit and watch television or relax.

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 were kept safe in the service as the service provided people with a pendent to call staff and they had call bells in their flats. Staff carried a mobile and cordless telephone at all times when on site so they could respond to calls from people in their flat.

Medicines were administered safely and people who took medicines had up to date risk assessments informing staff of possible side effects to be aware of.

Safe recruitment was followed as staff references and a criminal records checks were carried out before employment commenced.

Care was provided by staff who had up to date skills and knowledge and long term experience in giving care. Regular training was provided to staff and they had their medicines competence observed by management as part of supervisions and one to ones.

Staff understood the principles of the Mental Capacity Act and the need to assess peoples capacity on a regular basis. People had capacity in the service and nobody was restricted under Deprivation of Liberty Safeguards. Staff asked people for consent before giving care and before administering medicines.

People were cared for by kind and compassionate staff who took the time to listen to people and we observe them help people in the service.

Care plans were person centred and provided personal information about people so that staff could get to know the person as an individual. Families were involved in their relatives care and provided information to the service to help ensure care was personalised. Risk assessments with management plans were up to date

and reviewed regularly.

People told us they would like to see more activities at the service but these would require personal funding from people. However we did see that the extra care coordinator had worked to bring in different activities to the service such as a library service, fish and chip night, bingo and the local school visits.

Staff and people had regular meetings where they discussed what was happening in the service. Feedback was regularly requested from people at the service, staff and health professionals. The registered manager performed audits of the service to ensure the care provided was of good quality and records we viewed showed that action from audits were completed so that the service improved.

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 were kept safe in their flats as they were able to use a personal pendant to alert staff. Staff knew how to identify abuse and escalate concerns to have them investigated

Safe recruitment was followed to ensure staff were of a good character to look after people.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff recruited were supported to maintain their skills and knowledge.

Staff at the service sought people's consent before giving care and respected people's personal information.

Staff understood the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were supported by kind and compassionate staff. We observed staff take the time to help people in need and talk to them kindly.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People's care plans were detailed and person centred.

Staff knew people and responded to changes in people' needs promptly.

People told us they would like more activities.

Is the service well-led?

Good

The service was well led.

The atmosphere in the service was positive. People and staff said the management of the service was good.

The management of the service performed audits of the service and staff and people's views were regularly sought.

Millicent Preston House

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 took place on the 4 and 5 May 2016 and was unannounced on the first day.

The inspection team consisted of an inspector and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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. We reviewed the information we held about the service and looked at notifications received. We also spoke to the local Healthwatch.

We spoke to seven people using the service and one relative. We also spoke with four members of staff which included the registered manager, the extra care coordinator and the cleaner. We observed care, medicine administration and reviewed the records of three people and three staff files. Policies and procedures were also reviewed during the inspection which included safeguarding, whistleblowing, health and safety, risk assessments and the medicines policy.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. One person said, "I have my pendant to call for help and they [staff] come." Another person said, "It's lovely here, I feel safe." The same person told us, "My door locks".

People were provided with their own key and their flats had a key safe for care staff who attended to give personal care and support with medicines.

Care staff told us that they performed "call and seen" checks where they would ring people in their flats. These checks were to see if people were safe. One member of staff said, "If we haven't heard from them we will go to their flat and see if they are ok as well."

During the day a member of staff carried a cordless telephone handset and another carried a mobile which was linked to the call bell system. A member of staff told us, "This is to be carried at all times." We tested a call bell in a vacant room and staff answered promptly which demonstrated that staff were responding to keep people safe.

The service used CCTV so staff could see who was arriving at the service. This was a means of keeping people safe in their flats. There were staff on site from 7.00 am until 10.00 pm. After this time, if people needed assistance a service took over and when people pulled their pendant a direct call went to an external service and they answered or send the emergency services. Staff told us that they checked people's personal alarm before leaving the service and that everything was locked. We saw in the main office contact details of the care coordinator and the registered manager were available if people needed to contact them.

The extra care coordinator told us that the local police officer would also perform random site visits and some of these were during the evening. This was to check people were safe and that the premises were safe. These visits were not recorded however other care staff we spoke to confirmed they had seen the police officer perform this visit.

Records showed that staff had completed safeguarding training and were up to date. Staff knew how to raise concerns about safeguarding and could tell us the signs to look for should they suspect abuse. Also safeguarding was discussed in team meetings and we saw meeting minutes to confirm this. Staff also knew they could whistleblow in accordance with the service policy to the local authority, Care Quality Commission and the Police.

We did note in the safeguarding policy that the guidance on when to contact the CQC was incorrect. While the majority of staff we spoke to knew to contact the CQC with safeguarding concerns, the safeguarding policy advised to contact the CQC only where the service was a care home. We informed the registered manager of this and they advised it would be amended.

Staff had been trained in the safe administration of medicines and staff explained to us how they followed a

process of checking they were providing medicine to the correct person, right dose, right medication, correct time, the right route and correctly record in the medicine administration record (MAR) chart.

The extra care coordinator explained that medicines were personalised at the service as each person receiving support with medicines had their own chemist. We saw that people had up to date medicine assessments where it advised risks of certain medicines. For example, one person was using a paraffin based cream which meant they were at risk of catching fire so gloves should be used. Also within the medicine risk assessment staff were advised to observe for side effects after giving certain medicines such as feeling sick or dizzy.

We observed a medicine round and saw the member of staff had arrived on time to give the medicine and checked the medicines they were to administer and explain to the person what medicine they were being given. Medicine records showed no gaps in the recording of the medicine administration to people. One person said, "I get my medicine on time" and another person said, "They come round at the right times and help me take my medication, I take a lot of tablets you know."

Risk assessments were completed to keep people safe in their home environment and with the use of medicines. For example, records showed a risk assessment had been completed where one person who received insulin had to have it locked in their fridge due to their memory loss. This meant they were not at risk of missing their insulin and when the district nurses attended they could safely administer it to the person.

Safe recruitment of new staff was followed and the registered manager showed us the recruitment policy. New staff required to provide references and to complete a disclosure and barring service check (DBS). This was a criminal records check to ensure staff were of good character and able to work with a vulnerable client group. Records showed that this had been completed.

The service assessed there were enough staff on duty to support the number of people in the service. However staff did tell us they would like more staff to support in delivering activities. We reviewed the rotas for the last three months which showed the service had covered annual leave, training and other absence.

The service had recently had an assessment with the fire service and the extra care coordinator showed us the new sprinkler system that had been installed throughout the service and in people's flats. Records showed that each person had their own personal emergency evacuation plan (PEEP) which described how to safely take them out of the service should there be an emergency.

At the inspection the fire alarm was tested and this was done weekly and we saw records that the outcome of fire drills had been recorded every six months. Other health and safety checks included testing of portable equipment and fridge and freezer checks and these were up to date.

The lift at the service was not working during the morning of our inspection and we reviewed the maintenance records which showed that it often broke down. However during our inspection the repair man attended and repaired the lift. The extra care coordinator and the registered manager showed us how they had raised this issue with the local authority for it to be addressed as a matter of priority. Comments from people about the lift included, "The lift always breaks down" and "I couldn't go to my GP appointment as the lift was not working." Other maintenance issues were documented and resolved quickly for people in their flats.

Good

Is the service effective?

Our findings

People spoke positively about the staff at the service. One person said, "They [staff] are good at their jobs."

Staff received an induction which lasted five days and were provided with a staff handbook. New staff were supported by another more experienced member of staff before working unsupervised. One member of staff said, "I ask my colleagues for support. I can go to extra care coordinator or the registered manager, they are very supportive." Staff had a probation period of six months and would meet the registered manager or the extra care coordinator to review their progress regularly, . Records we looked at confirmed this. Staff had completed training in safeguarding adults and children, health and safety, manual handling, medicines, equality and diversity, disability awareness and challenging behaviour. The extra care coordinator showed us how a new member of staff had started the care certificate. The Care Certificate sets out skills staff should have to deliver care after their induction.

Training was regularly provided and the registered manager told us it was a combination of online training and face to face training. Staff told us they felt well supported to perform their role and one to one meetings discussed training needs and included medicines observation to see that staff were giving medicines safely. Records showed that staff received regular supervision and an annual appraisal which was performed by the extra care coordinator.

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. Any applications need to be made to the Court of Protection. Within this service no one was deprived of their liberty.

Staff, the registered manager and the extra care coordinator were able to explain the principles of the Mental Capacity Act 2005. The registered manager showed us records that staff were to attend further training on the Mental Capacity Act 2005.

Staff at the service sought people's consent and respect people's information. Staff told us they would not disclose people's confidential information in public.

Care records showed people's consent was asked. We saw in people's care files that they had to consent to the care being given, to medication being provided and information being shared with professionals. We also observed staff knock on people's doors before entering and asking for permission to come in.

People lived in their own flats and some were independent and made their own food. One person told us, "I like making banana sandwiches" and we observed them eating this at lunchtime. The service provided people with tea and toast each day if they wanted it. Those assessed as needing help with their meals received support from staff to make them. Some people had their food delivered by an external service.

People at the service had regular contact with health professionals and people were assisted to make appointments with health professionals. For example, we saw records the dentist and chiropodist attended the service. Records showed that district nurses attended people to provide insulin and people met with their social worker to discuss their needs. Staff recorded hospital appointments in a 'tenant's diary' and reminders to re-order medication. We looked at the services hospital book which recorded when people went into hospital and when they returned. Staff at the service would make a follow up call to check people in hospital and to inform their next of kin.

Good

Is the service caring?

Our findings

People told us staff were caring. One person said, "They [staff] are so friendly and ever so nice." One relative told us, "The staff are caring."

We observed people being spoken to in a kind manner by staff. The extra care coordinator told us they had introduced a key worker system where people had a direct member of staff who they could speak to and would update their care plan.

Records showed the service performed welfare checks to check people's emotional and physical well-being. One person said, "The staff ask how we are." The extra care coordinator said, "I never switch off. I'll sometimes come in on a Saturday and bring in food and help people with their shopping." This meant the staff were caring towards people and going above the duty to help people.

The extra care coordinator said, "Sometimes people just need comforting." An example was given when someone had lost a loved one and the care coordinator told us they were there for them even if it was to just sit in their flat and hold their hand. This was caring for people and showed compassion.

People's care files described their past histories, likes and dislikes. This helped staff get to know people and how to support them. In one care file it was noted that the person was a very private person and they did not want to join in on activities in the service. We spoke to this person and they told us they were not isolated and had regular contact and visits with their family. The service had documented the information so that their wishes were respected by staff in the service.

Staff knew people well and how they liked to spend their time. One member of staff said, "I'm going to play draughts with [person] on their iPad." The member of staff explained the person enjoyed their time together so this showed they made the effort to spend time with people doing an activity they enjoyed. The same member of staff said I know [person] likes knitting and crochet so I helped set [person] up with crochet.

People's privacy and dignity was respected. We observed staff knocking on people's front door and asking for permission to come in. Some people left their door ajar and we observed staff still knocking to ensure it was alright to enter. Staff said when people were in the bathroom they waited outside until they had finished and checked if it was ok to enter their flat.

We also observed staff help one person in a caring way. The lift was out of order during the morning of our inspection and someone was carrying a lot of shopping. One of the care staff said, "Let me help you carry your shopping upstairs." We saw the person was happy to receive the help as they said they had ice lollies in their bag that would melt.

People were able to invite family and friends over and the extra care coordinator showed us a guest room that was ready and available for relatives and other visitors to use. This meant people were supported to spend time with loved ones and given extra space to accommodate them which was caring.

People were supported to maintain their religious beliefs and the extra care coordinator had arranged for the local church to come and see people in the communal area of the service. One person told us they attended church themselves.

End of life discussions were offered to people if they wanted to talk about it. The extra care coordinator showed us they had put together an end of life guide to help staff on how to approach this with people.

Good

Is the service responsive?

Our findings

The service provided care to people that responded to their needs.

People's needs choices and preferences were recorded in their care plans. The registered manager and extra care coordinator told us that when a referral was received by social services, they would assess people's needs. A care package was then prepared with the involvement of people and their relatives.

The registered manager told us people's care was delivered the way people wanted it. The registered manager said, "It's their choice and decision". Care files we reviewed confirmed this as information provided was person centred and detailed. For example, information on their family history, how to enter people's flat was provided, their level of social interaction, how many calls they received and the breakfast they liked. Risks were assessed and plans were in place to minimise those risks so that people could be safe in their flat and live as independently as possible.

The extra care coordinator also provided fact sheets on particular health conditions people had so that staff were able to gain a better understanding to help people.

Care staff told us they monitored people on an on-going basis and if they had concerns about someone's level of need or if their level of need had decreased they would inform the registered manager or extra care coordinator.

Records showed that the service identified changes in people's needs and reacted promptly and informed the relevant health professionals. For example, records showed after an incident where someone burned their food with a microwave, the extra care coordinator had informed the person's relative and their social worker so that a reassessment could be completed.

On the second day of the inspection we observed a staff handover and each member of staff relayed important information about what had happened during the morning shift. The staff raised concerns about a person's mobility and the action that had been taken was to inform their social worker and physiotherapist. Staff were demonstrating that they were responding promptly to a change in someone's need that could affect their health. Staff also identified where a person had developed a pressure sore and they had called a district nurse to come that afternoon to review the person.

The extra care coordinator held staff and resident meetings. The registered manager told us they had led a staff meeting. We reviewed the minutes from the residents meeting on the 19 April 2016 and the service was advised a volunteer would be coming to the service weekly. We saw the minutes of the last team meeting on the 25 April 2016 and staff discussed their medicine policy and the CQC. The extra care coordinator told us if people were unable or did not attend the residents meeting they would ensure a copy of what was discussed was posted through their flat.

On the first day of the inspection we did see some people participating in bingo. While some people enjoyed

it some other people told us they would like arts and crafts at the service or to do exercise.

People and staff said there could be more activities. We raised this with the extra care coordinator and the registered manager and were told that certain activities would require people to pay.

The extra care coordinator told us how they had arranged activities for people. For example the local library brought books to the service every six weeks, a reminiscence sessions group had attended and the local school came to visit the service. Some people attended college and we observed some people watching TV, going into the local community and knitting.

Advocates were provided through people's social worker, some people knew they had an advocate and some people used family members.

The service had a complaints process and a version was available in easy read format. People we spoke to told us they would speak to the extra care coordinator or the registered manager if they had a complaint. One person said, "I'd tell my son but I'm never unhappy." Another person said, "I would tell [extra care coordinator] if I'm not happy." Records showed complaints had been responded to appropriately. We reviewed a compliment from a relative and they said, "Coordinator showed empathy."

Good

Is the service well-led?

Our findings

People and staff spoke positively about the extra care coordinator and the registered manager. Staff told us they had confidence in approaching management for support or to raise a concern.

Staff told us the atmosphere in the service was really positive. We spoke to a member of staff who said since management had changed a lot of improvements to the service had taken place for the better. The extra care coordinator showed us the improvements to the communal areas where new chairs had been bought for people, improvements had been made to the garden and an extra toilet installed for staff.

There was a registered manager of the service and they managed two other services by the provider. The extra care coordinator had day to day running of the service and was supported by the registered manager. The registered manager made regular visits to the service to see how everything was and staff and people confirmed this to us. The registered manager said they were available to speak to staff and people and we did see people come and knock to speak to them.

The extra care coordinator told us if people were unable or did not attend the residents meeting they would ensure a copy of what was discussed was posted through their flat. One person said "[Staff member] always posts something through my door if I can't make it." We saw evidence of the newsletters that detailed the key points of what had been discussed in residents meetings.

The registered manager performed an audit on a random sample of 10 care files in November 2015. They checked to see whether people's personal information was correct, risk assessments were up to date, assessments and referrals to health professionals were made correctly, safeguarding information, consent had been sought and if not had a family member sign on their behalf and that complaints had been addressed. The outcome of the audit identified recommendations which were all completed in December 2015.

People and staff spoke positively about the extra care coordinator and the registered. Staff told us they had confidence in approaching management for support or to raise a concern.

An audit of medicines was carried out and we saw evidence that after discussions the template to audit medicines was improved to record more information. The registered manager and extra care coordinator were pleased with this improvement as it helped capture important data from medicine audits.

Feedback from people was requested every six months. We could see that the extra care coordinator followed up on issues people had raised. We reviewed 12 surveys that had been returned and people all spoke highly of the care they received from the staff.

The service did try to seek feedback from professionals. Surveys were sent to them but none were returned.