London Borough of Greenwich

London Borough of Greenwich - 58 The Village

Inspection report

58 The Village
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Date of inspection visit:
19 September 2018

Date of publication:
22 November 2018

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

This unannounced comprehensive inspection took place on 19 September 2018. London Borough of Greenwich – 58 The Village provides care and support for people living in a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. 58 The village provides accommodation and personal care to a maximum of six adults and older adults with learning disabilities in one adaptable building. At the time of this inspection five people were living at the home.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At our last inspection on 27 April 2016 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

There was 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.

The provider had safeguarding policies and procedures and staff knew of their responsibility to protect people from abuse. Risk to people had been identified, assessed and had appropriate risk management plans in place. People's medicines were managed safely. There were appropriate recruitment practices in place and there were sufficient numbers of suitable staff to support people's needs. People were protected from the risk of infection because staff followed appropriate infection control practices. Accidents and incidents were reported, recorded and monitored to drive improvements.

People's needs were regularly assessed to ensure they would be met. People were supported to maintain good health and had enough nutritious food in sufficient amounts to eat. People were supported to use healthcare services and the staff worked in partnership with health and social care professionals to provide a joined-up service. People's individual needs were met by the design, decoration and adaptation of the home. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff were supported through induction, training, supervision and appraisals to ensure they delivered an effective service.

People were supported by staff that were kind, respectful and caring towards them. People were involved in making decisions about their care and support. People's privacy and dignity was respected and their independence promoted. People's communications needs were assessed and met and were supported to use assistive technologies to promote their communication and independence where required.

Each person had a care plan that provided staff with guidance on how their needs should be met. Staff understood the Equality Act and supported people in a caring way. People were supported to participate in activities that interested them and maintained relationships that were important to them. The provider had a complaint policy and people knew how to make a complaint if they were unhappy. People were supported to plan for their end of life care needs and wishes.

There was a registered manager in post who notified CQC of significant events that occurred at the service. The provider displayed their last CQC inspection rating at the home to ensure people had access to this information. There were appropriate monitoring systems in place to assess and monitor the quality of the service. People, their relatives, staff and health and social care professional views were sought to improve on the service delivery. The provider worked in partnership with key organisations to plan and deliver an effective service. There were systems in place which supported continuous learning.

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 remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

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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.

The inspection site visit took place on 19 September 2018 and was unannounced and was carried out by one inspector.

Prior to the inspection we reviewed information we held about the service including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority that commissioned services from the provider to obtain their views about the service. Information acquired was used to help us plan our inspection.

At our inspection, we spoke with one person and three relatives on the telephone to seek their views about the service. We spent time observing how people and staff interacted. We also spoke with the registered manager, deputy manager, two support workers and a visiting health professional. We looked at three care plans and five staff files. We also looked at records used in managing the service such as policies and procedures, audits, surveys and minutes of meetings.

Good

Is the service safe?

Our findings

The service continued to provide safe care to people. One person told us, "I feel safe here, if I am not happy I will speak to staff or the manager." A relative commented, "[My love one] is safe in there, the staff take really good care of him. There are no concerns at all."

People remained protected from the risk of abuse. The provider had safeguarding policies and procedures which provided staff guidance on abuse and processes to follow to protect people from abuse. All staff had completed safeguarding adults training and knew of the types and signs of abuse. A staff member told us, "I will alert my manager, or the on-call manager, I will report to the head office… you don't hide anything but speak out. I will whistle-blow to the top managers if I have to." The registered manager knew of their responsibility to protect people in their care from abuse and had reported any concerns of abuse to the local safeguarding team and CQC.

Risks to people had been identified, assessed and had appropriate management plans in place. Risk assessments were person centred and covered areas including behaviours, pressure sores, accessing the local community, having a bath, riding a bike, swimming, personal care, eating and drinking and medicines. For each risk identified there was appropriate guidance in place for people and staff on how to mitigate the risk safely. For example, for the risk of falling whilst having a bath or a shower, staff were to remind and ensure that the person used a bath mat to prevent the risk of falls. To prevent the risk of scalding whilst having a bath or shower, the provider had a regulated thermostat in place to ensure the water temperature did not get too hot. Healthcare professionals such as chiropodist, speech and language therapist (SALT) were also involved in assessing risks to people and providing guidance for staff on how to prevent or minimise risks such as fungal infection or choking occurring.

There were procedures in place to deal with foreseeable emergencies. Each person had a personal emergency evacuation plan in place. Regular fire test and fire drills took place and staff knew of how to contact emergency services in the event of a fire. One person who had mobility needs was supported to regularly take the stairs so in the event of an emergency they could evacuate the building safely without using the lift.

There were appropriate numbers of staff available to support people's needs. The registered manager informed us that staffing levels were planned based on people's assessed needs and any planned activities for the day. The numbers of staff on shift matched the numbers planned for on the staff rota. Where people's needs had increased, additional staff were booked to ensure their needs were met. All staff we spoke with confirmed the staffing arrangements in place was adequate and met people's needs. Staff vacancies were covered by the provider's internal bank staff or as overtime opportunities for permanent staff to promote consistency in the care delivered.

The provider followed safe recruitment practices. All staff had appropriate recruitment checks carried out before they started working at the home to ensure they were suitable to work with people using social care services. This included completed application forms which contained their educational qualifications and

employment histories, references, criminal records checks, health declarations, proof of identity and the right to work in the United Kingdom.

Medicines were managed safely. People received medicines from staff who had completed medicines training and had their competencies checked to ensure they had the knowledge and skills to support them safely. Medicines were stored safely in locked cabinets in the office or in people's bedrooms and daily temperature checks were carried out to ensure medicines remained effective for use. Each person had their own medicine book which contained their photograph, list of medicines, reasons for giving them, any side effects and how people preferred to take their medicine. Each medicine book included a medicines administration record (MAR) and these were correctly signed when medicines were administered. We checked medicines stock against information in the MARs and these matched each other. Two people self-medicated and there were appropriate assessments, guidance and support in place for them to take their own medicines safely.

People were protected from the risk of infections. The home was clean without any odours. Cleaning products were stored securely and cleaning equipment such as mops and buckets were colour coded to prevent the risk of cross contamination. There were hand washing facilities such as soaps and handtowels available. Staff told us they washed their hands regularly and use aprons and gloves when carrying out personal care or laundering clothes.

Accidents and incidents were reported, recorded and monitored appropriately to drive improvements. Staff knew of the importance of recording and reporting any accidents or incidents and the provider acted to ensure lessons were learnt to prevent reoccurrence. For example, we saw that one person who self-medicated forgot to take their medicines. The provider implemented a system where staff physically checked that the person had taken their medicines.

Good

Is the service effective?

Our findings

People's needs continued to be assessed appropriately. People's physical, social and mental health needs were assessed regularly by staff to ensure the home was still suitable and could meet their needs. One person had moved to another service following a reassessment of their needs to ensure they received care and treatment that met their needs. Where required the service involved appropriate healthcare professionals to assess people's needs and provided guidance for staff to achieve effective outcome for people.

People were supported to eat and drink nutritious food in sufficient amounts for their health and well-being. A relative told us, "[My love one] enjoys his food and staff take very good care with his diets … I am very happy with his food preparation. The food is healthy." People were given choices of food and were given opportunities to choose the types of food they would like to eat. Staff supported people with the preparation of meals and people could also make their own hot drinks or prepare basic meals or snacks such as sandwiches or scrambled eggs with appropriate support. A staff member told us, "We have a menu and it is a healthy menu, we give people choice of what they want to eat." The menu was in pictorial formats which supported people to make choices of meals they preferred. All staff we spoke with knew of the support people required to meet their nutritional needs.

People were supported to access healthcare services when they needed it. People were registered with a GP and records showed they have received treatment and support from dentists, dermatologists, opticians, chiropodists, the community learning disability team (CLDT) and NHS hospitals. People were also supported to maintain good health and attended annual health checks.

Staff continued to work in partnership with health and social care professionals such as GPs, pharmacists, social workers, community learning disability team (CLDT) and day centres to deliver an effective service. Each person had a hospital passport which included their medical history, treatment plan, list of medicines, allergies, communication needs and the level of support they required to ensure information was readily available to emergency and hospitals teams.

People's individual needs were met by adaptation, design and decoration of the home. A relative told us, "The dining room is big and the lounge too and there is a lift that takes them to their room." People's bedrooms were personalised to meet their needs and people were involved in decorating their rooms. There were handrails throughout the home and a lift which supported one person with mobility needs to access their room independently. The communal areas in the home promoted group or individual use. One person showed us the garden area which was well maintained by both people and staff. People also had their own vegetable patch where they planted their preferred fruits or vegetables.

People's rights were protected because staff sought their consent before supporting them. Staff knew of their responsibility to work within the principles of the Mental Capacity Act 2005 (MCA) and we observed staff asking people for their consent before supporting them. A staff member told us, "MCA started in 2005 and it is about people making decisions for themselves and we [staff] have to try and find the communication that

actually suited them most and they understand so they can make that particular decision before thinking of best interest decisions."

The 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. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People using the service could make day-to-day decisions for themselves; however, where a person was found to lack capacity to make specific decisions for themselves such as the management of finance, a mental capacity assessment and best interest decision were made involving the person, their relatives where appropriate, and health and social care professionals. Where people had been deprived of their liberty for their safety, appropriate authorisations were in place and the conditions were being met by staff.

Staff were supported through induction, training, supervision and appraisals. New staff completed an induction when they first started using the service. Staff working at the service had been in post for a long time and were supported through regular mandatory training courses in areas including medicines, health and safety, infection control, safeguarding adults, food hygiene, MCA and DoLS and epilepsy to ensure they updated their knowledge and skills to perform their roles effectively. Regular staff supervisions took place and covered areas such as key working, training, health and safety and annual leave. Staff appraisals were also carried out to assess staff performances, developments and set objectives for the coming year.

Good

Is the service caring?

Our findings

People were supported by staff that were kind, respectful and compassionate. One person told us, "I am happy here." A relative told us, "The staff are lovely, he is relaxed and happy and with a lot of smiles. Staff are always friendly, lovely and courteous." Another relative commented, "Staff are very good, friendly and caring and they are always taking good care of [my loved one]. We are very happy because the staff are very supportive of him and he is very happy too." A third relative commented, "The home is excellent and the staff are very caring, very thoughtful and do their very best to ensure that [my loved one] takes part in activities, and attends health appointments." We observed staff engaged with people in a friendly manner and we noted that both people and staff had established good relationships and had built rapport which made people feel relaxed and open when interacting with staff. We also noted that people were happy living at the home and those who required support to communicate with us had smiles on their faces.

People and their relatives had been consulted about their care and support. Care plans showed that people or their loved ones were involved in making decisions about their care and support and relatives confirmed this with us. Key worker sessions which were one-to-one monthly meetings between people an allocated member of staff was also used to give people opportunities to communicate their needs and how they would like to be supported. Care plans included guidance for staff to promote choices and staff we spoke with told us people were given choices regarding their everyday life including the food they ate, clothes they wore and activities they participated in and we observed people being given choices during our inspection.

People's privacy and dignity was respected. One person told us, "Staff respect me and they knock on the door." Staff told us of how they promoted privacy and dignity by knocking on people's doors, calling them by their preferred names, making sure that doors were shut during personal care and speaking to people with respect. Staff also told us information about people including records were kept confidential. They told us they used locked screens on computers and they spoke in private when on the telephone and that information about people was only shared on need to know basis. A staff member commented, "People have their own bedrooms and we always knock and even in hospital we make sure their dignity is maintained, and the screens are shut and they have appropriate clothing on."

People were supported and encouraged to achieve the most they could get out of life and their independence was promoted. One person told us, "I make my packed lunch and I travel on the bus to town." Things people could do for themselves and those they needed support with were recorded in their care plans so that staff knew the level of support they required. People were involved in house chores such as cooking, cleaning, mowing the lawns and gardening. People were also supported to self-medicate, learn how to pay their bills and to use the cash machine independently and safely.

People's communication needs had been assessed and met. People had varying communication needs and where required people had communication passports which provided detailed guidance for staff on how they communicated and the level of support to provide. Information was presented in formats that promoted people's understanding such as in large prints and in pictures where this was required. One person had been given a red card which they used to express themselves to staff. Staff knew people well and

understood each person's requests and bodily expressions and supported them appropriately.

Good

Is the service responsive?

Our findings

People's needs were met through the care and support they received. A relative told us, "I am very satisfied and very happy that everything is running very well." Another relative said, "I have nothing to complain about, we are very satisfied with the care. They [staff] take good care of him and manage his behaviour well, staff are very thoughtful and help him to get into the community and look after his health." Care plans were developed based on an assessment of each person's needs and included information on the support people required and guidance for staff on how individual needs should be met safely. Care plans covered areas such as personal care, medicines, communication, eating and drinking, skin care and daily routines.

Care plans included people's medical conditions, allergies, preferences and their likes and dislikes including activities that interest them. Care plans also included people's hopes and aspirations, social support network and healthcare professionals involved in their care. People were set realistic goals and supported to achieve them. For example, one person told us it was their aim to move into their own flat and live independently. Records showed that staff were supporting them to gain essential life skills such cooking, traveling independently and self-medicating for them to achieve this goal successfully. People's care plans were reviewed regularly to ensure their needs were met. Daily staff notes showed that the care provided was in line with the care planned for.

Staff understood people diverse needs in relation to their disabilities, religion, sexuality and cultural backgrounds and supported them in a caring way. Information about people's ethnicity, religion, sexual identifications and preferences were recorded in their care plans so that staff knew of the level of support to provide. For example, when one person expressed an interest in having a sexual relationship. We saw that staff supported them to understand different relationships that existed, how they could express their sexuality and they also completed a course on staying safe in relationships. Staff told us they were currently supporting the person to engage in social activities including group sessions so they could find someone they were interested in. Staff told us people's diversities was promoted at the service and people were not discriminated against.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Documents such as people's care plans, menus, activities and how to make a complaint were in easy read and pictorial formats to support people's communication needs. People also used mobile phones and tablets computers such as iPad to communicate and were supported by staff to understand how to stay safe online.

People were supported to maintain relationships that were important to them. Relatives told us they could visit people without any restriction and could take them out into the local community so they could spend time together. Records showed that people maintained relationships with their family by speaking to them on the telephone or visited them when this had been planned.

People were encouraged to participate in activities that interested or stimulated them. One person told us,

"I lost weight because of the dance and the acting I do. I enjoy it." They spoke with us enthusiastically about a drama performance they took part in and said, "I was the star of the show." They were given the lead role in a 'Grease' play and this promoted their confidence. People were encouraged to socialise, pursue their interest and hobbies including painting, gaming, gardening, visiting art galleries and attending day centres. Staff were forward thinking and found new activities for people to participate in. For example, one person had been supported to successfully participate in bicycle motocross (BMX) shows which was an off-road bicycle sport used for racing and performing stunts. This person spoke with us fondly about their BMX shows and how much they enjoyed it. Another person was being supported to participate in a horse riding session at a local school.

There continued to be effective systems in place to handle complaints. People and their relatives knew how to make a complaint and remained satisfied with the service. The registered manager informed us they had not had any complaints since our last inspection in April 2016; however, they had received compliments from people, their relatives and health care professionals. Compliments from relatives stated, "I am very pleased with the service at The Village."; "The service is person centred."

Where required people were supported with end of life care. The registered manager informed us that no one currently using the service required end of life support. However, end of life care needs had been discussed with people who wanted to talk about it. Some people had a funeral plan in place and this included their end of life wishes. The registered manager informed us if a person required end of life support, they would involve the person, their relative (where applicable) and healthcare professionals to ensure their end of life wishes were met.

Good

Is the service well-led?

Our findings

People and their relatives were complimentary about the service. People knew who the home manager was. One person said, "[Manager's name] is fine and she is okay." A relative commented, "I am happy with [the manager] and her level of professionalism, I am happy she has returned." Another relative commented, "The Village runs smoothly, the village knows how to set things up, the village is exceptional."

There was a registered manager in post who understood their responsibility to work within the principles of the Health and Social Care Act 2014 and had notified CQC promptly about any significant event at the service. The service had displayed their last CQC inspection rating at the home to ensure information was easily accessible to people and their relatives. The registered manager was supported by the area manager and an assistant manager to plan and manage the home effectively.

There was an organisational structure in place and staff knew of their individual responsibilities. All staff spoke positively about their manager and the management team and told us they felt supported in their role and they had an on-call system in place which provided out of hours management support. The providers values included providing person centred care, empowering people to be independent and to take positive risks to participate in activities that interest them and staff upheld these values when supporting people.

There were systems in place to monitor and assess the quality and safety of the service. The provider carried out various audits in areas including care files, medicines, health and safety, fire safety, infection control. Where issues were identified the service acted and addressed these promptly to ensure people received good quality care at all times. Other external organisations such as the local authority that commissioned the service and Healthwatch Greenwich had carried out their own monitoring visits at the service. The reports of these visits were good and showed that people using the service were experiencing positive outcomes. Where suggestions were made such as the use of close circuit television (CCTV) at the entrance of the home to promote people's safety and independence when answering the door; appropriate decisions were made in consultation with people and their relatives.

Feedback was sought from people, their relatives, staff and health and social care professionals to improve the quality of the service. Results from an annual satisfaction survey carried in August 2017 was all positive. People said they felt safe at the home, they felt involved in their care and support, they had enough to eat and drink and knew how to make a complaint. One relative commented, "We are very happy with the support [our loved one] receives, it could not be any better. A health and social care professional commented, "Staff interact positively with people and understand their needs, staff are approachable and people's needs are met."

Monthly tenants' meetings also gave people opportunities to express their views and make decisions that were important to them. Topics discussed at these meetings covered areas including health checks men's health, cooking, activities, Christmas celebrations and personal care needs. Staff encouraged people to talk about things that were important to them and we saw that some people talked about their plans to move

onto independent living.

The provider worked in partnership with key organisations such as the local authority that commissioned the service, community learning disability teams, day centres and community neighbourhood teams to plan and deliver an effective support for people. For example, the provider was working with a local pharmacist to ensure medicines were packaged in dossette boxes which people were familiar with and to prevent medicines errors occurring. Feedback we received from these organisations were all positive.

There were systems in place to support continuous learning and improve the quality of the service. Staff were supported in their role through training and supervision and accident and incidents were reported, recorded and monitored to prevent reoccurrences. For example, the provider had a medicines tray in place. The registered manager told us that a staff member popped a medicine and it went missing, therefore, to prevent this from happening again they put the medicines tray in place.