The Westminster Society For People With Learning Disabilities

Flat C 291 Harrow Road

Inspection report

291 Harrow Road
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 inspection was unannounced and took place on 28 and 29 March 2017. Flat C, 291 Harrow Road consists of five separate bedrooms, a communal lounge/dining area and a kitchen. The service is registered to provide support with personal care to people with learning disabilities. There were five people living in the flat at the time of our visit although one person was absent due to a hospital admission.

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 registered manager was well regarded by relatives and the wider staff team.

Relatives and health professionals were involved in planning people's care. Care plans were split into person-centred plans, health assessments, health action plans and risk assessments. However, staff were not always aware of specific details relating to people's health conditions, care needs and preferences and as a result people's human rights were not always being protected in accordance with the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff were trained in the safe administration of medicines and kept relevant and accurate records. However, people's medicines were not always being stored safely and securely.

People's risk assessments covered a range of issues including guidance around accessing the community, personal care, moving and positioning and safety within the home environment. However, risk assessments were not always being reviewed when people's health status changed or when new circumstances created potential risks to people's health and well-being.

There were sufficient numbers of staff deployed to the service. Recruitment procedures ensured that only staff who were suitable worked within the service. Staff files contained appropriate references and identity checks with the Disclosure and Barring Service.

New staff completed an induction programme which included shadowing more experience staff and completing elements of the care certificate which prepared them for their role and duties. Staff were given opportunities to develop professionally through regular training opportunities and ongoing supervision sessions. Staff told us they felt supported by the management team.

Staff received training in safeguarding adults and understood the procedures to follow should they have any concerns. The registered manager ensured that action was taken after incidents and accidents occurred.

People were cared for by motivated staff and positive relationships had been established between people using the service and staff. Staff interacted with people in a kind and caring manner and respected people's

privacy and dignity.

There were activities in place which people enjoyed. However, one person was not able to access the community due to a faulty wheelchair and repair delays.

People had sufficient amounts to eat and drink and were offered choices at mealtimes. Staff were aware of people's specific needs in relation to specialist diets and food preparation and had completed safe food handling training.

There was a complaints procedure in place and the provider listened to the views of staff, relatives and visitors. The manager understood the requirements of CQC and sent in appropriate notifications. Relatives told us they felt that the management was approachable and responsive.

There were procedures in place to monitor, evaluate and improve the quality of care provided though these systems were not always effectively identifying and addressing the shortfalls we found during our inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not safe.

People were not always being protected against the risks associated with the unsafe storage and management of medicines.

Risk assessments were not always being reviewed when people's health status changed or when new circumstances presented potential risks to people's health and well-being.

All staff underwent robust recruitment checks to make sure that they were suitable to work with vulnerable adults.

Is the service effective?

Requires Improvement

Aspects of the service were not always effective.

Care plans did not always contain sufficient detail to enable staff to support people effectively.

People's human rights were not always being protected in accordance with the requirements of Deprivation of Liberty Safeguards (DoLS).

People had a choice of healthy and balanced meals and hot and cold drinks were made available throughout the day.

Is the service caring?

Good

The service was caring.

People's privacy was respected and staff interacted with people in a positive manner.

Where possible people, their relatives and appropriate health professionals were involved in the care planning process.

Relatives told us staff were kind and caring and encouraged people to live fulfilled lives.

Is the service responsive?

Good

The service was responsive.

Relatives told us they felt listened to.

People were encouraged and supported to maintain links with their families.

Staff were aware of the reporting procedures for any accidents or incidents that occurred.

Is the service well-led?

Good

The service was well led.

Staff told us they had staff meetings regularly where they were encouraged to voice any concerns they may have and make suggestions about how to improve service delivery.

Staff and relatives said that they felt supported and that the management was approachable.

The registered manager was aware of their responsibilities with regards to reporting significant events, such as notifications to the Care Quality Commission and other external agencies.

Flat C 291 Harrow Road

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.

We undertook this comprehensive inspection on 28 and 29 March 2017. The first day of the inspection was unannounced and carried out by one inspector and an inspection manager. We informed the registered manager that one inspector would be returning for the second day of our visit.

Before the inspection, we checked information the Care Quality Commission (CQC) held about the service, which included the previous inspection report and notifications sent to CQC by the provider. The notifications provide us with information about changes to the service and any significant concerns reported by the provider.

We spoke with one of the people living at the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the provider's head of adult services, an operations manager, the registered manager and a deputy manager. Following the inspection we were informed that the deputy manager was no longer working at the service. We spoke with four support workers and contacted three relatives in order to hear their views of how the service was organised and managed.

We reviewed a range of key documents that included people's care records, health and safety checks, minutes of meetings, quality audits and the providers' procedures in relation to the management of the home.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found people were not always protected against the risk of unsafe management of medicines. This was because one person's supply of emergency medicine for use when out in the community had passed its expiry date. This issue was rectified and the medicines replaced at the time of our inspection. However, during this inspection, we again found issues with the safe storage of medicines. One person's emergency medicines had been sealed in a tupperware box potentially impeding ease of access. We observed staff failing to ensure medicines were stored in a cupboard that was kept locked when not in use. On one occasion we noted that keys to the medicines cupboard were left unattended and on another occasion saw that staff were unable to locate these keys when needed. The deputy manager told us the medicines keys were the responsibility of the shift leader and should be kept on their person throughout their shift. The registered manager has since informed us that this information was incorrect and that medicines keys are passed between staff members throughout the day. The provider must operate effective procedures to ensure the proper and safe management and storage of medicines at all times. This is not what was observed during the inspection. These issues indicate that people were not always being protected against the risks associated with the unsafe storage, management and administration of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt confident supporting people with their medicines. Medicines administration records (MAR) contained photographic identity pictures and recorded people's names, date of birth and details of prescribed medicines. Staff told us they had received classroom training in medicines administration and that their competency skills had been observed. MAR charts were initialled by staff and we saw that these were completed accurately and with no evident gaps.

Risk assessments centred on the needs of people using the service. Risk assessments covered areas such as personal care provision, eating and drinking and behaviour management. However, risk assessments were not always being reviewed when people's health status changed or when new circumstances presented potential risks to people's health and well-being. For example, we noted from local authority meeting minutes that one person had been referred to an ophthalmologist with a view to cataract surgery. We were unable to find guidelines relating to the management of this condition or relevant information relating to any potential impact on this person's well-being as a result of this diagnosis. Care records stated that this person should be encouraged to turn during the night to avoid pressure wounds. We could find no information stating how often this was required, how it would be achieved and in what way it would be monitored. Information directed staff to take this person's temperature during the night but again, we could find no mention of why this was required and what impact this might have on this person's sleeping pattern. The registered manager has since informed us that this issues has been rectified.

Relatives told us they felt their family members were safe and well cared for. Staff told us "Yes, people are safe. We always follow guidelines and procedures and assess risks. We're always checking [people's] support plans and checking risk." There were policies and procedures in place for safeguarding adults which were available and accessible to members of staff. Staff told us they had completed safeguarding training as part

of their induction and records showed this training was refreshed on an annual basis. Staff were able to demonstrate a clear understanding of safeguarding procedures and knew who to report to if they had any concerns. Staff were also aware of the provider's whistle blowing procedure and told us they knew how to put this into practice if needed.

There were effective staff recruitment and selection processes in place. Before staff began working at the service they were required to provide satisfactory references from previous employers, photographic proof of identity and proof of eligibility to work in the UK. Staff underwent checks with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions in order to help providers make safer recruitment decisions. We looked at five staff files and reviewed information confirming appropriate pre-employment checks had been carried out to help ensure only suitable staff were employed to work with people using the service. There were sufficient numbers of staff deployed to the service and procedures in place to cover any staff absence.

Requires Improvement

Is the service effective?

Our findings

People's freedom and personal preferences were at times subject to inappropriate restrictions. 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

During our inspection we heard that one person using the service had been confined to the home environment since February 2017 due to a faulty wheelchair considered unsafe for outside use. Whilst we acknowledge the registered manager had repeatedly raised these concerns with the wheelchair repair service and other health and social care professionals, this issue remained unresolved at the time of our visit meaning the person affected had been unable to attend the groups and activity sessions they normally enjoyed over a lengthy period of time. The registered manager has since informed us that a specialist seating assessment took place in May 2017. The current wheelchair has been temporarily repaired and a replacement wheelchair is on order.

We asked staff why another person had their hand enclosed in a mitten restricting free movement. We were told that the mitten was used to prevent this person from sucking their thumb and fingers which in turn caused hyper salivation. Staff considered this to be a dignity issue when this person was out and about in the community. However, the registered manager acknowledged that when at home "[This person] is allowed to do whatever [they] want." An occupational therapy assessment had been carried out in August 2016. The reason for the OT referral was to review the therapy programme in place to increase this person's upper limb activity with the long term goal being to increase functional ability in this person's left hand and upper limb. The OT stated that as a result of intervention this person was now able to wear the mitten less throughout the day. However, there appeared to be some confusion amongst staff in relation to this matter and we observed a staff member replacing the mitten when they began their shift despite the deputy manager having asked staff to remove the mitten earlier that day. Since our inspection the registered manager has sought clarification regarding this matter from the relevant healthcare professionals and provided further comment as to the reasons for the use of the mitten to prevent soreness and skin damage.

Records showed that staff were provided with essential training, which included safeguarding, medicines, moving and positioning, food safety, first aid and fire safety. One staff member told us, "I had so much training and did a lot of research on my own." Training was refreshed on a regular basis and involved both face-to-face classroom learning and e-learning programmes. Some staff had joined the service with national vocational qualifications in health and social care. The registered manager ensured that staff had regular supervision which looked at their individual training and development needs. This was confirmed by staff and the records held.

People were supported to eat and drink enough to maintain healthy, balanced diets. We observed lunch being prepared and served by staff. Staff were aware of people's individual preferences and where people needed support with their eating and drinking this was given in a dignified way. Staff ensured that where necessary people had their food cut up and liquid thickened in line with their care plans to reduce the risks of choking. One person required a raised platform for their feet when eating and this was put in place before the meal and removed afterwards. People had a choice of hot and cold drinks throughout the day. People's weight was monitored regularly and action taken to address any specific diet and weight issues.

People had access to a range of health professionals such a dietitians, psychiatrists, dentists and opticians. One person had recently received counselling following a bereavement and staff commented that this intervention had been helpful for the person involved. People were supported to attend annual health checks with their GP and had hospital passports in place that helped identify people's health needs and which health professionals were supporting them.

A health care professional who had visited the service recently was complimentary about the standard of care provided by staff. An email we were shown stated that staff had worked well with 'district nurses and tissue viability nurses in ensuring an improvement' in one person's health and well-being and thanked staff for all their hard work.

Good

Is the service caring?

Our findings

One relative told us, "I truly believe that staff are dedicated. They're good people. You have to be an extremely special person to look after people. I'm very happy about the way my [family member] is looked after.

Staff had developed positive and caring relationships with people. Companionable, relaxed relationships were evident during the day of our inspection. We saw staff using humour and touch when engaging with people. Staff spoke to people in a complimentary manner.

Relatives told us that there were no restrictions on visiting their family members. Relatives told us that staff were kind and caring towards them when they visited and they were happy with the care their family members were receiving. One relative commented, "We're allowed to visit whenever we want. We can go unannounced and that's a good sign. When we arrive, staff always say 'welcome' and I know they mean it. When we take [our family member] out and come back, [staff] always say 'welcome home' to [them]."

Staff supported people's dignity and respect. Throughout the day staff supported people with personal care and toileting. Staff discreetly prompted and supported people with this. We observed staff knocking on people's bedroom doors before entering. A member of staff told us how they carried out personal care, "We close doors, put a towel over [them], close the curtains and explain what we are doing. We offer reassurance, we are a caring team."

People's bedrooms were individually decorated with pictures and photographs of things that people were interested in and had chosen themselves. Rooms were clean and tidy.

People were well dressed and their appearance was maintained by staff. People wore appropriate clothes that fitted and staff combed and styled their hair which demonstrated they had taken time to assist people with their personal care needs.

The registered manager told us that staff were working to meet people's communication needs. Staff told us they used a range of communication methods such as Makaton (Makaton is a language programme using signs and symbols to help people to communicate), picture charts, objects of reference and eye contact to engage with people using the service. Where people were unable to communicate their choices and preferences using the above approaches, staff consulted family members and understood the importance of observing and interpreting people's body language, facial expressions and other verbal and non-verbal cues.

Staff supported people to make choices in their daily lives in areas such as personal care and grooming, activities and meals. Care plans contained detailed information about people's preferences and staff were well informed about people's lives, their family members and favourite past times. Relatives told us that staff understood the needs of their family members.

Staff told us they entered daily information in people's daily logs. Information included a brief overview of the support given, activities participated in and details regarding well-being and behaviour. Relatives told us they were kept updated about any changes in the health and welfare of their family members.

Good

Is the service responsive?

Our findings

People's care plans provided staff with information about people's preferences in terms of communication, personal care, nutrition and mobility needs so that staff were aware of and able to learn about people's needs before they started working with them. Where appropriate, relatives and health professionals were involved in care planning and reviews.

Staff supported people to reduce and manage behaviours which challenged where this formed part of the agreed care plan. The registered manager told us about one person whose behaviour initially challenged the staff and service. Staff supported the person by using strategies, which enabled the person to change this behaviour and who now participates more fully in life within and outside the service.

The service operated a keyworker system. This meant that one staff member was the main contact between a person and their family members. The keyworker was also responsible for updating and reviewing the persons care plans and risk assessments. Keyworkers had put together information about people's history, their likes and dislikes and the goals they hoped to achieve and how. This was evidenced in people's care records.

One relative told us that they can call the staff any time and they will be given updates and an overview of activities, appointments and people's well-being. The registered manager told us that one person using the service attended a group run by an advocacy project, where they were able to meet others to discuss their rights in the community and other issues of interest.

People were involved in a range of activities. A relative told us, "[Staff] give her all the help they can, they encourage [my family member] with her musical interests. Each person had an individual and personalised pictorial timetable in their room depicting their weekly programme of activities. Within the service people watched TV or listened to music, attended to daily chores, ate together, had their nails painted and were able to enjoy a massage from a visiting masseuse. Some people attended art groups and music sessions. Other activities included trips out, shopping, coffee and meals out, day trips and foreign holidays. A member of staff told us, "I went to the Aquarium with [person using the service] [they] were so calm, [they] really enjoyed it, the reflections on the water, the different fish. The registered manager told us about a successful 10 day trip to Lourdes where one person had been able to partake in daily excursions to visit beauty spots in the surrounding area.

People were encouraged and supported to maintain links with their families to help ensure they were not socially isolated or restricted due to their disabilities. The home invited families and friends in to their home for social events and birthday parties that were held.

Relatives told us that they felt listened to said and said they were kept up to date about their family members. The home had a complaints policy in place which detailed how a complaint should be responded too. Staff had a clear understanding of the complaints procedure and understood that they had a duty of care to report any complaints to the registered manager so they could put things right. No formal

complaints had been received
since our last inspection.

Staff were aware of the reporting procedures for any accidents or incidents that occurred and told us they would record any incidents in people's daily communication records and report the matter to senior staff and family members.

Good

Is the service well-led?

Our findings

Relatives and staff told us that the registered manager was approachable, open and supportive. One relative said "[The registered manager] is a wonderful man. He's extremely considerate."

A family friend of a person using the service wrote to the registered manager to say 'We are simply amazed at the fact that all residents there, despite very severe medical problems, are looked after so carefully and lovingly.'

The registered manager interacted with people with kindness and respect and took the time to walk around the service at various times of the day to make observations, talk with people and staff. Staff understood their role, told us they were happy in their work and had confidence in the way the service was managed. One staff member told us "[The registered manager] leads by example, he explains things and he's a good teacher."

The registered manager told us there were improvements he wished to make to the service to improve people's quality of life. This included following up health and social care referrals, developing the range and scope of activities, increasing staff training in areas such as epilepsy and diabetes awareness and ensuring staff clearly understood the medicines policy and procedures.

Staff told us they attended staff meetings regularly. We saw minutes of staff meetings, items on the agenda included care practise issues, updates on people's health and well-being and training. Staff were clear about their roles and responsibilities. Staff showed us the handover sheets and daily routine sheets which detailed which staff member was supporting whom and what else they were responsible for during their shift.

There were systems in place to ensure that quality care was provided and improved where identified. Various audits took place every few months looking at care and support, staff conduct, the environment and general observations. Service manager meetings were held regularly with registered managers of other services within the region where good practice and learning took place. From these audits the management team compiled action plans, which detailed what needed to be completed, who was responsible and the date action would be completed.

The registered manager was aware of his responsibilities with regards to reporting significant events, such as notifications to the Care Quality Commission and other external agencies. This meant we could check that appropriate action had been taken.

Annual satisfaction surveys, key planning sessions and residents meetings and healthcare reviews provided opportunities for people to feedback ideas, any complaints, concerns, ideas and compliments to staff about any area of their care and support.

External quality checks can provide useful insights and a different perspective about how a service is being run. The North West London Consortium, a service funded by the department of health conducted quality

checks on request from the provider. After the visit carried out in June 2016 the visitors provided an action plan for suggested improvements and overall made positive comments about the service and staff. The registered manager had taken on board feedback received and made changes where these were required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always being managed safely. 12 (1) (2) g