Look Ahead Care and Support Limited

Tower Hamlets LD Service

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

We carried out on this inspection on 26 and 27 July 2016. We gave the provider 48 hours' notice of this inspection. This was the first inspection since the provider registered with the Care Quality Commission to provide this service in February 2015.

Tower Hamlets LD Service is a supported living service for people with learning disabilities, which provides personal care for three people who live at the service, with another three people who received support from the service but not with personal care. The service is a large house on Old Ford Road with eight bedrooms including a staff sleep-in room, a staff office downstairs, two kitchens, a shared garden, two shower rooms and a bathroom. One bedroom was unused at the time of our inspection and one person was in hospital.

The service had a registered 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.

The provider had plans in place to manage risks to people, which were reviewed regularly. There was a robust system of health and safety checks to ensure that the service was safe, and when incidents and accidents had occurred these were appropriately recorded and necessary actions were taken.

Staff operated in a person-centred way, ensuring that people's care plans reflected their needs, and supported people to achieve their goals, which included increasing their independence and going on holidays and day trips with staff support. People were involved in the running of the service, including being given roles by the provider to support health and safety and the security of the building. People were supported to make choices about their home through regular house meetings. We saw that people were treated with respect by staff who promoted their privacy and dignity. Issues of consent and mental capacity were dealt with appropriately by the provider, who had correctly applied to the local authority when they thought people may be deprived of their liberty.

The provider ensured that it met people's needs and supported people to speak up through regular keyworking sessions and by reviewing care plans and people's levels of support. People had communication passports in place, and the provider was using accessible communications and objects of reference to ensure people could communicate their wishes. People were supported to achieve good health outcomes, through the use of health action plans and hospital passports and by providing people with accessible information about their health. Staff had sought specialist advice and planned to meet people's changing needs. People were supported to eat a balanced diet which met their health needs, make choices about their food and develop their independence.

Managers maintained good systems of audit and provided a strong presence in the service and good leadership through team meetings and supervision. People knew how to make complaints, and complaints

were investigated and appropriate actions taken in response.

Medicines were stored and administered safely, although we found that the way the service documented medicines and assessed people's needs was not always in line with best practice. We have made a recommendation about how the provider manages medicines.

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.

Health and safety checks were carried out regularly and were sufficient to ensure the building was safe.

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

Medicines were managed safely, however we saw that in one case the provider was not working in line with best practice.

Is the service effective?

Good

The service was effective.

Staff had adequate training to carry out their roles, and the provider carried out observations of staff competency, although these were not carried out systematically.

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

People were supported to have balanced diets which met their needs and make choices about their food.

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

Is the service caring?

Good

The service was caring.

There was evidence that people were involved in the running of the service through house meetings and involvement in recruitment processes and by having specific roles.

There was accessible information available on activities and

people had communication passports which documented how they liked staff to communicate with them.

We saw evidence of respectful interactions between staff and people who used the service, and staff ensured that people's dignity and privacy was promoted.

Is the service responsive?

Good

The service was responsive.

Support plans contained detailed information about people's needs, preferences and goals, and these were reviewed regularly to meet people's changing needs.

Keyworking sessions took place regularly to ensure people's views were taken into account. The provider had taken steps to plan for people's future needs.

People knew how to make a complaint if they were not happy about something. Complaints were recorded and investigated, and appropriate actions carried out in response to these.

Is the service well-led?

Good

The service was well led.

Managers maintained a presence in the service and were approachable. There were systems of checking and audits in place to ensure that care was delivered appropriately and safely.

Supervisions and team meetings were taking place regularly and were used to ensure staff understood their roles and responsibilities and to provide a good standard of leadership.

Managers had brought about a significant improvement in the quality of the service since taking over from the previous provider in February 2015.

Tower Hamlets LD Service

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 26 and 27 July. The provider was given 48 hours' notice because the location provides a supported living service for people who are often out during the day; we needed to be sure that someone would be in.

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 information we held about the service, including notifications of significant events that the provider was required to tell us about. We also spoke with a contract monitoring officer from the local authority.

The inspection was carried out by a single inspector. In carrying out this inspection we spoke with the registered manager, the team leader and two support workers. We also spoke with four people who used the service and one relative. We reviewed records relating to three people's care, and information about the management of two people's medicines. We looked at four staff files, including records of recruitment and supervision, and records of training and meetings for the staff team. We also looked at other records relating to the management of the service, such as daily records, rotas, incident and accident forms, health and safety checks and records of complaints. We also carried out observations of people's daily support and interactions with staff.

Good

Is the service safe?

Our findings

People who used the service told us that they felt safe living there and that if they had any concerns they could speak to managers about this. Staff provided accessible information on safeguarding, consent to relationships and personal safety. Staff had undergone training in safeguarding adults, were aware of the signs that a person might be being abused and how to whistleblow if their concerns were not being acted on by managers. One staff member said "I've never had to complain."

Risk assessments met people's needs and were kept up to date, and included appropriate risk management plans. Where people were at risk of falls, these plans included the use of equipment such as walking frames and ensuring that this equipment was cheeked regularly for safety. We saw appropriate equipment was in use to detect falls, for example a person had sensor mats on their bed and chair, which would detect if they had got up in the night and not returned to bed, which had replaced a baby monitor staff had previously been using. The provider had guidelines in place for supporting people who were at risk of falls. As some people may have been at risk from opening the front door, the provider had installed an alarm on the front door. There was a risk management plan in place for a person who had behaviour which may have challenged the service, and this contained suitable information on possible triggers for this behaviour.

The provider had a system in place for logging incident and accidents, which recorded that appropriate action was taken as a result of these, such as supporting a person to attend a GP appointment in response to a fall or illness. Where injuries were recorded such as bruises, these were recorded and follow up actions were recorded.

We saw that food was being stored safely. For example, the fridge was kept clean with food labelled with the date of opening, and one staff member was responsible for carrying out weekly checks to ensure that out of date food was disposed of, and maintained a list of what was out of date and what needed to be used soon. Fridge and freezer temperatures were checked daily, with clear guidelines for staff on what was a suitable temperature. Chopping boards were labelled and colour coded for different purposes to protect against cross contamination. There was a meat thermometer in the kitchen and a log was kept when meat was cooked and the temperature had been checked. The kitchen had received a 5 (very good) rating from the local authority in November 2015. All cupboards were labelled with contents, including those that contained hazardous chemicals. There was hand wash available by sinks and accessible information about correct handwashing was displayed next to sinks.

Automatic fire doors were installed, which were activated by the fire alarm. The health and safety officer demonstrated the safe functioning of these to us. We saw records of fire alarm and call point testing and faults were reported. An engineer was attending at the time of our inspection to fix a reported fault. Records showed that there had been a yearly check on emergency lights and staff also checked these weekly. Fire drills were taking place quarterly and there was a quarterly fire safety checklist being carried out. Staff and people who used the service signed to show that they had undergone a fire safety induction.

First aid kits were checked for their contents monthly and a health and safety check was done weekly. This

included looking at the condition of doors, furniture, carpets, lights, electrical sockets and the bathroom. An annual water check was carried out by the landlord and temperatures of the water were recorded weekly by staff. Testing of portable appliances and gas safety were also carried out yearly. The health and safety officer aided in the reporting of faults, and it was clearly recorded when a fault had been reported, along with a date when this had been successfully completed. All faults had been addressed by the staff team in a timely manner. The provider told us they were planning to arrange maintenance training for staff, so that minor faults could be repaired safely and immediately by the staff team.

The provider carried out monthly checks to look at the cleanliness and safety of people's rooms, including furnishing, floors and curtains. People had shower chairs when these were required, and these were labelled with the person's name for hygiene purposes. There was a lifting rail in place to allow people to safely use the toilet, a separate bin for contaminated waste, and a pull cord alarm for people to use in an emergency.

There was a signing in book for visitors to the service, which was maintained by the security officer with the support of staff. Staff maintained a "grab and run" file by the front door, which contained essential information such as personal emergency evacuation plans, business continuity plans and medicines information.

Staff were managing people's money safely. Money was stored in a locked safe in the staff room. There were guidelines in place for collecting people's money in line with the requirements of the Court of Protection. Finances were checked by the shift leader on a daily basis, and any discrepancies recorded on the shift plan. Monthly monitoring was carried out to verify the amount in the person's cash tin agreed with the amount in the book, and that all expenditure was recorded and verified against receipts. This had been effective at noting and addressing minor discrepancies such as missing receipts, which were recorded in a monthly report.

Staff slept in the service every night in a dedicated sleeping in room. Staffing rotas showed that two staff were on duty in the morning and evening in addition to a team leader. This meant that even when two staff were required to support one person, there was still one member of staff available to support others. Staff roles included support workers and peer support workers who worked flexibly in order to support people with specific activities. The provider told us that they had not used agency staff since February this year. We saw that the provider was recruiting staff in line with safer recruitment processes. 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 Service (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.

We looked at the arrangements for two people's medicines. Medicines were stored and recorded appropriately. The provider had recently started to use a blister pack system supplied by the pharmacy, and these packs along with other medicines were either stored in locked boxes in people's rooms, or stored securely elsewhere where people had chosen this. Keys to the medicines cabinets were stored in the staff room. Medicines recording charts (MRCs) were correctly signed by staff to show that people's medicines had been administered, and there was a specimen signature sheet kept with the records to ensure it was clear who had signed for which medicine. Staff were allocated to carry out a medicines stock and check of the MRC on a weekly basis, and a monthly audit was carried out by the team leader to ensure that these were correctly carried out; this had highlighted issues for staff to address, for example that a PRN protocol needed to be reviewed. Currently prescribed medicines were correctly recorded on the medicines profile, which staff told us was what they worked from. However, this same information was duplicated in some other

documents, such as the hospital passport and front sheet, which meant it was difficult for staff to update all documents when a medicine was changed.

In one instance, we saw that there were discrepancies between what the care plan, risk assessment and medicines profile said about the level of support a person received with their medicines. However, staff told us they were working from the person's medicines profile, which accurately described the level of support required. The medicines profile showed that the person was given a tablet from the blister pack to take to a day service in a dosset box, where they self-administered this. This was accurately recorded by staff, and staff told us they checked with the person on returning home that this had been taken, and said that there had never been a problem with this arrangement. However, these steps had not been recorded in a risk assessment, and the secondary dispensing had not been risk assessed to ensure that this was the safest option for the person.

We recommend that the provider seek advice from a reputable source such as the National Institute for Health and Clinical Excellence (NICE) guidelines on managing medicines in care homes.

Good

Is the service effective?

Our findings

People were supported by staff who had the skills and knowledge to meet their needs effectively. Staff told us that they were happy with the level of training they received. Records showed that staff had up to date training in essential areas such as personal care, health and safety, equality and diversity, infection control, food safety, nutrition, mental health, data protection and first aid. The provider had systems in place to ensure that these were kept up to date, and people's training needs were reviewed in supervisions. Observations of staff competency was taking place, for example we saw observations of staff administering medicines, and practice observations where staff were observed carrying out tasks such as menu planning with people who used the service. Managers made observations of staff body language, communication and listening skills. We saw these were not taking place regularly, which may have meant that not all staff were receiving regular checks of their competency in essential areas.

The provider 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. People had signed to indicate that they had consented to their care, and appropriate consent was documented for using photographs and sharing information where necessary using accessible formats. This indicated the provider had taken steps to support people to understand decisions. Staff had received training in mental capacity and Deprivation of Liberty Safeguards (DoLS) and understood their responsibilities in this area.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that the provider had met its responsibilities by carrying out assessments of people's capacity and applying to the local authority to deprive people of their liberty where staff thought this was in the person's best interests.. It was not clear that people were being deprived of their liberty in all cases, for example the provider had made an application for a person who would not be able to leave the building safely without support, but this person needed physical support from two staff to leave the building, however this application ensured that the provider was complying with the law. In two cases, these applications had not been processed by the local authority, which meant the provider was not yet required to notify CQC. In one case an urgent seven day authorisation had been granted but not a full assessment, and the provider had not notified CQC of this outcome. Managers told us that they had not understood that an urgent authorisation also required a notification to CQC.

People were supported to have balanced and healthy diets. People had personalised pictorial menus in place, which were reviewed monthly, except for one person who confirmed with us that they didn't want this in place. These menus included a person's picture, and were used as objects of reference for a person to point to if they could not say the item they wanted. We saw that people's choices were being supported, for example staff told us everyone had a different favourite yoghurt, and there were many different types of yoghurt in the fridge which were labelled with people's names. We also saw examples of food being used as

objects of references to support people to make healthy choices. For one person who was lactose intolerant, we saw that they were supported to purchase non-dairy options in line with their care plan. Care plans had detailed information on people's dietary needs where necessary. People had separate cupboards for storing their food, and these were labelled with the person's name and photograph. We observed that people were supported to cook meals by staff if necessary, and saw that several people were preparing their meals independently. Before meal preparation began, we saw staff speaking to each person individually to ask what they wanted, and everyone was supported to prepare a different meal.

The provider had measures in place to promote good health. For example, accessible information on staying healthy was displayed in appropriate places in the building, with information on healthy eating displayed in the kitchen, information on oral hygiene was kept by the sinks in people's rooms and information on personal hygiene was kept in the bathroom. Health action plans were in place for everyone who used the service, these detailed people's health needs and the support that they needed to stay healthy. One was carried out by the community learning disability team and one was carried out by the provider. There was significant overlap between these documents, but the provider's health action plan gave a useful account of appointments people had attended and their outcomes. We saw evidence of GP appointments to look at specific concerns, and people had been referred to specialist services such as continence, cardiology and endoscopy. Where one person's health had deteriorated significantly, we saw extensive records of contact with health professionals to address this person's health needs, including supporting the person to hospital where necessary, and a pain management plan was in place for one person with acute pain. Staff were using a free patient transport service to support people to appointments. People also had hospital passports, which are documents which provide essential information on people's needs to hospital staff, and these had all been reviewed in the past year.

Good

Is the service caring?

Our findings

People told us they enjoyed living at the service, and that they made choices about their activities. A relative of a person who used the service said "He seems to like it here. Always has an activity to do."

We saw good evidence of positive caring relationships with people using the service. For example, people had roles in the house, where they took responsibility for an aspect of the running of the service. For example one person was the health and safety officer and was responsible for working with staff in carrying out health and safety checks and reporting maintenance issues. The provider had designed an accessible health and safety form to support them in this. Another person was responsible for security, and signed in visitors to the service and checked identification with staff support. The provider told us they were planning on introducing a role of recycling officer. All people with roles in the service had their own identification badges from the provider.

We saw that people who used the service had discussed gardening in a tenants meeting, and as an outcome from this people had all planted vegetables of their choice in the back garden and were supported to maintain these. The garden was well maintained, and people had chosen what flowers to plant and the colour of the outdoor lights. There were fresh flowers from the garden in communal areas. The provider told us they had obtained funding to replace the garden shed to provide a place for storing garden tools.

People had chosen what activities they wanted to do for learning disability week, and had held an arts and crafts session in the house which people from other services attended. They had also made t-shirts of their choice. People who used the service told us that they had recently chosen to buy a karaoke machine for the kitchen, and one person demonstrated how to use this.

House meetings were carried out every month, and began by reviewing actions that had been agreed at the last meeting. These provided a forum to discuss and agree activities, rules for the house and to ensure that relationships were positive between people who used the service. People had been supported to review a set of house rules, which were agreed by everyone and displayed in the kitchen. Meetings were also used to ensure that people were happy with staff and to see if any changes were needed, for example to keyworking arrangements. House meetings were sometimes held alongside the staff meeting in order to support everyone to have a say in the service, this had covered areas such as the provider's policies, satisfaction surveys, activities, holidays, the management of pooled money and changes to the staff team. People had signed a 'kindness contract' which outlined what was expected of people who used the service, and we saw that a rota was in place for dividing up household tasks to ensure that nobody was doing more than other people.

The provider maintained a customer information folder in communal areas, this included information such as a newsletter for all services managed by the provider, information on healthy eating, birthdays and possible activities, including a day trip to Belgium and those taking place for learning disability week. The provider was running a "Masterchef" competition, a poster for which was displayed in the kitchen. Staff profiles were also displayed, this included information about staff, their personalities and interests. People

who used the service had participated in the recruitment of staff, and we saw on staff files that people had asked them questions of their choosing and recorded whether they were satisfied with the candidate's answer.

People had communications passports in place, these providing information on how best to communicate with people and what they liked and didn't like. One person was a Bengali speaker, and the provider told us they had two staff members who spoke Bengali, and that when these staff were not available they were able to use staff from another service to ensure this person could always communicate with staff.

Throughout our visit we saw kind and respectful interaction between staff and people who used the service. For example, one person came in to ask the advice of their keyworker, and we saw that the staff member was respectful, listened to the person, asked them questions and encouraged the person to take responsibility for themselves. Guidelines for personal care included guidelines on how to ensure the person's privacy was respected, and staff told us how they would maintain people's dignity whilst carrying out personal care, for example by keeping doors closed, and asking people what they would like staff to do for them. We saw one person being politely reminded by staff to keep their door closed whilst changing in order to protect their privacy.

Good

Is the service responsive?

Our findings

People's individual needs were met as support plans were person-centred and goal-orientated, and had a good level of detail about what tasks people could do for themselves, what skills they had and what levels of support they required. For example, one plan identified that the person needed staff support to eat healthily, and agreed that a staff member would go shopping with the person and support them to buy healthy meals.

There were good examples of people being supported to achieve their goals. For example, two people had identified that they wanted to go on holiday with staff support, and they were supported to choose a trip to Barbados and chose the staff that went with them. The provider had funded this staff support time mostly within available staffing hours, and had reached an agreement with people for them to pay for the additional staffing. The provider had documented this process, and included examples of activities that they had undertaken, such as a safari and a tour of reefs.

Support plans contained people's preferences on the gender, skills and qualities of their staff, and specific guidelines were in place for carrying out personal care for each person. There was detailed information on people's dietary needs, toileting, health needs and mobility. Plans had clear information on people's activities and there were timetables displayed in the staff office to show people's regular activities and their preferences outside of these. Staff gave examples of how they worked to increase people's independence, even when their needs had increased. Although plans were based around people's goals, in many cases these goals were quite broad and general, and therefore did not contain specific detail about how people should be supported to achieve these and how this would be measured.

Support logs provided brief information on the support provided to a person on a particular day. In most cases these reflected people's support plans, but in one case we saw that a person's care plan stated that they were to be supported to bathe daily, but this was not always recorded on support logs. However, we used other information such as handover sheets to verify that this was taking place and being recorded. Records reflected how levels of support had changed to meet people's needs, for example where a person's health had deteriorated, plans showed that this person was now supported by two staff. This person was currently in hospital, and staff had planned ahead for their return home, for example by requesting waking night staff from the local authority.

Staff told us the building "could be better" and placed limitations on their practice. The building was old and not fully accessible. There were steps between the bedrooms and the bathroom, and the provider said that they did not have space to install a stairlift for one person who lived on the first floor and had deteriorating mobility. However, the provider told us that they had been able to support the person to move into a vacant room on the ground floor, and we saw that they had sought specialist advice from occupational therapists to see if any adaptations could be made to allow this person to continue living at the service, and had written this advice into the person's care plan. The provider had requested additional staffing hours to allow some people to remain in the service as they were getting older and finding it harder to move around the house, and where necessary, people had been referred to advocacy services to ensure their views about

their future living arrangements were taken into account.

Keyworking sessions were carried out weekly, and additional sessions took place to discuss particular areas such as activities and the development of life skills. A special session had taken place for each person to explain the EU referendum, to find out if the person wanted to vote and to arrange the appropriate support for the person. Keyworking sessions were responsive to people's needs, for example one member of staff had retained keyworking duties for a particular person on the advice of a psychologist, even though they had changed roles, and when a person had deteriorating health there were more frequent sessions which discussed their needs and support. Staff had recently started adding pictures to make these more accessible, and there were agreed actions at the end of each session. There was an index at the front of the keyworking file so that dates and subjects discussed could be easily seen.

People told us that they would talk to the manager if they were not happy about something and wanted to complain. There was an accessible complaints policy which was made available for everyone. Complaints were recorded by the provider, and this showed how complaints were investigated and that appropriate actions were taken.

Good

Is the service well-led?

Our findings

People who used the service knew the managers well, and managers had a visible presence in the service. Staff were confident that managers took their concerns seriously, and were positive about changes made by managers. One staff member said "they decorated the sleep in room and built a shower for us."

The team leader had put in place a handover file, with a detailed shift plan. There were clear responsibilities for allocated staff, such as a rota check, checks of communal areas, room checks, fridge checks and emptying bins, and a list of shift leader responsibilities displayed in the staff room. The daily shift plan required staff to indicate that certain tasks were carried out, such as checking people's money and medicines and whether personal care had taken place. However, in some cases these had been ticked off incorrectly, for example staff had indicated that they had provided personal care when a person was in hospital, but comparing these with support logs showed that care had taken place appropriately. Appointments were recorded on the back of these forms using information from the daily diary. There was a weekly task plan in place which included tasks such as keyworker sessions and health and safety checks, and this was signed off by a manager to ensure these checks had taken place. Monthly audits were also carried out of medicines and of people's money.

Casework management meetings took place in staff supervisions, where people's support needs were discussed. Files were audited with keyworkers, and an action plan was made on what documents needed to be reviewed or updated. Staff told us that supervisions took place every month, and that managers were always on hand if they needed to speak with them. One staff member said "If I'm in need I can always come to [them]". Records showed that supervisions were taking place at least every two months, and the provider indicated that they wanted to ensure that these were taking place monthly. Supervisions were recorded appropriately, and subjects covered included keyworking duties, workload, responsibilities in the service and training and development needs.

Team meetings were taking place monthly, and were well attended by staff. Meetings began by reviewing the action plan from the previous meeting to ensure that these had been carried out. Meetings were used to discuss internal policies, allocate tasks such as developing the garden, clarifying staff responsibilities with regards to health and safety and to review essential information such as health information, updates on people's needs, activities, shopping, service improvement, mental capacity and DoLS.

The staff information files contained information on policies, activities and specific guidelines for people around their medicines and personal care, and what staff should do in response to an incident. This was used to induct new staff into the service. The provider maintained a 24 hour on call system for emergency use.

The contracts monitoring officer at the local authority told us that they rated services "red", "amber" or "green" based on concerns and perceived level of risk to people who used the service and/or the operation of the service , and that when the provider took over the service in February 2015 this was rated "red", but now considered this to be "green." This person told us "The Service has done particularly well in completely

turning around medication management and monitoring, and delivering the aspirations of Service Users to travel abroad" and expected the findings of their next monitoring visit to be "nothing short of positive."