Metropolitan Housing Trust Limited

Old Hospital Close (21)

Inspection report

21 Old Hospital Close
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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

This inspection took place on 10 January 2017 and was announced. At our previous inspection on 4 December 2015 we found the provider was meeting the regulations we inspected.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Old Hospital Close (21) provides accommodation for up to five people with learning disabilities. It is located in Balham, close to local amenities and transport links. It shares staff with a sister home based at number 12. At the time of the inspection there were four people using the service.

People using the service told us they were happy and enjoyed living there. They spoke positively about the day centres they attended and said that staff were kind towards them.

People were encouraged to maintain their independence. We observed people making their own breakfast and getting themselves ready to go out on the day of the inspection. We also observed care workers encouraging people to carry out their personal care and to complete daily living tasks such as collecting their laundry for washing.

Relatives that we spoke with told us they were happy with the support their family members received from the service. They told us that they knew the staff and were kept informed if anything happened. People were supported to maintain relationships that were important to them.

Regular meetings were held where people were able to discuss issues that were relevant to them in a group environment, which included activities, menus, staffing and any concerns. People were also able to discuss issues privately through one to one meetings with their key workers who they met on a monthly basis.

People had their health and medicine support needs managed appropriately by the provider. Healthcare professionals such as therapists and psychiatrists were involved in providing additional support if needed.

The provider was complying with the Mental Capacity Act 2005 (MCA) and had submitted applications to legally deprive people of their liberty where it was felt they were not free to leave the service on their own for their own safety.

Care plans were individual to people and based around encouraging their independence and improving their daily living skills. These were reviewed on a monthly basis.

Staff told us they felt supported and enjoyed working at the service. They received regular training which

was monitored to ensure it was up to date, which helped them to support people more effectively. They also received regular supervision and were given areas of responsibility which helped them to motivate them to carry out their duties.

The service was well managed. We received positive feedback about the registered manager from relatives and staff. A number of audits were carried out to monitor the quality of service provided to people, some of these were based around the ratings systems used by the Care Quality Commission (CQC).

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.

Staff were familiar with safeguarding procedures and what steps to take to protect people.

Risk assessments for people and the environment were carried out which helped to ensure people were supported in a safe manner.

Recruitment procedures were thorough.

People were supported to take their medicines and accurate records were kept.

Is the service effective?

Good

The service was effective.

Staff received regular training which helped them to support people effectively.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). Where people did not have the capacity to understand decisions related to their care, these decisions were made in their best interests.

People's dietary and health care needs were being managed appropriately.

Is the service caring?

Good

The service was caring.

People told us that staff were friendly and they liked them, cared for them and respected their privacy.

Staff promoted people's independence and care plans were written in a person centred way.

Is the service responsive?

Good

The service was responsive.

People told us they enjoyed the day centres they attended.

People were supported to raise concerns through a number of ways. Where complaints had been made action was taken to resolve them.

Care plans were outcome based and revolved around improving people's daily living skills.

Is the service well-led?

Good

The service was well-led.

There were a number of quality assurance audits which took place at regular intervals.

Staff told us they felt well supported and given opportunities to better themselves.

Old Hospital Close (21)

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 unannounced comprehensive inspection on 10 January 2017.

The inspection was carried out by one inspector.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

We spoke with four people using the service, four relatives and six staff members including the registered manager, team leader and two care workers. We looked at three care records, training records, four staff records, complaints and audits related to the management of the service.

After the inspection, we contacted nine health and social care professionals and heard back from three of them.

Good

Is the service safe?

Our findings

We spoke with and observed people before they went to their day centres on the morning of the inspection. They looked well-presented and happy. They told us they liked living at the service and that staff treated them kindly and looked after them.

Relatives that we spoke with also told us they had no concerns about the safety of their family members. They said, "Yes, [my family member] is safe. I trust the staff. I have known them for a long time", and "They seem kind and always keep me up to date with anything that goes on."

A safeguarding folder was available in the office, containing the policy and guidelines for staff on what to do if they had any concerns about the well-being of people using the service. Care workers were aware of safeguarding procedures and what steps to take if they had concerns about the safety of people. One care worker said, "Customers can be vulnerable so safeguarding is making sure they are safe and looked after."

No safeguarding concerns had been raised with the local authority since the previous inspection.

We checked the financial record keeping for two people using the service. People had their own bank account and staff would go with them to withdraw money. Accurate records were kept of every transaction and audited at every handover. The provider managed the finances for some people using the service but had contacted the local authority to assign an appointee as the registered manager felt that this was a potential conflict of interest. Financial capability assessments were completed for people using the service assessing their capacity to understand financial matters and if they understood the value of money.

We found that there were enough staff employed to meet people's needs. On the day of the inspection, there were two care workers on shift between 07:00 and 14:30, two between 14:00 and 22:00 and two between 21:45 and 07:15, one sleep-in member of staff and one waking night staff. The registered manager confirmed that these were the normal staffing levels. We reviewed the staff rotas for the month of December 2016 and January 2017 and confirmed they were as stated.

Some people using the service were provided with additional one to one support on top of the normal staffing levels throughout the day. The registered manager and team leader also worked during the week as supernumerary to the care workers.

Evidence was seen of Disclosure and Barring Service (DBS) and identity checks. The DBS check assists employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people and includes criminal record checks.

We were unable to view references for care workers as all pre-employment checks were carried out centrally from head office rather than from the service. The registered manager sent us a copy of the recruitment procedure which stated that 'all offers of employment are subject to Metropolitan's pre-employment checks, which are carried out by the Metropolitan Recruitment Team: Written references covering the last 3

years of employment / study, Declarations of Interest, Proof of ID / right to live and work in the UK and DBS checks, where appropriate. Appointments will not become unconditional until these checks have been deemed satisfactory to Metropolitan.'

Where people had been identified as being at risk in certain areas of their daily living there were risk assessments and associated care plans in place which helped to keep people safe and gave staff the appropriate guidance.

Risk assessment management plans were in place, providing background information about the person. They also included the area of risk, identified hazards, people who were at risk and existing control measures in place to manage the risk. Control measures included potential triggers and tips for staff on how to manage the risk.

There was evidence that relevant information that came from health and social care professionals related to people's risks were considered and used when developing their risk assessment management plans.

A number of environmental checks were undertaken to assess risks to people and promote their safety at the premises. Other checks that were completed included temperature checks for cooked food, the fridge, medicine room, bathing and showering. Fire alarms were tested weekly and fire drills completed quarterly. Emergency lighting was tested weekly.

People received their medicines safely and as prescribed. Medicines administration records (MAR) were completed correctly by care workers. People received their medicines in blister packs.

Customer profiles included people's preferences about how they liked to take their medicines, any special instructions and their GP contact details.

Care workers completed a medicines handover checklist at every shift confirming the quantities of medicines stored. Any medicines that were ordered in were accounted for.

Good

Is the service effective?

Our findings

Care workers received appropriate training that enabled them to meet people's support needs. They told us they were happy with the level of training they received. One care worker said, "We get regular training, the last one I went on was manual handling in August."

The registered manager told us they had implemented the Care Certificate and new employees were expected to complete this training as part of their induction. The Care Certificate is the new minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. There are 15 different standards that are covered as part of the Care Certificate, these include duty of care, equality and diversity, working in a person centred way, communication, privacy and dignity, fluids and nutrition, awareness of mental health, dementia and learning disabilities, safeguarding, basic life support, health and safety and infection control. No new employees had been recruited recently so we were unable to check completed records, however, the registered manager sent us the Metropolitan Care Certificate Induction Portfolio which showed all the modules covered as part of the induction.

All training records were stored online and each employee had an individual development pathway in place for their training. The training delivered was a mixture of e-learning, face to face and workshops. Training delivered was based on their roles and was split into core learning, care and support core learning, care and supported registered learner and learning disabilities. Automatic notifications were received by staff and the registered manager when training was due to expire. This helped to ensure that care workers kept up to date with their training. The registered manager told us he reviewed staff training during one to one supervision meetings.

Care workers received regular supervision through one to one meetings that were held every six weeks. They also completed and an annual appraisal held every April and a mid-year review in October during which staff set themselves objectives for the upcoming year.

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).

Staff demonstrated a good understanding of the Act and its purpose. One care worker said, "Mental capacity is where the customers are not fully capable to make a decision so we have to decide for them in consultation with social workers, family and other professionals."

We observed staff encouraging people to make their own decisions about everyday things such as what they

wanted to eat and what they wanted to wear. Care workers told us that people were encouraged to make choices and give their opinions about how they wanted to spend the day and what they wanted to do on weekends.

The registered manager had submitted DoLS applications for people using the service because they were not free to leave the service on their own and were under supervision and control. Best interests' assessors and a doctor had visited the service to carry out the assessments.

Relatives of people using the service told us they had no concerns about the support that their family members received in relation to their diet. They told us they sometimes brought in food from home for their family members.

The kitchen area was clean and well stocked. We saw people making their own breakfast and helping themselves to food items.

Food guidelines were on display in the dining area and these were in relation to people's nutritional needs. Weekly menus were also on display. This included a cooked breakfast on weekends and a variety of meals for supper such as pizza, spaghetti bolognaise, casserole, chicken and rice, stir fry, pies and pasta dishes. Lunch was usually provided at the day centres.

Care records showed the input of healthcare professionals, demonstrating a multi team approach to supporting people. These professionals included dietitians, speech and language therapists, psychiatrists and psychologists. Specialist support plans were also in place, for example supporting people with epilepsy. Care workers were aware of people's health needs. One care worker said, "We've contacted the dietitian for [person] and [person] is diabetic which we control by tablets and diet."

People had health action plans and hospital passports were in place. The aim of the hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health needs when they are admitted to hospital.

Good

Is the service caring?

Our findings

People using the service told us that staff treated them well and they were kind. One person said, "I'm happy", another said "Everything is OK, I'm waiting to go Baked Beans (a day centre)." People using the service were well dressed and looked presentable. The majority were waiting for transport to take them to different day centres.

Relatives were happy with how staff treated their family members. They told us that care workers were "Friendly", "Everyone is lovely, I know [staff member] well and she/he is lovely."

Many of the care workers and people using the service were familiar to each other as they had worked and lived at the service for a number of years. It was clear from our observations that they were comfortable in each other's company. Care workers were familiar with people's preferences and how they liked to be supported. People were also supported to maintain relationships that were important to them. This included visiting family during the weekends.

People's privacy was respected as each person had their own bedroom and care workers did not enter people's rooms without their permission. People were given choices and freedom to choose how to live their life. They were consulted about activities, food choices and how they wanted to spend the day. Bedrooms were individual to each person and were furnished according to their needs.

People were provided with information in a format that was accessible to them, which included minutes of their meetings and information about raising complaints. A pictorial staff noticeboard was on display in the main hallway, identifying the staff that were on shift. Staff told us that people liked to get involved and put pictures up of staff themselves.

We observed people preparing breakfast independently, with gentle staff encouragement. One care worker said, "They are independent, they all make their own breakfast and look after themselves. We just need to remind them most of the time. For example, this morning I told [person] to go and shave and he did it." Care plans also included a one page profile giving a brief person-centred snapshot of people that described how best to support them, what's was important to them, what people liked and admired about them, and what they didn't like.

People had a person centred care plan in place. These had been reviewed recently. They gave staff person centred information such as how to communicate effectively with people, their life history, their religious and cultural needs and how to support their independence.

Good

Is the service responsive?

Our findings

People using the service attended different day centres for people with learning disabilities during the week. Some of the activities they did included drama, musical theatre, woodwork, horticulture and digital skills. People's daily activities were on display in the dining area and they spoke positively about the day centres they attended, telling us they enjoyed going there. One person said, "I'm going to Baked Beans today. I play there."

People usually spent their weekends with their families or having their families visit them. They also did shopping and went out with their key workers. They said, "[Staff member] is my key worker. [They] take me out", "I go to the shops on weekends" and "I go to see my [family member]."

People using the service had individual care plans in place. Care plans included a front page with basic information about the person they were written for including the date they started using the service, details of next of kin and professionals such as social workers, psychiatrists and therapists involved in their care and basic health diagnosis.

Each person had a support plan in place which was 'outcome based.' This meant that there was a desired outcome and associated short term plans in order to reach the desired outcome. For example one person's desired outcome was 'to be fully independent in maintaining good hygiene, dressing appropriately, keeping room clean and prepare simple meals.' Their goals towards achieving this outcome were to maintain self-care without prompting, improve domestic skills and keep home and living environment clean. They had an action plan in place, which consisted of prompting to take their dressing gown to the bathroom, encourage to use mouthwash and prompt to shower, ask them to wash hands preparing food, support to make breakfast and prompt to clear up afterwards, prompt to do laundry and encourage them to participate in health and safety checks, including the fire drill.

These were achievable goals that were monitored through regular reviews and meetings with key workers.

At the time of the inspection, not all of the care plans were in this format. The registered manager told us that care plans were in the process of being changed to this outcome based version. The previous support plans which were in the process of being replaced were included as part of people's person-centred plans.

Monthly key worker reviews took place which included discussing current review notes, family and social contact, health and medical issues, activities of interest, daily living skills, day care/education, personal finances, accidents/incidents and behavioural observations and general well-being.

Relatives of people using the service told us they did not have any complaints about the service but felt confident that if they approached the registered manager with any concerns, they would be listened to.

People using the service were encouraged to speak up and raise any concerns they had through key worker meetings and residents meetings. There was a complaints information sheet on display in the hallway, this

was in an easy read format.

There had been one recorded complaint in the last year. We saw that the complainant was supported to raise their concerns and their complaint was investigated and action taken in response. The provider completed an investigation report about the complaint, however this was not signed off by the registered manager. We highlighted this to him at the inspection and he agreed to record this in future.

Good

Is the service well-led?

Our findings

There was a high level of satisfaction amongst staff and relatives with regards to the registered manager. Staff told us "[The registered manager] is incredible", "I enjoy working here" and "[The registered manger] is very good, we are so lucky to have him." Relatives told us that the service was well-managed and that they were able to call and visit at any time. They also told us that staff kept them informed about any changes in relation to their family members.

Staff were given different areas of responsibility such as drafting menus, gardening, activities, cleanliness, medicines, shopping and health and safety checks. They told us they welcomed this sense of ownership as it gave them motivation to carry out their roles effectively.

Staff files included evidence of regular supervision. These included discussions related to any current concerns, outstanding actions, progress against objectives, and feedback on any areas of responsibility and performance against company values. Performance reviews were carried out if required.

Care workers were given the opportunity and encouraged by the registered manager to progress within the organisation to senior care worker or team leader roles. The team leader was in the process of completing a course in The Institute of Leadership and Management (ILM). They spoke to us about the topics they covered as part of this which included supervision, coaching skills, conflict management, delegating and effective management.

Monthly staff team meetings were held, some of these were attended by professionals such as speech and language therapists. These provided an opportunity for care workers to discuss any relevant issues in a group environment. Residents meetings were also held monthly and topics discussed included holiday ideas, menus, staffing, maintenance, if people were happy or sad and activities.

Quality assurance checks to monitor the service were completed. These included 'quality walks' carried out by the area manager looking at the environment, people using the service, staff and documentation. Any issues that were highlighted were reviewed by the registered manager and action taken to try and rectify them.

A health and safety self-certification form was completed every month by the team leader confirming that health and safety checks were being completed as required. A separate health and safety inspection checklist was completed looking at documentation, workplace safety, Display Screen Equipment (DSE), personal belongings, training, lone working, Personal Protective Equipment (PPE), storage, external and internal building, laundry, bathroom, bedrooms, kitchen, fire, gas, water and electricity safety, COSHH, hygiene and pest control. Each area was given a RAG rating and action identified to be taken to rectify any issues found. The RAG system is a popular project management method of rating for issues or status reports, based on Red, Amber (yellow), and Green colours used in a traffic light rating system.

Other audits included checking the financial records for people using the service. This was checked at every

handover but also reviewed by the registered manager. Medicine stock levels were also checked at every handover.

The registered manager said he completed a monthly 'Pathway to Independence Report' which helped them to monitor the effectiveness of our support on helping people to be more independent in various areas. On a quarterly basis, a quality assurance key performance indicators report which is modelled on the CQC's five key questions was prepared. This was moderated by the area manager and submitted to the provider's risk and quality assurance team.