Metropolitan Housing Trust Limited

Old Hospital Close (12)

Inspection report

12 Old Hospital Close
St James' Drive, Balham
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SW12 8SS

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 27 January 2016 and was unannounced. This service was previously registered under a different name; this was the first inspection of this service under its new registration.

Old Hospital Close (12), (formerly called St James' Care Home (12)), 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 21. At the time of our inspection, there were four people living there, three males and one female. The home is arranged over three floors. People live in single bedrooms, with shared bathroom and kitchen facilities.

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.

We were not able to speak with any people using the service as they all had limited verbal communication. However we did observe staff supporting and caring for people which they did in a calm, measured way. They spoke with people gently and encouraged them to be as independent as possible, supporting them when needed and letting them take control when appropriate. There was a good atmosphere at the service on the day of our inspection.

Care workers were familiar with people's support needs and how they communicated. Care records contained communication profiles for each person, explaining the best way to communicate with them and ways to help communicating easier.

Care workers spoke about the Mental Capacity Act 2005 and its uses in relation to people using the service. Where people were not able to consent to their care or treatment, best interests decisions were made on their behalf and restrictions placed on people to keep them safe only when the provider was legally authorised to do so.

People's support needs in relation to their medicines, general health and nutrition were all met by the provider.

People spent the majority of their time at the day centre during the week and were supported by staff when going out in the community. They ate out together on a regular basis and went to the cinema and day trips. Families were encouraged to maintain contact with people and relatives told us they were kept in the loop by the provider and had no concerns about the safety of their family members living at the service.

Care workers were motivated and felt supported by the registered manager. They were provided with training opportunities to make them more effective in their roles and received regular supervision from the

management team.

Care workers spoke highly of the registered manager saying that he led by example and was always available to offer support and advice. The registered manager was passionate about the changes he had implemented and spoke about his vison for the service with clarity.

Some major changes had been made to how the care records were written. We found that although the new style was person centred and more simplified than the previous style, records had not been completed and some of the support plan goals did not always correlate to the assessed support plans in place for people.

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.

Relatives of people using the service told us their family member was safe. Staff had a good understanding of safeguarding procedures.

Risks to people had been assessed and reviewed which helped to keep them safe from harm.

There were enough staff to meet the needs of people using the service.

Staff were trained and competent in administering medicines.

Is the service effective?

Good

The service was effective.

Staff told us that they received good training which helped them to carry out their role.

The provider was meeting its requirements in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People's health and nutritional care needs were met by the service.

Is the service caring?

Good

The service was caring.

We observed staff caring for people in a kind and friendly manner.

People were involved in their care and care records were person centred and focussed on people's support needs rather than being task oriented.

Is the service responsive?

Requires Improvement

The service was not responsive in all aspects.

Steps had been taken to develop some new care records, however this was not fully complete.

Relatives told us the provider would listen to their concerns, if they had any.

Is the service well-led?

Good

The service was well-led.

Care workers told us that they felt motivated and the registered manager led by example.

The registered manager had begun to implement positive changes to the service.

Quality assurance checks were completed to monitor the service.

Old Hospital Close (12)

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 27 January 2016 and was announced. The inspection was undertaken 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 asked the provider to complete a Provider Information Return (PIR) prior to our inspection. The PIR is a report that providers send to us giving information about the service, how they met people's needs and any improvements they are planning to make.

During our inspection we spoke with three staff members and the registered manager. We were unable to speak with people because those that were at the service during the time of our inspection were not able to communicate verbally. However, we did observe staff supporting them during the inspection. We reviewed two care records, three staff files, and other records related to the management of the service.

After the inspection we spoke with relatives of three people using the service. We also contacted nine health professionals after the inspection to gather their views and received responses from three.

Good

Is the service safe?

Our findings

Relatives told us they had no concerns about how their family members were treated and told us they felt they were safe.

Care workers were aware of their responsibilities under safeguarding procedures and told us they would not hesitate to raise any concerns with the registered manager or contact the safeguarding team directly if they had concerns. Care workers received safeguarding training and demonstrated a good understanding of the tell-tale signs of potential abuse. A care worker told us, "People are safe. We support them so we notice any changes."

Where allegations had been raised, the provider had worked with the local authority to investigate the concerns, demonstrating an open culture.

People were assessed on their ability to manage their finances. The registered manager told us they had contacted the local authority to act as appointees for those people that did not have capacity to understand their financial affairs and whose money they currently managed. We checked the record keeping for one person using the service which we found to be accurate. Each person had a ledger book in which accurate records were kept. Only the registered manager or the shift leader had access to people's petty cash, and records were checked on every shift handover. This helped to ensure that people were safeguarded against financial abuse.

Care workers understood the potential risks to people and followed the risk management plans in place for them which helped to keep people safe. Risk assessments had been reviewed in January 2016 which indicated they were current and up to date. They were based on people's individual circumstances and included control measures to help manage the risk and reduce the possibility of harm coming to the person.

Each person had a Personal Emergency Evacuation Plan (PEEP) that had been reviewed recently. This is a bespoke 'escape plan' for people who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency. These documented their level of awareness, methods of assistance and any equipment needed to support the person in case of an emergency.

A monthly internal health and safety self-certificate check was conducted to help ensure that the service was adequately risk assessed against any health and safety concerns. A quarterly health and safety audit which was used to further monitor risks to health and safety was also completed. This was assessed using a Red, Amber or Green (RAG) rating. This 'traffic light' system is used as a coding system for good or bad performance. For example, red would mean inadequate, amber would mean reasonable, and green would mean ideal. This enabled the provider to focus on any areas of improvement.

Recruitment systems were robust which helped to make sure that the right staff were recruited to keep

people safe. New care workers submitted a criminal records check and provided evidence of their work history and other documents, including references from previous employers and proof of identify. These documents were all held within the central Human Resources (HR) team but the registered manager had access to them if he needed to refer to them.

We found there were enough trained staff on duty to make sure that practice was safe. Care workers told us they felt staffing levels at the home were sufficient to support people safely. When we arrived for the inspection, two people were ready and waiting to be taken to the day centre. And there were two care workers supporting the remaining two people with their personal care. We looked at the staff rota for January and February 2016. This showed that there were two staff on duty during the day and evening from 07:00 until 22:00 and one staff sleeping in overnight. No agency staff were used but regular bank staff were called in to provide cover on occasion. One person at the service needed one to one support on certain days of the week and extra staff were added to the rota to provide this support. The one to one care worker supported this person to go out in the community when they were not at the day centre.

Care workers managed medicines safely. Each person had a medicines profile which had details of their GP and pharmacist and the medicines they were currently taking. People's medicines files contained information sheets related to people's medicines and their use. GP authorisation was sought for medicines that were required 'as needed' such as pain relief medicines. Medicines were stored correctly, in a locked cabinet. Medicines in liquid form were labelled with the date they had been opened and those that needed to be kept in a fridge were stored appropriately.

Some of the rooms had been refurbished, with new carpet and paint. Others were still waiting for works to be carried out. Although parts of the home had been redecorated, the carpet in the passage way and staff room were heavily marked and needed to be replaced.

Good

Is the service effective?

Our findings

People's needs were met consistently by staff who had the right competencies, knowledge, qualifications and experience. An assessment record had been introduced in some cases which involved the potential new care worker interacting with a person using the service to see how they worked with them. This helped the registered manager know if potential employees were suited to caring for people using the service. The registered manager showed us the induction programme that new care workers completed when they first started working. It included an introduction to the organisation and also role specific induction during which any gaps in knowledge were identified and training booked.

Each staff member had access to their 'learning zone' and all staff were put onto a learning pathway when they first started with the organisation. The registered manager had oversight of this and we checked the system and confirmed that care workers had booked themselves onto available courses including infection control, safeguarding, the Mental Capacity Act 2005 (MCA) and manual handling. The registered manager told us the regional training team sent out a list of available courses on a monthly basis which were cascaded to the staff team to book onto. Training needs were discussed during staff one to one meetings.

Training modules were grouped according to the service and the role of the staff member. For example, core learning modules were available to all staff members. These included equality and diversity, manual handling, health and safety, and safeguarding. Other modules were available specifically for staff working in registered care services and learning disability services and then more specifically to the actual location, such as positive behaviour support. Care workers told us, "Training is ongoing. We do both e-learning and classroom based", "I did medicines training in September" and "The training is good, [the registered manager] is always telling us to book onto courses. We discuss it in team meetings."

Care workers were supervised every six to eight weeks and were able to discuss outstanding actions, any concerns, progress against objectives, and what had gone well since the previous session.

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 are called the Deprivation of Liberty Safeguards (DoLS).

Care works demonstrated a good understanding of the MCA. One care worker said, "Mental Capacity Act is used to make decisions for people that are unable to make decisions. This leads to best interests meetings." The registered manager had introduced some new assessments to record people's consent to care which had helped in identifying whether people were able to give valid consent. Two people had been identified as

having restrictions placed on them without having the capacity to consent to this and as a result applications to deprive them of their liberty had been submitted to the authorising body.

We observed care workers asking people for their consent during the inspection when supporting them, for example during breakfast. We also saw staff supporting people to make decisions using communication tools to help them understand. For example, they were offered a choice of meals through picture cards.

The kitchen area was clean and colour coded preparation boards were used for particular food types to prevent cross contamination. The kitchen was stocked well with good quality food and opened food in the fridge was labelled with the date it had been opened and when it was to be used by.

There was a menu on display in the dining area. Generally, lunch was provided at the day centre and a cooked breakfast was prepared for people on a Saturday. One care worker said, "[Person] likes his cultural food, yam and okra. He also goes out for an African meal." Supper was varied and included meals such as tuna pasta bake, pizza, shepherd's pie, roast chicken and curry. Alternate choices were available if people did not like what was on offer, including fish and chips, stir fries and soups. Care workers told us that all the shopping was done online but people using the service were involved in planning menus through the use of picture cards that were available. People were supported by staff to go out shopping for personal items.

Some people were on a prescribed food and fluid plan. There was current guidance on display from the community dietitian team in the dining area for these people. Information was provided on the type of food to be given, the seating position, equipment needed and the level of support required. Staff were familiar with this information and also the dietary requirements of other people using the service. For example, one person only ate halal meat and another person had a complex medical condition that meant they had to have a restricted diet that was closely monitored. Staff were able to demonstrate that they understood the condition and the person's needs and how they met their dietary requirements. This meant that people were supported in an appropriate manner.

Staff were familiar with people's health needs and preferences. The provider engaged with health and social care agencies and acted on their recommendations and guidance in people's best interests. Appropriate referrals were made to other health and social care services if needed. New health action plans were being introduced, however these had not been rolled out for all the people using the service. They contained an 'About Me' section which contained health related information about the person including relatives to contact if they fell ill, allergies, how they communicated, and people that supported them in relation to their health. There was evidence that the health action plans were developed in a person centred manner because a series of questions were used to develop them based around people's support needs in relation to their health and well-being. Health action plans included hospital passports and records of correspondence and appointments with health professionals such as GPs and opticians, and screening checks.

Good

Is the service caring?

Our findings

Relatives of people using the service told us that staff were "caring", "lovely people" and "I have no problems with them, they treat [my family member] well, look after him, do everything for him."

People received care from care workers who demonstrated compassion and empathy towards them. One care worker said, "I treat people how I would like to be treated" and "[the registered manager] always asks us would you be happy for your mother to live here?" We observed care workers talking with people in an appropriate, kind and encouraging manner. We saw a care worker supporting a person to make breakfast. They tried to promote his/her independence by encouraging him/her to get milk and cereal on their own.

Care workers knew and understood people's personalities and their history. They were also familiar with people's individual methods of communication and preferences. They told us, "People may be non-verbal but they can understand and know what they want, for example [person] will make a choice and tell you. You have to present [them] with choices", "[Person] is the newest resident here and he has been here five years, so we know them well" and "[person] is the most independent. Helps everyone; he/she does their own personal care but needs a little support. He/she loves routine."

People were involved in making decisions related to their care and support. A pictorial staff noticeboard was on display to help people identify which staff were working with them on a particular day. Care plans were in the process of being written in a person centred way, and documented how people wanted to be supported and their preferences. People were encouraged to make decisions about what they wanted to eat, and what activities they wanted to take part in. Care workers told us, "[People] have chosen paint for their room" and "They were all involved in choosing their furniture."

Care plans included people's communication support needs. This contained their level of verbal skill, how they communicated, for example using communication and picture boards to plan activities and express preferences and choice, and tips to help other people communicate with them. The information contained in these records provided staff with useful ways to interact with people which meant people were supported in the most appropriate manner.

Relatives told us they were able to visit at any time and told us that they observed staff to be caring and there was a good atmosphere at the home whatever time they visited.

Requires Improvement

Is the service responsive?

Our findings

People's care, treatment and support was set out in a written plan that described what care workers needed to do to make sure they were supported in the most appropriate manner.

The registered manager told us about the changes he had introduced in relation to the new care records. These included the creation of a new one page profile for each person using the service, and the separation of the existing care records into separate support plans and health action plans.

Previously, care records were grouped into separate support plans, a person centred plan and a personal care and support plan. The registered manager told us these were to be brought together into a new document called the 'person centred plan'. The main driving force behind this move was to avoid duplication of information and make the information more accessible so that staff would be able to support people more effectively. The registered manager said, "The new person centred plan needs to speak to the customer. The support plans and support plan goals are contained within the person centred plan."

We reviewed the new look person centred plans and found that although some sections were not fully completed, work had begun to transfer the information into the new format. There was a front cover and a one page profile for each person. These contained personal information about people including their next of kin, details of healthcare professionals involved in their care and emergency contact numbers, but also some person centred information related to them such as what was important to them, their strengths, likes and dislikes and how best to support them.

Other sections contained within the person centred plan included people's consent to their care and treatment, their support plans and support plan goals, risk management records and key worker reports. Information related to people's health was contained in a separate health action plan.

The support plans contained a good level of detail about people's history and identified their skills and strengths, for example, 'I am active around the house' and 'I can express a choice when presented with alternatives'. The qualities and characteristics of people who would be best suited to support them and their communication needs were also documented. There was also information about the ways in which staff could meet people's needs, for example by using open ended questions, giving them options and using simple phrases. This enabled staff to provide personalised support to people.

People's support plans were grouped according to a main area, which was further broken down. For example, 'supporting my independence' was broken down into various activities such as meal times, tidying up, going shopping, around the house, leisure time and transport. Each identified activity documented people's level of independence, the support needed and ways in which they could become more independent.

Support plan monitoring forms were in place for people, these were completed daily in a timely manner. These were used to evidence some of the daily skills people were encouraged to get involved in or to

monitor their progress with respect to their support plans. For example, setting the table, responding to objects of reference, personal shopping and outings, day centre activities and appointments.

A separate support plan record sheet was used to record issues, events and activities not included with the support plan. For example we saw one entry which stated that following a dietitian visit, staff were required to monitor a person's weight and to also complete a seven day food diary. Staff confirmed that this was completed and the information passed on to the dietitian to review and feedback to them.

Key worker review meetings took place on a monthly basis. The registered manager told us, "Key workers just need to meet with people once a month to monitor progress towards their support plan goals." Topics of discussion included feedback on previous action points, family social contact, health/medical issues, and activities of interest, daily living skills, personal finances, behavioural observation and general well-being. There was also a monthly review of support plan goals and outcomes.

In the records we saw, the support plans goals and outcome monitoring in the key worker reports did not always follow the goals identified in the support plans, which meant that people were not being supported in the way that had been initially identified. We discussed this with the registered manager who acknowledged that that identified goals were not being monitored correctly in the records that we saw. He said that the work was ongoing and some care workers were not fully up to speed with the new care records. He said, "The support plans are still a work in progress, the key workers are working through them but I am having to quality check the work." A care worker told us, "We are using new templates for support plans. It's quite a big challenge but we are working on it."

The majority of the people went out to various day centres during the week and most of their day was taken up there. Due to people's high support needs, they were not able to go out independently. However, some people were provided with one to one support in the community and went with care workers to do their personal shopping. Other group activities included trips to the cinema and day trips. One care worker said, "They go to the cinema and restaurants. In the summer they went to the seaside." Another care worker said, "They go with their key worker if they need to go shopping."

Relatives told us they did not have any concerns about the service but they would contact a staff member or the registered manager if they did. They told us their family members would be able to speak up for themselves if they were not happy. People using the service attended house meetings during which they were asked if they were unhappy about anything. We read minutes of some of the meetings and saw that people's concerns were recorded and acted upon, for example if they were not happy about the food or with their room or their planned day trips. People were also given the opportunity to speak with their key worker in a private environment.

We looked at a record of complaints that had been received and saw that no formal complaints had been received by the provider from people using the service, relatives or other professionals. An easy read format explaining how people could raise concerns was on display in the dining area.

Good

Is the service well-led?

Our findings

Relatives of people using the service told us that the registered manager and the staff team were approachable and open in their communication with them. They told us they were kept up to date about their family member.

The registered manager spoke passionately about the ideas that he had for the service. He spoke in detail about the expectations he had of staff and the direction that he wanted to take the service. He spoke about his vision for the service and showed us the changes he wanted to make, for example the care records for each person, the environment, and changes to the way that staff worked. He said, "I'm insisting on the key workers of coming up with a programme of what people are being supported with on a daily basis. I don't want to leave people just watching TV" and "I want the staff to take ownership and pride in what they do." He also told us that he felt that he had good support from the regional team saying they had made resources available to him to develop the service and drive improvement, "The new management team are proactive and listen to what I have to say."

Care workers praised the registered manager for the changes he had implemented, saying, "There has been a definite positive change", "He's changed a lot of the systems which weren't clear", "He is what we needed" and "He is supportive. He is building a team." Staff had a good understanding of their role, talked in a positive way about their work and told us they had confidence in the way the service was being managed. They said that the registered manager had an open door policy and made himself available to them, providing guidance and constructive feedback when needed. Another care worker said, "He's good. He believes in his team and he's always trying to motivate us."

Staff and house meetings were held which were used as a basis to gather the views of both people using the service and staff. House meetings were facilitated by staff and people were able to discuss issues such as activities, menus, maintenance of the house and fire awareness. Staff meetings were held monthly and care workers were given the opportunity to discuss any concerns or put forward any ideas they had in relation to supporting people using the service, the environment and their way of working.

Quality was measured both internally and externally. Daily and weekly checks were completed around the home to ensure appliances were working satisfactorily. Food was temperature checked before serving which helped to minimise the risk of infection. Fridge and freezer temperatures were checked daily and hot water temperatures were checked weekly. Medicine cabinets were monitored to ensure medicines were kept at the right temperature. Monthly audits on finances and cross checking against receipts were also completed. Weekly fire alarms took place and a fire evacuation took place every two months, the last one in November 2015. An area manager also completed audits of the home every quarter which helped to ensure that regional oversight into any areas of improvement was maintained.

Feedback that we received from healthcare professionals was that the service was good and that staff were sensitive to the needs of people using the service. They told us that they had good links with the service and found that people's needs were being met.