Metropolitan Housing Trust Limited

Old Hospital Close (12)

Inspection report

12 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

We inspected Old Hospital Close (12) on 08 August 2018. This was an unannounced inspection.

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

At this inspection, we found the service remained Good.

Old Hospital Close (12) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Old Hospital Close (12) provides accommodation for five people with learning disabilities. It is in Balham, close to local amenities and transport links.

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

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 received positive feedback from people and their relatives about the caring attitude of the care workers. They told us they felt safe living at the service and were settled there. Each person was assigned a key worker who met with them every month to discuss any issues they had and to also formally monitor how they were progressing.

People were supported by staff to take their medicines and had records in place which promoted their health needs. People were able to see their doctor or another health professional if they were not feeling well and the staff supported them to do so. Relatives told us they were kept informed by the provider of any changes to their family member's health.

Meals were planned during regular resident's meetings and people with support needs in relation to eating and drinking were supported by staff. Where appropriate, advice and support was sought from community therapy teams.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were only deprived of their liberty to receive care and treatment when this was in their best interests, the provider sought legal authorisation to do so under the Mental Capacity Act 2005 (MCA).

People lived independent lives and were supported by staff to access various community activities. People attended various day centres and enjoyed going to the gym and bowling.

Risk assessments were reviewed regularly and any control measures were proportionate to the level of risk identified. Staff were aware of risks to people's wellbeing and how to keep them as safe as possible.

People's support plans were based around their goals and what care workers could do to help to maintain or improve their independence. Key workers helped people to achieve their targets.

People were consulted about how the service was run, regular resident's meetings were held and feedback was sought and acted upon. Staff were familiar with how to communicate with people and used a range of tools to do so, for example visual aids, objects of reference and Makaton.

Staff told us they felt supported by the registered manager. They received regular training which helped them to carry out their role more effectively.

The service was well-led. The registered manager was aware of his responsibilities. Regular monitoring and quality assurance audits were carried out which helped to maintain the service provided to people. An external team carried out mock CQC style inspections and specific medicines, finance and health and safety audits took place. An action plan was in place to take remedial action where necessary.

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 remains Good.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service had improved to Good.

The care plans were now up to date, person-centred and focussed on how people could maintain their independence.

Each person had a key worker who met with them every month.

Is the service well-led?

Good

The service remains Good.

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 comprehensive inspection took place on 08 August 2018. The inspection was carried out by one inspector and was unannounced.

Before the inspection, we reviewed the information we held about the service. This included notifications sent to us by the provider and other information we held on our database about the service. Statutory notifications include information about important events which the provider is required to send us by law. We used this information to plan the inspection.

During the inspection we were only able to speak with one person using the service as the others were not able to communicate verbally. However, we did observe staff supporting people during the inspection. We spoke with the registered manager and two care workers. After the inspection, we contacted relatives of four people using the service and six health and social care professionals to gather their views of the service.

We reviewed a range of documents and records including; two care records for people who used the service, three staff records, as well as other records related to the management of the service such as complaints and audits.

Good

Is the service safe?

Our findings

People using the service told us they liked living at the service. One person said, "I like it here." Relatives that we spoke with told us they had no concerns about leaving their loved ones at the service and said they were well looked after. Comments included, "[Family member] is safe, they look after them" and "Yes, I believe they are safe."

Care workers were familiar with safeguarding procedures and were able to identify different types of abuse. One care worker said, "Safeguarding is protecting people from harm and danger. If we feel they are being abused, we have to report it. We can contact the police or the local authority." There were posters on display in the service advising staff on what steps to take if they had concerns. Training records showed that staff had attended safeguarding training.

People using the service were supported to take their medicines in a safe manner. Relatives said they were confident their family members received their medicines as prescribed.

Each person had a medicines profile which included their picture, details of their GP, pharmacy, any allergies or special instructions and a list of their current medicines. Risk assessments in relation to medicines were also completed alongside guidelines on how best to provide medicines support to people.

Medicines were stored appropriately in a locked cabinet that was checked daily to ensure they were stored within acceptable temperature ranges. Medicines Administration Record (MAR) charts were completed appropriately by staff in a timely manner when they administered medicines to people. Non-blistered medicines were counted at handover correctly to ensure there were no discrepancies and stock of medicines were counted when they were received and disposed of.

There were enough staff employed to meet people's needs. On the day of our inspection, there was only one person at home. The others were out at the day centre or in the community. Staffinglevels were adjusted according to the needs of people. For example, during the busy morning period there were more staff on shift than at less busy times. Some people using the service were supported by a one to one care worker who was allocated in addition to the care workers on the rota. The team leader or the registered manager were also available on shift during the day.

Appropriate recruitment checks were in place which helped to ensure only suitable staff were employed. All pre-employment recruitment checks were completed and vetted centrally, this included checks on identity, right to work and references. We saw evidence that the provider completed Disclosure and Barring Service (DBS) checks for each staff member. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

Incidents and accidents were documented appropriately and there was evidence that the provider used these as a learning opportunity. There was an incident and accident reporting flowchart in place and an internal reporting procedure for the provider which staff followed. There had been three reported incidents

in the past year, these records were completed fully with details of who was notified and the action staff were to take to try and prevent these from occurring in future. In one example, the action included referring people to community mental health teams and updating risk management plans. There was also evidence of learning, the registered manager held reflective practice sessions at team meetings following incidents.

Risk assessments were person-centred, proportionate and reviewed regularly. Care records included a summary of potential risk called 'keeping me safe'. This gave staff a brief overview of risks to people and how to support them. There were more detailed risk assessments completed which gave staff more thorough control measures on managing the risk. The control measures were proportionate to the level of risk identified. For example, if the risk was low then minimal controls were in place. If the risk was more likely to occur, more stringent controls such as a written contingency and a plan to reduce the risk was in place. Staff are aware of risks to people's wellbeing and how to manage them.

Each person had a Personal Emergency Evacuation Plan (PEEP), this included their awareness around evacuation procedures, any assistance or any equipment needed. These were tested through regular fire evacuation tests which took place every three months.

There had been a recent fire safety inspection by the London Fire Brigade during which some remedial action had been identified. We saw the provider had acted upon the recommendations made to make the service compliant with the relevant fire safety regulations.

Other steps were taken to ensure the environment was a safe place for people. For example, an internal fire risk assessment had been completed, weekly hot water temperatures for all baths and sinks were taken to ensure the temperatures were acceptable. Bathing and showering temperatures were also taken before people were supported with personal care.

Current safety certificates were seen for gas safety, smoke detectors and call points. Fire alarms and emergency lights were tested weekly.

The service managed the control and prevention of infection well. Staff received training in infection control and prevention and understood their role in maintaining standards of cleanliness and hygiene in the premises. Staff were observed cleaning the service which was generally well maintained.

The importance of food safety, including hygiene, when preparing or handling food was understood. Staff followed required standards and practice and colour coded food preparation boards were in use. Daily fridge/freezer temperatures were taken which helped to ensure food was stored at the appropriate temperatures. Food in the fridge was labelled with the date it had been prepared or opened. Food cooking and serving temperatures were recorded which helped to ensure food was cooked properly.

Good

Is the service effective?

Our findings

Staff told us they received training that was appropriate to their role and which helped them to support people. One care worker said, "I had a full induction when I started, they introduced me to the customers and their files. I shadowed somebody for a whole week and I had a lot of help."

New staff completed the Care Certificate as part of their induction. The Care Certificate is an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new support workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. Each new starter was issued with a learning portfolio which included the Care Certificate. The registered manager acted as the mentor, guiding new starters through the process.

A learning pathway was in place to support and facilitate care workers with their ongoing training. The organisation's training provision was managed through an online portal and included e-learning, workshops and on the job training. Various training modules, some considered mandatory and others that were specific to the needs of people using the service were delivered to staff. These included person-centred working, awareness of mental health and dementia, epilepsy and medicines.

Staff told us they felt well supported by the registered manager. Each staff member received regular supervision with the team leader or registered manager. Topics of discussion included outstanding actions from previous meetings, specific areas of support, any concerns, what was going well and the staff members performance against business themes.

Relatives told us their family member's health and wellbeing was managed well by the service. They told us, "They contact the GP if [family member] is poorly or if they have a cold or flu and keep us informed." The registered manager gave us an example where a person's deteriorating health had meant they had stopped going to the day centre. With the support of the home in collaboration with local health teams, the person's health had improved and they were now back to good health. On the day of the inspection, they were out at the day centre.

There was a section in the support plans called health and well-being which gave staff details of how to support people with this area. There were more detailed health related documents including Hospital Passports and Health Action Plans. The hospital passport is a document to support the care of adults with learning disabilities and autism when going to hospital. It provides hospital staff with information about the person during a hospital visit. For example, current medicines, medical history, how medicines were taken, how pain was expressed, any support needed with eating, drinking, sleeping and any allergies.

Health Action Plans were in place to focus on and promote people's health needs. They included areas where people needed support in relation to their health and included records of appointments.

People's care and support provision was reviewed regularly and appropriate referrals were made to health

and social care professionals when needed. Staff worked collaboratively with community services to continue meet people's needs. For example, we saw evidence that people were referred to community mental health and learning disability teams as required. One person whose anxiety was acute was referred to psychology who produced both proactive and reactive strategies for staff to help the person cope with anxiety attacks.

People were supported to eat and drink enough to maintain a balanced diet. There was a rolling menu in place which people were consulted about and there were pictorial images available to help people make an informed decision about what they would like to eat. We saw one person helping themselves to a snack, telling us, "I'm just going to make myself a sandwich."

People that needed support with eating and drinking were assisted by staff. Food diary instructions and prescribed food and fluid plans were available for staff to refer to. Dietary advice from a dietitian for a person at risk of losing weight was available and being followed by staff. Care workers were familiar with the requirements of people using the service which were in line with their care records. Care records also included preferences in relation to eating and drinking and listed the food and drink people enjoyed. One care said, "[Person] has had input from dietitians. They eat most food, but it needs to be cut down very small. They have a nutritional thickener which we need to add to any liquid."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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). We checked whether the service was working within the principles of the MCA.

All the people using the service had a DoLS authorisation in place, due to restrictions in place to prevent them from leaving the service independently and for not being able to consent to their care and treatment. The provider had followed the correct procedures by carrying out mental capacity assessments and applying for legal authorisation to deprive people of their liberty. One care worker said, "[Person] is able to leave but still needs to be observed, we need to know where they are going and for how long. They are restricted to the local area."

People's views and consent in relation to their daily support needs were considered. Care workers used pictorial aids and other means of communicating effectively with people, such as Makaton. Staff demonstrated that they knew how to communicate effectively with people which reflected their communication profiles. They told us they were always careful to offer people a choice, comments included, "[Person] is non-verbal but knows what s/he wants. If they don't want to do something, they will make it known. They can make a decision about what they eat and how they dress."

The home was in reasonable decorative order. People's bedrooms were furnished according to their individual needs and taste. There was a lounge with enough seating for people and a separate dining and kitchen area. There was an outside space which was used by people. One person with poor mobility had access to an en-suite bathroom which was adapted to their needs.

Good

Is the service caring?

Our findings

One person using the service said they liked living at the service. Relatives also praised the staff for their caring and friendly attitude. Comments included, "Yes I am very happy [my family member] is there. They have lived there for many years" and "They look after [family member] very well."

Care plans were person-centred and reflected their individual needs. They included a 'One Page Profile' which gave a summary of the person, what was important to them, what people liked and admired about them, what they didn't like and how best to support them. This gave an accurate picture of people's individual support needs. Other person-centred information included people's hopes, dreams and aspirations and their skills and strengths. People's religious and cultural needs were documented.

People lived independent lives and staff encouraged them to maintain their independence. Care records included details about what people could do well, such as being able to carry out domestic chores, use public transport and make their own breakfast and snacks. There was also a section called, 'How best to support me' which described the qualities of their ideal care worker and the areas in which they needed support.

Staff demonstrated they understood and supported people how they wanted to be supported. One care worker said, "[Person] needs support with personal care, we have to support them to brush their teeth. They can do their own breakfast but we have to be there to observe. We encourage them to strip the bedsheets and wash their clothes."

We observed positive interactions between people using the service and staff. Care workers spoke with people in a friendly manner and were aware of both their preferences, how best to support them and most appropriate ways of communicating with them.

People were encouraged and supported to maintain relationships that were important to them. One care worker said, "I invited [person's] family round to celebrate their birthday." Relatives told us they were kept up to date with any changes in relation to their family members. They said they were able to visit them home whenever they wanted and some people went to stay with their families on weekends. One relative said, "We are going around this weekend to visit [family member]."

People were involved in decisions related to their care and support. Staff supported people to make informed choices about how they lived their lives. They were guided to do so through person centred records and communication profiles. One person with no next of kin was supported to make decisions with the support of an independent advocate.

Good

Is the service responsive?

Our findings

At the last inspection, this key question was rated as 'Requires Improvement.' This was because the provider had taken action to develop new care records, however this was not fully complete. At this inspection we found improvements had been made.

People's support plans were based around their goals and what care workers could do to help to maintain or improve their independence.

For example, one person had three support goals which were developing independent living skills, leading an active social and community life and living a healthy lifestyle. Each area included reasons why the person needed support in that area and their short and long-term goals. Each area also included a number of targets for the person to aim towards. For example, for developing independent living skills, the person had 10 targets which included prompt to do my own personal care, prompt to do my own bed, encourage household chores, prompt to make breakfast and buy ingredients for meals. These targets were evaluated every month by their key worker. We saw some examples where the monthly evaluation contained the same text so it was not always clear what progress had been made from one month to the next. We spoke with the registered manager about this who agreed to consider how the evaluations could be improved.

People had assigned key workers who were responsible for ensuring their needs were met and who met with people every month and compiled key worker records. These reports Included feedback on previous meeting action points, family contact, health issues, activities of interest, daily living skills, day care/education, employment, personal finances, accident/incidents and behavioural observations.

Care records also included guidance for staff about how to communicate with people effectively. They included people's verbal and literacy skills such as their comprehension and auditory memory and tips to aid communication such as visual timetables, shopping lists and environmental prompts. Care workers demonstrated that they were aware of people's communication needs when we spoke with them.

People using the service had access to a number of community based activities and attended day centres regularly. On the day of our inspection, three people were at the day centre and one person was out being supported in the community. The registered manager spoke about how they encouraged people to go out in the community. One care worker described the activities one person took part in, "They have a one to one and go out twice a week to the gym and out shopping. When they don't have one to one, we do activities with him, they love to go bowling and swimming. I contacted a day centre workshop 305 and he spent two days there, they observed him and he seemed to cope well."

Relatives told us they had never put in a formal complaint. There was a complaints policy in place which included details of escalation levels, timescales for responding and details of who to contact if the complainant was not satisfied with the outcome. There was an easy read format available for people to refer to if needed.

There had been no formal complaints received from people, relatives or other stakeholders. However, people were encouraged to raise complaints or concerns during key worker and resident's meetings. We saw some examples of 'I've got something to say' forms, these were informal gripes that people wanted to talk about with care workers. These were acted upon by staff.

Good

Is the service well-led?

Our findings

Relatives of people using the service told us they thought the service was well-led and their family members were settled there. They said there was an open culture at the service and they were able to visit the service at any time to see their family members or speak with staff. Comments included, "It's a good service, the staff there are friendly. I have no complaints" and "Everything is going well, no problems at all."

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. The registered manager was aware of her legal responsibilities and the need to notify the Care Quality Commission of any reportable incidents such as any serious injury or safeguarding concerns.

Relatives and staff both told us the registered manager was always a visible presence at the home. One care worker spoke about the qualities of the registered manager and told us, "He is a very good manager, really good. He is extremely supportive."

Other staff said that the registered manager was somebody they would speak to for advice and who was knowledgeable about how to run a service. The registered manager told us he kept up to date with industry trends and networked with other registered managers through Skills for Care and via the London Care and Support Forum for registered managers. In addition, he was registered with the Social Care Institute for Excellence which allowed him access to a lot of resources to build on his knowledge, competence and skills.

The service carried out regular engagement with people using the service and staff.

For example, people were supported to complete customer satisfaction surveys by independent people such as staff from the day centre. They were asked about the service, their community and if they were listened to. We saw positive comments from people. Resident meetings were held every two weeks. These were facilitated by staff. People were consulted about holiday ideas, menus, upcoming events, the staff team and if they were happy or unhappy about anything. Both the surveys and the meeting minutes were available in easy read formats.

Monthly staff team meetings took place. Topics for discussion included customer updates, training, health and safety, best practice and reflective practice.

Quality assurance checks were completed which demonstrated the service was well-led. A Risk and Quality Assurance team visited the service on a regular basis and carried out mock CQC style inspections covering the key lines of enquiry as per the CQC methodology. Following these visits, some recommendations were made. The registered manager was receptive to this feedback and incorporated the recommendations into the improvement action plan for the service. Some of the recommendations were to act on the London Fire Brigade action plan, complete a full medicines audit, and mandatory training thresholds. There was

evidence the registered manager had acted upon the findings.

Specific audits were completed focusing on specific areas, for example a training compliance reporting tool which identified any gaps in training was completed, which were then covered by the registered manager during individual supervision meetings. Weekly and monthly medicines audits, looking at storage, administration, recording and disposal were done. We saw an external medicines audit completed by the pharmacy which was comprehensive in scope and did not find any remedial action for the provider to take.