London Borough of Barking & Dagenham

Ted Hennem House

Inspection report

Jacobs 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 Ted Hennem House on 4 March 2016. This was an announced inspection. We informed the provider 24 hours in advance of our visit that we would be inspecting. This was to ensure there was somebody at the location to facilitate our inspection.

Ted Hennem House is operated by the London Borough of Barking and Dagenham. It provides care and support, but not nursing care to people aged 55 and over in an Extra Care setting. People who live in Extra Care Housing have their own self contained homes and receive support from carers that are provided either by an external agency or by Ted Hennem House. At the time of the inspection eight people were receiving personal care from Ted Hennem House.

There was a registered manager in place at the time of our inspection. 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.

Systems were in place to ensure that people using the service were safe. Care staff had undertaken training about safeguarding adults and had a good understanding about safeguarding principles and how to raise an alert. Risk assessments were carried out and were robust and detailed.

Medicines were managed safely for people. Effective systems for the management, administration, storage, and disposal of medicines were in place.

Care staff were aware of their responsibilities under the Mental Capacity Act 2005 and how to ensure people using the service were given support to make decisions. Care staff were mindful of consent and ensuring that people were given autonomy and respect.

Care staff received relevant training to their role as well as a detailed induction programme and we saw records of robust recruitment. Relevant checks had been carried out before staff commenced employment.

Staff appraisal, training, and supervision supported them in their role. Care staff understood best practice guidance and implemented them to meet the needs of people. The coordinator for the service and registered manager supported staff so that they were effective in their role to care for people and deliver quality care.

People had access to health care services to meet their needs and professional guidance was implemented to maintain their health.

Care plans were detailed and person centred and people were involved in their care planning and decision making. Staff knew people well, were aware of their personal histories, and understood their likes and

dislikes. Care and support delivered to people centred on their individual needs, preferences, and choices. Care staff provided care and support to people in a way which respected their dignity and privacy.

The coordinator for the service had a good relationship with care staff and the people using the service and their relatives. There was open communications between all parties. The service had quality assurance methods in place.

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. Care staff were able to explain to us what constituted abuse and the action they would take to escalate concerns.

Risk assessments were in place which set out how to manage and reduce the risks people faced. They were detailed and robust.

Medicines were administered and recorded safely. People were given their prescribed medicines and any refusals were documented.

Recruitment records demonstrated there were systems in place to ensure care staff were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective. Staff took part in a week long induction programme and undertook regular training and one to one sessions with their manager.

Staff demonstrated the importance of seeking consent and putting the principles of the Mental Capacity Act (2005) into practice.

People were being supported with meal preparation and staff had understanding of individual nutritional needs.

People had access to health care professionals as appropriate.

Is the service caring?

Good

The service was caring. Positive and caring relationships were developed between care workers and people using the service.

The service supported people to express their views and be involved in making decisions about their care, treatment and support.

The service supported people in promoting their independence.

Is the service responsive?

Good

The service was responsive. Care plans were person centred and included details about the person's history and life.

People's cultural beliefs were respected and care workers told us about the different religious and cultural needs of people using the service.

Complaints and concerns were encouraged and responded to. People's care plans had information on how people could complain.

The service kept records of the compliments they had received and we saw specimens of this.

Is the service well-led?

Good

The service was well led. The service promoted a positive culture.

Regular monitoring and review of the service took place and actions implemented to drive improvements.

The coordinator for the service involved people and staff in the development of the service.

Ted Hennem House

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.

Before the inspection we checked the information we held about the service. This included any notifications and safeguarding alerts. We also contacted the local borough contracts and commissioning teams that had placements at the service and the local borough safeguarding team.

The inspection was carried out by one inspector. On the day of the inspection we spoke with the coordinator of the service, two care workers and five people who used the service. We looked at three care files, daily records of care, three staff recruitment files, training records and policies and procedures for the service.

Good

Is the service safe?

Our findings

People using the service told us that they felt safe. One person said "yes, I do [feel safe]. Sometimes I will use my call bell and someone will come to my attention. I have no trouble".

Staff told us they had attended training courses in safeguarding and were able to identify different types of abuse. They were aware of their responsibility to report any allegations of abuse. One care worker told us "I feel confident making safeguarding referrals. I know where the forms are and how to fill them in. I would send them to the relevant local authority". We saw an example of a safeguarding concern regarding suspected financial abuse and the actions taken. These were documented in the person's care plan and included actions such as "bank called immediately to stop any activity, police called and attended within 30 minutes, police not going ahead with investigation due to lack of evidence, [person using the service] asked and agreed to pull emergency cord if any of his family access 'round the back'". The service had sent us notifications for safeguarding incidents and we saw they had dealt with any incidents accordingly. This meant that the service was aware of their responsibilities in reporting any potential safeguarding's or incidents so that CQC was able to monitor safeguarding issues effectively.

We saw that policies and procedures were in place for safeguarding and whistleblowing. The safeguarding policy clearly stated how to raise a safeguarding alert and who to contact. In addition, the whistleblowing procedure was clear in explaining who to contact in the relevant circumstances. One care worker told us that they were aware of the whistleblowing policy and how to raise an alert. They told us "I would tell CQC and escalate any issues by following the procedure".

The service had a robust staff recruitment system. All staff had references and Criminal Record Checks were carried out. This process assured the provider that employees were of good character and had the qualifications, skills and experience to support people using the service.

We saw documentation within care plans that people consented to being supported with their medicines. People had signed consent forms stating "I give permission to the Extra Care Service to assist me with my medication".

We saw that consent to care and treatment was sought and documented by care staff. For example, for one person using the service a recent entry in their daily log stated "[person using service] did not want any paracetamol. 500mg (372) left in box. [person using service] fine on leaving".

People had specific risk assessments in relation to their medicines and these were present in care plans. They included details about their medicines, the dosage and how to correctly record the administration of medicines. For example "make sure all Medication Administration Record (MAR) sheets are signed and any refusals are appropriately recorded". We saw documentation and observed staff recording any medicine refusals on MAR sheets during our inspection. This meant that care staff followed guidance and procedures for administering and recording medicines.

The risk assessments in relation to medicines were thorough and robust and included details of how to deal with certain situations, for example what to do if medicines were administered or recorded incorrectly as well as how to deal with specific medicines such as eye drops. For example, we saw that one person using the service had a risk assessment in place for their eye drops and a step by step pictorial guide for care workers to use if necessary. We also saw that people using the service who had epilepsy had specific risk assessments in relation to this and a 'what is epilepsy' fact sheet in their care plans for care workers to access. In addition, those with epilepsy had a sticker on the front of their care plans so that this was clear to care workers or health professionals at a glance.

Care staff told us what they would do in case of emergency relating to medicines, for example one care worker said "I would call the pharmacy or 999". In terms of administering medicine, one care worker told us "the medication comes in blister packs. We check the date. People have a right to refuse their medication. If this happens, we document it and tell the manager". During the inspection we observed a care worker administering medicines (with the consent of the person receiving care) and saw that they sought consent before giving medicine and also sought consent before carrying out care.

The coordinator for the service told us and records showed monthly medicines audits were carried out. This involved observation of staff whilst they administered medicines and recorded elements such as whether start dates were correct on MAR sheets, whether the number of tablets left matched the balance expected from the MAR chart and whether drug allergies were recorded.

As well as risk assessments for medicines, people using the service had general risk assessments in place and these were detailed and robust. For example, one person using the service had a risk assessment in place for their use of compression stockings. The risks highlighted were "stockings could be the wrong size/too tight; risks could be injury, pain, skin flap opening, bleeding, infection and ulceration which could be triggered by staff wearing jewellery on fingers or arms". The risk assessment then provided guidance for care staff when applying the stockings so that the risks identified could be prevented. This showed that the service was thorough in their approach to risk assessments. The coordinator for the service advised that they were responsible for carrying out the risk assessments and stated "I will research to see what could happen and look at the persons skin. I go to the worst possible scenario. If you don't put that in the risk assessment it lacks impact. That is the point of a risk assessment".

We saw that one person using the service suffered with COPD (Chronic Obstructive Pulmonary Disease) and their care plan contained details about the condition and how it presents itself. This person suffered with breathing difficulty and their care plan had clear instructions for care staff on how to manage and relieve this if the person had such difficulties and what to do in an emergency. In addition, there was a pictorial guide for care staff on how to support the person with their treatment if necessary. Care staff told us that if any new risks were to arise, they would document it and then tell the manager or coordinator immediately. This meant that risk assessments were current and any changes in needs were being recorded.

The coordinator for the service told us they had recently worked with the London Fire Brigade to devise a system where on each person's front door they have a green sticker or a red sticker. Green meant that the person was able to evacuate the building independently in the case of a fire and red meant that they would need assistance and support. We saw examples of this system on people's front doors and the coordinator showed us a document which included all of the people residing at the service by room number, their care provider (whether in-house, agency or 'self care') and their 'status', for example we saw that one person was documented as being an amputee and would therefore require an attendant in an emergency. This system showed us there were plans in place for everyone at the service in case of a fire or other emergency with easy to access to documentation supporting these plans for everyone to see, including care staff.

Accident and incident policies were in place. Procedures of how to raise alerts were clearly documented in the relevant policies. We also looked at policies such as dignity in care, end of life, infection control, health and safety, medications and recruitment.

Accidents and incidents were recorded and documented and we saw instances of this. For example, one person was recorded as having cut their finger. The actions taken were recorded, for example the cut was examined by a care worker and any medical attention received was recorded. We saw that this incident was followed up in the person's daily logs in a 'monthly welfare check'. The update read "update on finger cut, healing well". This showed that the service recorded and reviewed accidents and incidents.

Staff working at the service told us that during each shift there are two care workers when there should be three. The staff we spoke to told us that the service was "short staffed", but that they had time to carry out their duties with each person using the service. One staff member told us "even though there aren't enough staff, for example giving medicine isn't a rushed job. We have to document things properly. There are two people on in the morning and two people in the evening. We are not cutting people short but there is not enough staff, however there is also agency staff that come and help when needed. They will cover when needed. We have enough time to support people as individuals". Another member of care staff reiterated this and stated "agency staff fill in the gaps". The coordinator for the service told us that they use the same agency staff to maintain consistency and any staff absences that can't be covered by agency staff will be covered by staff from within the scheme. People using the service told us that their carers spent enough time with them. One person told us "I know my carers. They spend time with me and support me with the help I need.".

Good

Is the service effective?

Our findings

Staff told us they received regular training which included a week long induction programme at the commencement of their employment. One member of care staff told us that during their induction they shadowed experienced care workers for a week, both on a day shift and night shift and this was reflected in the induction records that we looked at. Records of the induction programme showed that there was a time table set out where new staff met with the team and their 'buddy' as part of a mentor system, had a tour of the building and undertook various training courses. Examples of training during the induction included the code of conduct, health and safety, food hygiene, personal care, infection control, manual handling and first aid.

We saw records of training courses attended by all staff on a training matrix provided by the registered manager which showed that staff were undertaking training annually in areas such as safeguarding, manual handling, medication, first aid and personal safety. One care worker told us "I've had lots of training, some in a classroom and some via e-learning. If I want more training I will ask. The training we have had has been good".

The registered manager told us and we saw it recorded in supervision notes that they were planning to implement the Care Certificate as part of staff training and development. The Care Certificate sets standards for the induction of health care support workers and adult social care workers.

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.

We found the service had up to date policies and procedures in relation to the MCA so that staff were provided with information on how to apply the principles when providing care to people using the service. The coordinator for the service and care staff had an understanding of the MCA. The coordinator explained to us that consent to care was always discussed with the people using the service and that care plans were signed to show that consent had been obtained. We saw records of this in people's care plans. Care staff told us that they obtained consent each time they entered people's homes to carry out care and explained to us the importance of seeking consent from people. One member of care staff told us "I seek consent all the time. I can't assume. I wouldn't want it for me. Sometimes they tell me to stop asking but I wouldn't'". This meant that staff were putting the principles of the MCA into practice.

Staff received regular formal supervision and we saw records to confirm this. One staff member said, "Supervision is useful. We will get an email reminder when it is due." Recorded supervision topics included discussion on the people using the service, training, personal development, morale and key working. Records showed that appraisals were completed annually.

Records showed that care staff had training on food safety and the nutritional needs of people using the service was identified in assessments in people's care plans. People were being supported with meal preparation such as heating microwave meals or making sandwiches. One person using the service told us that the support they were getting with meal preparation was "helpful".

People were supported to maintain good health and access to healthcare services. We saw that within care plans, people had a 'hospital letter' which had information about who they were (name, date of birth, address, next of kin) as well as information about their medicines and health needs. The coordinator for the service told us that when someone is taken to hospital, they take their letter with them and it was an effective way for the hospital to identify the person and their health needs "at a glance".

People's care plans included information and assessments from healthcare professionals. For example one person had recently had a visit from a respiratory nurse and the details of the visit, along with their recommendations were documented in the person's care plan. Another person's care plan and daily log records showed that a care worker had to call a district nurse to carry out specific treatment. A written record was made in the person's daily log as well as recording that the district nurse had visited and treatment was given. This showed that the service was effective at recording the involvement of any healthcare professionals and any relevant actions that were subsequently taken.

One member of care staff told us that they were able to make referrals to healthcare professionals such as occupational therapists, stating "now that key-working is in place, we will be able to pick up the need for referrals much quicker". A keyworker is a staff member who is responsible for overseeing the care a person receives and liaising with other professionals involved in a person's life. This meant that people using the service had access and support to healthcare professionals when needed.

Good

Is the service caring?

Our findings

People using the service told us they were happy with the care they were receiving. One person said "I am very happy here, I've been here since 1993. I've got super carers, a good team of carers". Another person using the service told us "the carers are lovely to me. I have no trouble with them. They're all good to me, they respect me. If I wasn't happy with anything I would tell [the coordinator]". Another person using the service said "all the staff are brilliant. I get on great with my key worker. I've got a nice flat, it feels safe. Generally I am happy".

We saw that positive and caring relationships were developed between care workers and people using the service. One care worker told us that key-working was a good way to develop relationships with people and get to know them well stating "you build relationships, for example one person I key work, we find each other interesting, we like to discuss history such as the Greek Gods and Egypt, [person using the service] likes to find plot holes and has always studied religion, we have a good intellectual relationship". The same care worker also spoke to us about the efforts they have made to stay engaged with people using the service saying "before I went into care I didn't follow any sport, but people here do so now I know when all the games and matches are on. I like to have a common ground with the tenants".

One care worker talked to us about giving people choice and freedom, stating "it's not what they can't do; it's what they can do. Sometimes they say no and that's fine. It's their decision".

Another care worker told us about the atmosphere at the service stating, "there are so many friendly characters here, some great humour. I have job satisfaction".

We saw in one person's communication book that they had been feeling lonely. The care worker for that person recorded that "[person using the service] feeling very lonely this am. Stayed and chatted a while then rang her sister to come over". It was then documented that the persons sister had visited and that they had got "pie and mash" and the person was "feeling a bit better". This demonstrated the caring attitude of the care staff in ensuring the person was no longer feeling lonely and that something was done about it and that all actions that were taken had been recorded.

Care workers spoke to us about how they ensure people using the service are treated with dignity and respect. One said "respect is everywhere. I put myself in their position. I think of my mum and dad. For example, leaving someone to take their time on the commode, and giving them time and privacy, I respect that". The same care worker also said "everyone is different, I learn something every day. You have to love your job. It's about the quality of care people receive". Another care worker told us how they implement treating people with dignity and respect, stating "treating people how they want to be treated, respect and treating people with kindness, treating them fairly. In practice this means, for example with personal care, do they want to wash their private parts themselves? I give them choice. I am very flexible. If someone wants to go to bed at 6pm that's their choice. I can accommodate. I give them freedom".

The service supported people in promoting their independence and one care worker gave us an example of

how they did this; "one person was relying on carers to carry out personal care but I encouraged him to do it himself with support. Now I only help with the bits they can't manage and we have also encouraged this person to walk a lot more and this is helping them with their independence".

Good

Is the service responsive?

Our findings

Care plans included a 'resident's guide' which contained the objectives of the service. This included "to maintain and encourage a homely, friendly atmosphere. Residents are encouraged to discuss their support and care needs and have these assessed appropriately by competent trained staff". People told us they felt included, one person telling us they felt, "part of the planning of my care". The resident's guide stated, "prior to a resident moving to an extra care scheme, a care manager or social worker will have carried out an assessment". We saw that care plans had copies of these assessments and that their individual preferences and interests were documented. For example we saw that one person enjoyed art, drawing and social activities. We saw in this person's daily logs they were supported to take part in these hobbies and this was documented accordingly. This meant that the service was supporting people to follow their interests.

Care plans were person centred and included details about the person's history and life. For example, one person's care plan detailed where the person was born, the significance of World War II and the impact it had on their life, the jobs they had, as well as their current likes, dislikes and hobbies. This meant that the service was actively getting to know the people using the service and documenting the historical information that people had provided within their personalised care plans. One care worker told us that they got to know the people they were caring for by "going through their care plan and their preferences, making sure everything is accurate and then it can all be followed". They told us that they always had access to care plans and if a person's needs changed they would "speak to the manager". One care worker told us "personalised care is what the person wants, for example if they want to have breakfast at night, then they can!"

People's cultural beliefs were respected and care workers told us about the different religious and cultural needs of people using the service. For example, one care worker told us about a person who practices a particular religion and someone from that faith group will visit them regularly. Care workers told us they were aware of the beliefs within this religion and that they were respectful of practices within it.

The coordinator for the service told us that activities were an important aspect of the service and that there were weekly newsletters that were posted through people's door's and on communal notice boards in the lounge telling them about the events and activities going on that week. We saw examples of the newsletters. One dating back to Christmas contained information about the festive activities and foods. We also saw a recent newsletter relating to Easter which included information about an Easter 'Mastermind' quiz, a knitting circle and film club. The coordinator told us about a weekly lunch club that took place in the lounge whereby she "cooked a whole roast dinner every Wednesday from scratch". She told us that people who wished to be involved gathered in the lounge and many would go to the kitchen "to watch the Yorkshire puddings rise". One person using the service told us that this was a "great part of the week" and that they enjoyed the lunch club "very much".

The coordinator for the service told us that she was passionate about keeping the activities at the service "open to everyone" and explained that she had recently purchased a dart board but told us that she would not put it up until it's location on the wall could be adjusted so that wheelchair users and people of all

heights could use it comfortably and safely. She also told us about plans to purchase a collapsible pool table for the lounge as she had recently received interest from people using the service to have one.

People received personalised care that was responsive to their needs. We saw that this was happening by the information in their care plans and by speaking to the people receiving care. Care plans were detailed with what care people were receiving, for example one person's care plan showed that they were supported with their personal care, getting dressed, medicines and getting ready for bed. We saw that this recorded within the daily logs. For example a recent entry stated "administered medication, taken and given two paracetamol. Applied eye drops and gel into both eyes. Assisted with night wear, helped into bed, made comfortable, hot water bottle made, had a chat". This showed that care plans were adhered to and care needs were recorded.

We saw that people's care needs were generally reviewed every six months but sooner if necessary. We saw that one person's care needs were reviewed on a monthly basis due to a recent issue with hoarding medicines. Records showed monthly reviews were carried out in relation to the issue and in addition, risk assessments were updated accordingly. General reviews documented any changes to people's needs and what actions were taken. For example one person's care records showed they were having difficulty putting in their hearing aid independently. The actions taken in relation to this included guidance was given to staff showing them how to support the person. In addition, we saw in this same person's care plan that there was a step by step pictorial guide on how to insert a hearing aid effectively and safely. This meant that the service was responsive to people's needs.

Complaints and concerns were encouraged and responded to. People's care plans had information about how to complain, the time frames and stages within a complaints procedure and details of the local government ombudsmen. The coordinator for the service advised us that there had not been any formal complaints made but that people using the service were very "open and vocal" about anything they weren't happy about. People using the service told us that they knew how to make a complaint. One person told us that if they were unhappy about anything they would "speak to the coordinator". Another person told us that they knew what the complaints procedure was and that they would "speak to a carer to help them" if necessary.

The service kept records of the compliments they had received and we saw examples of this. A recent email from a relative of a person using the service stated the care their father received was "excellent". Another recent email from a relative said "I could not wish for better care for my father and I very much appreciate the help and support he is receiving. The organisation at Ted Hennem House is perfect. I was impressed and I know my father is happy and content to be a resident. Please congratulate the staff on the good work they are doing". The service also received a letter from the relative of a person who had used the service stating, "I thought I should write to you regarding the care of my relative during the last three years of her life. In a word it was exemplary".

Good

Is the service well-led?

Our findings

The service had a registered manager in place that was supported in the running of the home by a coordinator. At the time of inspection, the coordinator was present. One member of care staff spoke to us about the coordinator and their role, stating "she is great, she's brilliant. It's like a big happy family. The registered manager is great at getting people in the lounge, she is very encouraging and does her best. There is an open door policy for them both, you can always go in and see them". Another member of care staff stated "the coordinator is very approachable and supportive. She's really good, when you get on with your manager, things run smoothly. She is good at working with people".

We saw that staff meetings were taking place, with the most recent on the 8 January 2016 and included discussions such as training, annual leave, key working, staff allocations and events. The coordinator for the service told us that team meetings took place "as often as needed" and that there were daily discussions about any issues. Care staff told us that this arrangement "worked well", especially as "on a handover we talk every day, there's lots of communication, even on the phone if necessary when a shift has finished".

The coordinator for the service told us about the quality assurance practices they carried out. This included auditing care plans at random to ascertain whether there were any issues or updates that needed to be made. We saw records of these audits which were carried out on a monthly basis and detail about any changes that needed to be made to care plans, for example updating next of kin or advocate details.

The coordinator for the service spoke to us about how they deliver high quality care by sending out annual feedback questionnaires to stakeholders. We looked at the returned questionnaires during our inspection. One questionnaire had been completed by a social worker who described the service as "good" and said they were "very satisfied" with the service overall. People using the service also completed the questionnaire. One of the questions asked was "do you feel empowered to decide how your service is delivered?" to which one person answered "yes". Another person using the service gave the following feedback; "service user happy with the service". The coordinator told us that feedback from people was essential to making sure that a high quality service was being provided and said "people give me feedback every day. I know my site, I know my tenants. There is always communication".

The coordinator told us about their involvement in working with other agencies in the borough and stated "we work well as a team in the whole borough". This was seen in feedback the service had received from a social care professional. The coordinator explained that they had recently implemented key-working to the service which was working well to ensure people were receiving consistent care. The coordinator told us that the service was at full capacity with a waiting list and that this was indicative of the service "providing high quality care" and that the feedback received from families and advocates supported that.

There were policies and procedures in place to ensure staff had the appropriate guidance and staff confirmed they could access the information if required. The policies and procedures were reviewed and up to date to ensure the information was current.