# Ms Theresa John

# Sisserou

## Inspection report

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Date of inspection visit:
04 March 2016
08 March 2016

Date of publication:
20 April 2016

## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Good** |

# Summary of findings

## Overall summary

The inspection took place on 4 and 8 March and was announced. The provider was given 48 hours' notice as it is a small care home and we needed to be sure that someone would be in. The service is a small care home for up to three people with learning disabilities. At the time of our inspection two people were living in the home. The home shares a staff team with another service run by the same provider in the local area. The service was last inspected in October 2013 when it was found to be compliant with the outcomes inspected.

The home did not have a registered manager in post, as the provider is an individual who is considered a 'registered person.' 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 home was not always applying the principles of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards. Staff had not received specific training in this area and did not fully understand the principles behind it.

Risk assessments were not robust and care plans lacked detail on how support was provided. The knowledge of the staff supporting people was not captured in the documentation. This was brought to the attention of the registered provider who updated care plans and risk assessments to a good standard.

Records of care delivered were brief and task focussed. This meant that the service was not routinely capturing all the information about how people received support. We have made a recommendation about record keeping.

People were supported by trained staff to receive their medicines, however, records of medicines administered were not always clear. We have made a recommendation about recording medicines.

There were sufficient numbers of suitable staff employed by the service. Staff had been recruited safely with appropriate checks on their backgrounds completed.

Staff were knowledgeable about safeguarding adults and knew how to protect people from harm. People told us they felt safe.

Staff received regular supervision and ongoing training to support them to develop the skills and knowledge required for their role.

People were supported to eat and drink sufficient amounts to maintain a balanced diet. The service provided culturally appropriate food to meet people's needs and preferences.

People were supported to have their health needs met. Records showed people were supported to attend appointments with healthcare professionals when required. Any advice from healthcare professionals was

shared so that staff knew how to support people to maintain their health.

Staff were caring and had built up strong relationships with people living in the home. Staff and people living in the home had a shared cultural heritage which meant that cultural and language needs were met. People were supported to attend religious services of their choice.

Care files were reviewed regularly and records showed that people were involved in making decisions about their care. Preserving people's dignity and respecting people's right to make choices were embedded in care plans.

The service had various feedback mechanisms, including formal complaints, house meetings and feedback surveys. This meant the service routinely listened to and learnt from people's experiences.

The home had a strong open, and person centred culture. Staff and people living in the service knew each other well and the home had a relaxed and homely feel.

People and staff spoke highly of the registered provider and described her as supportive.

The registered provider conducted appropriate audits and checks on the service to ensure it was delivering consistent, good quality care.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

The recording of medicine administration was not always clear.

Risk assessments were updated during the inspection to include the measures in place to manage risk.

Staff had a good understanding of safeguarding adults and knew how to protect people from harm.

There were enough staff to keep people safe and meet their needs.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff did not fully understand the Mental Capacity Act 2005 and its implications for people living in the home.

Staff received appropriate support and supervision to carry out their roles and responsibilities.

People were supported to eat and drink enough to maintain a balanced diet.

People were supported to maintain good health and access healthcare services as required.

### Is the service caring?

**Good**

The service was caring.

The staff team was small and stable and had developed strong relationships with people living in the service.

The cultural and spiritual needs of people living in the service were supported well.

People were treated with respect and upholding their dignity was integral to care plans.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

Records of care delivered lacked detail and did not include all the support provided.

People received personalised care that met their needs. People's bedrooms were decorated to their own tastes.

The service had a robust complaints policy. People and their relatives were encouraged to provide feedback about the service.

## Is the service well-led?

Good

The service was well led.

The registered provider promoted a person-centred and inclusive culture at the home.

Staff and people who used the service spoke highly of the registered provider and told us they felt well supported.

Systems were in place to ensure good management of the home.

# Sisserou

**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 4 and 8 March 2016 and was announced. The provider was given 48 hours' notice because the location is a small care home and we needed to be sure that someone would be in.

The inspection was conducted by one inspector.

Before the inspection we reviewed the information we already held about the service including statutory notifications. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority but did not receive any feedback as they do not place people in the home.

During the inspection we spoke with two people who used the service, two care workers, and the registered provider. We observed how the staff interacted with people who used the service. We looked at two people's care files including support plans, risk assessments, reviews, monthly updates, health records and medicines records. We looked at three staff files, including recruitment records, training, supervision and appraisal. We viewed the staff duty rota, a range of audits and feedback, various meeting minutes, maintenance logs, incident and accident log, and policies and procedures for the home and other documents relevant to the management of the service.

Requires Improvement

# Is the service safe?

## Our findings

The registered provider completed both individual and service level risk assessments in the home. Care files contained a range of risk assessments relating to different areas of support, such as accessing the community, medication and, challenging behaviour. However, risk assessments did not full describe the actions in place to reduce risk and were unclear in their instructions to staff. For example, measures to reduce the risk of refusing medication were described as "Lots of coaxing" and, "Coax, give space. Return and coax again." These were not clear measures for staff to follow to reduce risk. Although the documentation was not clear, staff were able to describe in detail the actions they took to reduce risks. For example, they described how they supported one person to accept support if they were refusing assistance with their personal care.

This was brought to the attention of the registered provider who took on board our feedback and sent us updated risk assessments after the inspection. These were more robust and contained specific instructions for staff on how to reduce and manage risk. For example, staff were instructed, "[Person] responds well to being praised each time [they complete aspect of task]" The assessment then contained details of de-escalation and response techniques. People's right to refuse care and support was embedded within the risk assessment. This meant the re-written risk assessments ensured that risks were managed so that people were protected and their freedom supported.

People told us they felt safe in the home. One person said, "I feel safe." The registered provider had a robust policy regarding safeguarding adults from abuse. Staff were knowledgeable about the different types of abuse and described the action they should take if they had concerns that someone was being abused. The provider told us they would report any concerns to the local authority to investigate. Incident records showed the service had had one serious incident since the last inspection. Although the home had taken appropriate action in response to the incident, including referrals to external agencies and updating risk assessments, they had not notified CQC of this incident as required. This was brought to the attention of the registered provider who informed us they had not realised this incident needed to be reported. The requirements for notifications were discussed and appropriate notifications were submitted on the day of our inspection.

Staffing levels at the service were determined by the needs of the people living in the home and varied according to the activities planned for the day. For example, if a person had an appointment or activity scheduled additional staff worked to ensure safe staffing levels. Staff absences were covered by colleagues, a small pool of bank staff or known staff from an agency. This meant people were not supported by staff they did not know.

Records showed that the registered provider carried out appropriate checks on staff before they commenced employment. Staff recruitment records showed relevant checks had been completed before staff had worked unsupervised at the service. Records included completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records.

People had support plans in place regarding medicines. These included information regarding what medicines they were taking and potential side effects. The home used printed medicine administration records (MAR) supplied by their local pharmacy. Daily and weekly checks on medicines were completed by staff to ensure that people had taken their medicines as prescribed. Staff recorded when medicines had been administered, however, where people had refused medicines this had not been appropriately recorded. Staff had recorded in people's daily log books that they had refused medicines, but the MAR record had been left blank. This meant it was not clear what had happened to that dose of medication.

We recommend the service seeks and follows best practice guidance on recording medicines administration.

Requires Improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. One person living in the home had an appropriate DoLS authorisation in place. However, the checklist used to assess whether DoLS applied to another person was out of date and did not reflect the changes made to the application of the DoLS guidance that came into place in 2014. This person was having their liberty restricted without the appropriate authorisations being in place. This was brought to the attention of the registered provider who submitted the application for authorisation.

Staff talked about and we observed people being offered choices and being encouraged to make their own decisions as far as possible. However, staff did not fully understand the MCA and its implications for people living in the home. When asked about the MCA one staff member said, "I'm not really sure about that, I would ask for advice." Another member of staff said, "I think I'm doing training on that soon." Records showed staff had not received specific training in this area.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff had recently completed a level 2 qualification in dementia care and had started work on a level 3 qualification in health and social care. Staff told us, and supervision records confirmed, the manager promoted learning and development in the staff team. Records showed staff had completed training in medicines, safeguarding adults, first aid, moving and handling, food hygiene and basic nursing skills. Some of this training was due for renewal and the registered provider was seeking appropriate courses at the time of inspection.

Staff told us, and records confirmed, they received regular supervision from the manager. Supervisions were used to discuss professional development, any concerns regarding people using the service and work practice. Areas for development and strengths of staff were also discussed. Staff told us they found supervisions useful and supportive. One member of staff said, "It's useful, we can make things better for the home."

People told us they liked the food and we observed people being offered choices at mealtimes. Care plans contained details of people's dietary preferences and needs. For example, one person had been assessed for swallowing difficulties and appropriate guidelines were in place for staff to follow. People were provided with a culturally appropriate diet which reflected their preferences. People were supported to eat and drink

enough to maintain a balance diet.

People living in the home had complex health conditions and multiple diagnoses. The service supported people to access healthcare professionals as required and clear records were kept of healthcare appointments and medical advice. Staff knew the people living in the home well and were able to identify signs that people were unwell and the impact that may have on their behaviour. For example, it was recognised and recorded that people became less cooperative with taking their medicines when they were unwell and the GP should be contacted in these situations.

Good

# Is the service caring?

## Our findings

People told us they liked the staff. One person said, "They are nice." They also told us, "[named staff member] helps me" Interactions between staff and people living in the home were observed to be positive, friendly and supportive. When the inspector could not understand one person's communication staff understood and explained easily. Staff knew the people they supported well and spoke about them with affection. One member of staff said, "I call it my second family."

Staff shared a cultural background with people living in the home and met people's cultural and language needs. Staff and people living in the home spoke the same languages and were easily able to communicate with each other in both English and their mother tongue. People were supported to listen to music that reflected their culture and staff would share new music with people. People living in the home chose not to practice their religion, but staff continued to offer opportunities to do so and facilitated access when this was requested.

The staff team was small and stable, the newest member of the team joined nearly two years ago. Staff described how they spent two weeks shadowing more experienced staff spending time building up a rapport with people before working more independently. When a new person moved into the home, staff told us they had the time they needed to build up their relationship with them so they felt comfortable accepting support.

People were supported to maintain their dignity. This was embedded into care plans as the people living in the home did not have insight into the concept of dignity and were known to put themselves in situations where their dignity would be at risk. Care plans contained guidance for staff on how to ensure people's dignity was maintained and staff described in detail what steps they took. These included supporting people to move to a different area of the home, and creative solutions to continence issues.

Staff told us they supported people to be as independent as possible. One member of staff described how one person was now more independent in completing their personal care. Another person's care plan contained a section called "Things I can help with." This included aspects of care and daily living activity. Staff also described how they sought activities based on this person's interest in fixing things.

Requires Improvement

# Is the service responsive?

## Our findings

One person told us they liked shopping and that staff supported them to do this when they wanted. People were supported and encouraged to be involved in the daily activities of the home. Staff knew people well and described people's "Best days" in detail. These days included being supported to go out and join community activities. Observations of support provided showed that people were treated as individuals and were receiving personalised care.

One person showed us their bedroom, which had been decorated to their taste. They pointed out pictures of their favourite singer and family members on the wall. When asked about person centred care, one member of staff said, "It's about the person, how they feel and what makes them happy."

Care plans contained details of people's key relationships and described when they were most likely to engage. Care files contained details of people's interests and their lives before they lived in the home. Initial feedback regarding care plans was that they were task focussed and did not provide sufficient detail on exactly how care should be delivered. Despite this, observations of care delivered showed it was person centred. Staff knowledge of how to support people in a person centred way was detailed. The registered provider took immediate action to address this and showed us updated plans during the inspection. These were person-centred, positive and reflected the knowledge of people that staff had shared with the inspector.

Care plans and risk assessments were reviewed and amended at least every six months. Staff meeting minutes and supervision records showed that staff discussed where needs had changed and support needed to be amended. Records of meetings with people who lived in the home showed they were involved in making decisions about their care. House meetings had been used to plan holidays and people took a vote on where to go.

The home had a complaints policy which was on display in the home. It detailed the timescales for response and how to escalate concerns. Records showed that complaints had been responded to in an appropriate manner. The home also had systems for receiving and recording feedback from people and their relatives. Records showed that people were happy with the support they received and relatives said people were well supported.

Records of care delivered were brief and focussed on personal care provided. This meant the service was not always capturing the full range of activities that people participated in. For example, it was not always recorded when people were supported to go to the corner shop or what in-house activities they had been involved with. This meant it was not always clear what people had done and whether or not they had enjoyed it.

We recommend the service seeks and follows best practice guidance on record keeping.

Good

# Is the service well-led?

## Our findings

Staff spoke highly of the registered provider. They told us she was very supportive and encouraged them to develop in their roles. One member of staff said, "She's easy to talk to and is very sympathetic." Another member of staff said, "She gives us lots of support." A person living in the home said, "I like her, she takes me shopping."

The registered provider had a calm approach and spoke about the people who lived in the home with kindness and affection. She knew them, their needs and preferences well and this was also true for the staff. The atmosphere of the home was calm and the culture was person-centred and inclusive. The registered provider had been managing the service since it was established and had been involved in supporting all the people who lived in the home to move there.

The service held regular staff meetings which staff told us they found useful. Records showed these were used to discuss holidays, staff leave, training and people's needs. The home is small, and the registered provider told us she was able to ensure consistency in the care delivered through the use of supervision and observations. Although supervisions were recorded, the observations were not. However, supervision records showed that if the manager had a concern over how a member of staff had been working this was addressed appropriately.

The home had a system of feedback forms for people, their relatives and visitors. People had used the service questionnaire to provide feedback on a recent holiday and to suggest new activities. The registered provider met regularly with the people living in the home to seek their feedback. The registered provider also conducted regular audits of health and safety checks, log books and care files. They completed a weekly management audit which included reviews of any incidents and accidents, medicines, policies and staff records. Records showed the provider took action to address any issues uncovered in the audit. There were policies and procedures to ensure staff had appropriate guidance for their roles. Staff confirmed they could access the information if required. The policies and procedures were up to date which ensured the information was current and appropriate. These systems ensured the registered provider was monitoring the quality of the care provided.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>Staff had not received training in the Mental Capacity Act 2005 and were unclear about its application for people living in the home. The checklist used by the provider to consider whether DoLS applied was out of date. |