# Independence Homes Limited

# Mayfield Road

## Inspection report

17 Mayfield Road
Sutton
Surrey
SM2 5DU

Website: www.independencehomes.co.uk

Date of inspection visit:
26 October 2016

Date of publication:
21 December 2016

## Ratings

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

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

# Summary of findings

## Overall summary

This inspection took place on 26 October 2016 and was unannounced.

Mayfield Road provides personal care to up to 12 adults with epilepsy and a range of other needs, including those arising from acquired brain injuries, physical disabilities and learning disabilities. At the time of our inspection there were 10 people using the service. There was a registered manager in post. 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.

At our last inspection in January 2016 we found the provider was in breach of the regulation about safe care and treatment because medicines were not managed safely. We rated the service 'good' but the key question, "Is the service safe?" was rated 'requires improvement.' At this inspection, we found the issues were not sufficiently addressed and the provider was still breaching the regulation about safe care and treatment. There were no protocols in place for administering 'as required' pain medicines or homely remedies, which meant we could not be sure people were able to receive these safely. Homely remedies are medicines that people can buy without a prescription. The policy to follow when giving people medicines covertly (without their knowledge) was not easily accessible to staff, which meant people were at risk of receiving medicines in an unsafe way or without their consent. There were no systems in place to ensure all medicines held at the service were accounted for or to ensure that excess medicines were disposed of. This meant medicines could be misused or lost without the provider knowing. Medicines were not always stored at appropriate temperatures, which could make them unsafe or ineffective.

We also found the provider was in breach of the regulation about good governance, because their audits and quality improvement processes were not effective in making the required improvements in their management of medicines. We also found out of date information in a care plan even though it had been reviewed recently.

We will add full information about CQC's regulatory response to any concerns found during inspections at the back of this report after any representations and appeals have been concluded.

People were protected from harm and abuse, because staff knew how to report any concerns they had and there were systems to ensure staff did not use inappropriate restraint. Risk management plans were in place to keep people safe while restricting their freedom as little as possible. There were checks and management plans in place to ensure there was a safe environment for people to live in and the provider had systems to monitor accidents and incidents to identify any trends and address them.

There were enough staff to care for people safely, although the service was experiencing some problems with staff absenteeism. However, at the time of the inspection this problem was being addressed by the

provider. They also vetted new staff to ensure they were suitable to work at the service. Staff received an induction, training, supervision and support from relevant professionals to equip them with the knowledge and skills they needed to work effectively, including specialist knowledge and advice on best practice.

The provider was meeting the requirements of the Mental Capacity Act (2005). This helped to ensure the correct legal procedures were followed when decisions needed to be made on behalf of people who did not have the mental capacity to do so for themselves. Where people needed to be deprived of their liberty to receive care, this was done within the appropriate legal framework to ensure people's rights were upheld. Where people did have capacity, staff gained their consent before carrying out care tasks.

People were able to choose from a variety of healthy food that met their nutritional needs. They received the support they needed to access healthcare services.

Staff were caring in their interactions with people. They knew people well, communicated with them in ways that were suitable for their individual needs and understood when people needed space or quiet time. Staff enabled people to make choices about their care and how they lived their lives. They worked in a way that promoted people's dignity and independence.

Care was planned to meet people's physical, emotional and social care needs. Care plans were comprehensive and described in detail how staff should support people with care tasks. Although people's likes and dislikes were not always included in descriptions of how to care for them, there were lists of likes and dislikes that staff could refer to. Logs showed that people received their care as planned. The service had a diverse range of planned activities to meet people's needs.

There were systems in place for the provider to deal with complaints and concerns, including accessible information and forms to support people in making complaints.

People said they liked the home manager and staff were able to access the support they needed, including out of hours. There was a fair and open culture, which enabled people and staff to speak up about any concerns they had, and the staff team was supportive. Managers and senior staff communicated effectively with the staff team about any changes in the way they needed to work.

The provider carried out regular checks of the environment and the quality of interactions between staff and people. They involved people and their relatives in the quality improvement processes and this contributed to an empowering culture where people's voices could be heard.

## 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. Medicines were not managed safely and there was a risk that people did not receive 'as required' or covertly administered medicines safely. Some medicines were not stored at appropriate temperatures and medicines were not disposed of appropriately.

There were arrangements in place to help protect people from harm and abuse. People had risk assessments and management plans to help keep them safe while not overly restricting their freedom.

There were enough suitable staff to keep people safe.

### Is the service effective?

**Good**

The service was effective.

Staff had the training, specialist knowledge and support they needed to carry out their roles effectively.

The provider complied with legal requirements about making decisions on behalf of people who did not have the mental capacity to do so for themselves. Staff obtained people's consent, where they were able, before carrying out care tasks.

People received a variety of nutritious food and were able to access healthcare providers when needed.

### Is the service caring?

**Good**

The service was caring.

Staff knew people well, communicated well with them and were empathetic and understanding.

People received the support they needed to make decisions about their care.

Staff supported people in a way that promoted their dignity and independence.

## Is the service responsive?

Good

The service was responsive.

People had detailed care plans so staff knew how to meet their physical, emotional and social needs. There was a variety of activities to keep people occupied and engaged.

There were systems in place to deal with people's complaints and people received the support they needed to raise any concerns they had.

## Is the service well-led?

Requires Improvement

The service was not always well-led. Quality improvement systems were not always effective and we found the issues identified at our previous inspection had not been improved. Care plan reviews were not always effective in making sure care records were kept up to date.

The provider involved people and their relatives in assessing and monitoring the quality of the service. They carried out regular checks of the environment and quality of care.

People and staff fed back that managers were available, approachable and good at communicating with them.

# Mayfield Road

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 October 2016 and was unannounced. It was carried out by an inspector and a pharmacist inspector.

Before the inspection, we reviewed information we held about the service. This included reports from previous inspections, notifications the service is required to send us about significant events, and feedback we received from social workers and other people who contacted us about the service.

We spoke with three people who used the service and carried out observations of staff interacting with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with three members of staff, the registered manager who was also the area manager, and the home manager. We looked at two people's care plans, recruitment information for three members of staff and other records such as incident reports and staff supervision logs.

Requires Improvement

# Is the service safe?

## Our findings

At our previous inspection in January 2016, we found that the provider was in breach of the regulation about safe care and treatment because medicines were not managed safely. There were some errors in medicines stock and administration records, meaning we could not always be sure people were receiving their medicines as prescribed. There were no protocols in place for administering PRN ('when required') pain relief or homely remedies. Homely remedies are medicines that people can buy without a prescription.

At this inspection, we found the provider had not taken sufficient action to address these concerns. Although we saw that protocols were in place for PRN medicines to manage people's epilepsy, there were still no protocols in place with regards to PRN pain relief medicines. We did not see any evidence that staff carried out regular pain assessments for people prescribed PRN pain relief medicines. There were no assessment tools or documentation of how and when assessment was carried out. This meant we could not be sure people received their PRN medicines as prescribed.

We also found there was still no homely remedies policy in place. Staff told us this was because nobody at the service was currently using homely remedies. However, the lack of a homely remedies policy meant that the provider could not be sure that people who wanted to start using homely remedies, or people already using them who began using the service, would receive the appropriate support to use them safely.

Medicines were stored securely, including controlled drugs (CDs). Registers were in place to record the handling of CDs and we saw evidence of regular balance checks. Room temperatures were appropriately monitored to ensure that medicines designed to be kept at room temperature were stored within the recommended range. However, there were no records of daily temperature monitoring for the medicines fridge. On the day of inspection, we noted that the fridge thermometer was reading 16°C. This was outside the recommended fridge temperature range of 2 to 8°C and we were therefore not assured that medicines kept in the fridge were stored safely. Storing medicines at inappropriate temperatures could make them ineffective or unsafe to use.

We did not see any documented records of medicines returned to the pharmacy or disposed of in the last six months. We asked the service manager about this and they told us logs of recently returned medicines could not be found. We also found large quantities of medicines in a second medicines cupboard that could not be reconciled with medicines administration records (MARs). These discrepancies meant that not all medicines at the service were accounted for. There was a risk that staff were unaware of how many medicines were stored at the service and for medicines to be misplaced or lost.

There was a policy regarding the administration of covert medicines, but it was stored on a computer drive that was not easily accessible to staff. This refers to when medicines are given to people without their knowledge. We saw that one person was receiving their medicines covertly but there was no evidence of any discussions or authorisation from the medicine prescriber or the chemist to assess if it was safe to administer the medicine in a covert way. This meant the provider could not be sure the medicines were administered safely and in line with the person's rights.

The provider continued to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and people who used the service understood how to recognise and report suspected abuse. One person said, "I would report it and leave it in the manager's hands. I know I can't intervene." Staff knew what they should do if they were concerned the provider was not taking action in response to issues they raised. This was consistent with the provider's safeguarding procedure. They were able to discuss safeguarding at staff meetings so all were aware of any concerns. Staff were trained in the use of physical interventions for behaviour that challenged the service. The technique was designed to keep people safe without the use of inappropriate restraint and people's care plans clearly stated which interventions were unsafe to use with them due to disability or health issues. This showed the provider had the necessary arrangements in place to protect people from harm and abuse.

There was an alarm system to alert staff when people needed additional help or support. We observed staff responding immediately when the alarm sounded and going to the part of the home indicated by the system. There was a robust system for reporting and investigating accidents, incidents and other concerns, which were reviewed by the home manager and sent to the provider where any trends and patterns were identified and fed back to the service. This helped to ensure that managers were aware of any new or increased risks and were able to take timely action to address these.

We discussed with managers how they worked to keep people safe while restricting their freedom as little as possible. The service supports people who experience seizures and are therefore likely to fall and sustain injuries. The provider had worked to reduce the severity of the risks by adapting the environment so there was a lot of space for people to move around, furniture had rounded edges and large floor cushions were available to break people's falls. We saw one person had these next to the sofa they were using to reduce the likelihood of injury if they fell from the sofa. People had comprehensive, personalised risk assessments and risk management plans so staff had the information they needed to keep people safe from foreseeable harm.

There was a dedicated member of staff employed to carry out maintenance of the property. Firefighting equipment was available and was serviced regularly to ensure it was safe to use. Fire exits were unobstructed and alarmed so staff would be alerted to anyone leaving the building. People told us they were familiar with evacuation procedures as there were regular drills. Upper floor windows were fitted with restrictors to prevent people falling from height. We saw evidence that staff checked the temperature of hot water in baths every time they were used. The recorded temperatures all fell within the safe range. This all helped to maintain a safe environment for people to live in.

Most people told us there were enough staff to keep them safe. However, one person said there were not always staff available when they needed help and a member of staff told us staffing levels were often below the required levels. Managers explained that they had recently experienced problems with staff absenteeism, but this was now addressed. Staff confirmed this and we saw evidence on staff rotas that staffing levels were improved and were high enough to meet the needs of people currently using the service. Staff told us most people currently using the service required one member of staff per person at all times during the day, but some people who were more independent could remain safe without an allocated member of staff for short periods and one person confirmed this applied to them. When we arrived at the service there were eight staff on duty for 10 people. However, staff explained they had already arranged cover for two staff who were absent and we observed relief staff arriving within an hour. We observed throughout the day that there were enough staff on duty to care for people safely.

At our last inspection in January 2016 we found that the provider had robust recruitment processes in place to help ensure that staff were suitable to work with people. At this inspection, we did not check this in depth but we saw that the provider's recruitment systems were still in place and had been used for employees recruited since our last inspection.

Good

# Is the service effective?

## Our findings

People told us staff were knowledgeable about epilepsy and other areas relevant to their needs. There was a variety of training to help staff, including volunteers, maintain the knowledge and skills they needed to work effectively and staff received one-to-one supervision to support them in their roles. Staff told us the training they received was good and one person who used the service told us they had done some training courses as they did voluntary work for the provider. New staff received a robust induction that was based on Care Certificate standards. These are national standards that help providers to ensure that care workers have the skills, knowledge and behaviours they need to provide compassionate, safe and high quality care and support.

Staff had access to expert advice and best practice information from a number of sources, such as the organisation's medical director who was a doctor and an epilepsy nurse specialist who visited the service at least monthly to review people's care. This helped ensure that staff had the support and knowledge they required to care for people effectively.

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act (MCA). The 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 provider was meeting these requirements. There was evidence of assessments to check if people had the capacity to make specific decisions and where they did not, appropriate processes were in place to ensure that decisions were made in their best interests. For example, assessments showed that one person had the capacity to consent or otherwise to most decisions about their care but was not able to understand why they needed residential care and wanted to live alone. The provider, social workers and the person's family had discussed this and agreed that living at the home was in the person's best interests at present.

People told us staff asked for their consent before carrying out care tasks. One person said, "They always knock on my door" and told us staff never came into their room without their consent. Staff gave examples of times when they had supported people to make decisions about their care. If people had capacity, staff respected their choices even if they believed them to be unwise or unhealthy. One example staff gave was where people smoked and were aware of the risks to their health.

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 at our inspection in January 2016 that the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At this inspection we found DoLS authorisations were in place where required and the provider was continuing to meet legal requirements. Where a person had been deprived of their liberty because they needed residential care but did not want to live in a care home,

we saw they were able to move unrestricted around the home and that staff supported them to leave the home for activities. Another person told us they were not able to leave the home without staff support as part of their risk management plan but they were still able to go out when they wanted to because staff were available to accompany them. They told us they understood why this happened and were happy with the arrangement.

People told us they were able to choose what to have for their meals and that the food provided at the home was good. One person told us, "We are encouraged to sit in the dining room and socialise but we don't have to. We have a choice." Another person explained that they were having breakfast at their usual lunchtime because they had not slept well and got up late. There was information in care plans to help staff provide people with the support they needed around choosing a healthy diet with food suitable for their needs. This showed staff supported people to make choices about how they ate their meals.

People received a variety of therapies to meet their needs, including physiotherapy and speech and language therapy. Staff supported people to see epilepsy consultants regularly to receive the specialist care they needed. We saw evidence that people had access to other medical professionals when they needed it.

Good

# Is the service caring?

## Our findings

One person told us staff were "courteous." It was evident that staff knew people well. They communicated with each person in ways that were suitable for their level of understanding, knew how to respond if people became upset and asked us not to disturb one person because they needed space. Another person told us staff were very understanding when they wanted to be left alone and communicated this to other staff. We observed staff talking with one person in a sympathetic way about a problem the person had told them about. The member of staff assured the person that they were confident the person was capable of solving the problem.

The home had a board with photographs identifying people who used the service, managers and staff. We saw information displayed for staff about how to use communication aids and there was information in people's care plans about how to communicate with them so people received information in a format they understood. The speech and language therapist working at the service told us communication strategies they developed were led by the people themselves and they were able to decide how they wanted staff to communicate with them, for example whether to use specialist communication aids. This helped staff build positive caring relationships with people by enabling them to understand how best to communicate with people.

People told us staff enabled them to make choices about how they lived their lives. Information was displayed in the home to help people make choices about their care. This included information about activities that were happening outside the home with alternative choices so people had the opportunity to decide which they wanted to do. People were able to choose how to spend their time because there was a variety of quiet and more social space within the home. We saw staff supporting people to use quieter areas when they wanted their own space and we heard another member of staff tell a person, "If you're tired and want to give it a miss today, that's OK." Managers told us about a taster session that staff held to give people the opportunity to try new foods and help them decide what meals they would like included on future menus. They had recently introduced fortnightly menu planning meetings where people could make requests for the menu. These things helped to ensure that people were able to make choices about their care.

People told us staff respected their privacy and personal space. Staff explained how they promoted people's privacy and independence when they needed staff with them at all times for safety reasons. For example, staff told us they asked people if they wanted a member of staff with them while they were bathing. If the person said no, they told people they were waiting outside and checked on them every few minutes. We observed staff supporting one person to adjust their clothing to help preserve the person's dignity.

Good

# Is the service responsive?

## Our findings

One person told us, "I like living here. I really enjoy it. There's nothing really that I don't like." Another person told us they did not enjoy living there but managers were supporting them to find another home and they received news during our inspection that this had been successful.

At our last inspection in January 2016, we found that people's care was planned in a way that met people's physical, emotional and social care needs. At this inspection, we checked two people's care plans and found this was still the case. Staff were able to describe people's different support needs and the care plans we looked at were comprehensive and described in detail people's individual care needs, with clear descriptions of how to give people the support they required. Information staff recorded daily showed that people received their care as planned and that staff asked people if any changes were needed to their care plans.

We fed back to managers that people's preferences, likes and dislikes were not always apparent in the instructions for staff about how to complete care tasks for them, although there were separate lists of people's likes and dislikes about things like food and activities. This meant staff who were not familiar with people might do things in ways people did not like or that they were uncomfortable with. The registered manager said they would look at ways of making care plans more person-centred.

Care plans had detailed information about people's needs around their epilepsy, including types of seizures they experienced, their frequency, known triggers, signs and symptoms of an approaching seizure, how staff should respond, how to identify when people needed emergency care and the aftercare they required when their seizure was over. Staff recorded all seizures on charts to identify any patterns in the onset of seizures or changes in frequency. This helped to ensure that staff consistently gave people the support and care they needed in regards to this condition.

We spoke with a speech and language therapist who worked at the service and told us about how they supported staff to meet people's communication needs. For example, one person needed staff to communicate with them in highly specific and complex ways, but all staff we spoke with were able to describe consistently how they did this. This showed that the service was responsive to people's needs in this area.

People told us, "There is plenty to do. It varies daily." There was an activities timetable and we saw the activities scheduled for the day were taking place. People had access to activities equipment at the home such as board games. Staff told us about an adventure holiday they had supported some people to access at a venue adapted for people with disabilities. The provider had a programme of social activities that took place outside the home, known as 'FOCUS.' The activities included various sports, art and craft activities and life skills such as cooking. One person told us they enjoyed the voluntary work they did at FOCUS. Managers told us they encouraged staff to hold their own activity sessions if they had any particular talents or interests. This meant people had access to a variety of meaningful activities that helped protect them from the risks of boredom and social isolation.

The service had a large, pleasant garden with a sunken trampoline that people could use with minimal risk of falling off. One person showed us their bedroom, which was large with en-suite facilities, and explained that it was kept at a high temperature to meet their medical needs. We noticed this room felt warmer than the rest of the home.

At our inspection in January 2016 we checked that the provider had effective systems to deal with people's concerns and complaints. At this inspection, people told us they knew how to make complaints but the service had not received any since our last visit except for one that was currently being investigated in line with the provider's policies. We saw evidence that the home manager had responded appropriately to the person making the complaint. Accessible complaints forms were available to enable people to raise their concerns.

Requires Improvement

# Is the service well-led?

## Our findings

One person told us, "The manager is good." Another person said, "I have no problems with the manager. They listen."

Although the home manager had identified medicines management as a weakness during their service review in July 2016 and had made an action point to change this, our findings showed that the provider had failed to take sufficient action to address this in a timely manner. The problems we found with medicines stocks and the lack of protocols for 'as required' medicines and homely remedies had not been addressed since our last inspection. This meant people were at risk of receiving poor quality care because the provider's systems for improving the service were not always effective.

There was evidence that staff carried out monthly quality checks of the environment. We also saw monthly quality assurance checks that the provider carried out. These covered care plans, whether people received their care as planned, staff training and other quality indicators. However, we noticed some out of date information in a care plan relating to the care a person had needed immediately after a fall but no longer needed, although the date the care plan was last reviewed was a month before our inspection. Staff confirmed the person had recovered and no longer needed the support described in the care plan. This showed that the care plan review had not been effective in ensuring the documentation remained up to date. There was therefore a risk that staff working with the person would not know how to meet their needs, as the service often used temporary staff to cover absences. The home manager told us they would remove the out of date information to avoid any confusion about the support this person needed.

The above issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During their quality assurance checks, the provider looked at whether actions from previous quality assurance visits were complete and set action points to be completed by the next visit. We saw a copy of an observation tool used by staff to record interactions between people and staff for managers to review. This helped managers to monitor the quality of caring interactions between staff and people who used the service. As part of the quality improvement process, the home manager gave a presentation to senior managers about the service's strengths, weaknesses, opportunities, threats and priorities. This included a plan for how they would address problems they identified and exploit opportunities to make the service better. This helped the provider identify improvements they needed to make to the service.

Managers told us relatives of people who used the provider's services took part in making improvements at the services. They paid unannounced visits to other services within the organisation to check the quality of the care and support people received. Those checks looked at areas such as activities to measure aspects of people's quality of life. One person told us staff sometimes asked them for information about epilepsy and other things relevant to them because they had "a lifetime of experience." This showed how the provider worked to create an empowering, inclusive culture that recognised and made use of the expertise people and relatives had through their experience.

Staff told us they got on well with managers, who were good listeners and accessible when staff needed them. The service had an on-call manager whose details were displayed so staff could access leadership and support in an emergency. Staff said the service had a fair and open culture and that they felt confident raising any concerns they had. The home had a friendly, welcoming atmosphere and we saw people chatting together and engaging with staff. Managers told us the staff team was supportive and worked well together. They told us they had supported their staff when they had identified that this was needed by offering the staff therapy sessions to help them cope with a difficult time at the service.

The provider held a six-monthly epilepsy and health forum that people, relatives and staff were able to attend. This gave people the opportunity to have their questions answered and to receive advice about managing their epilepsy. We saw evidence that managers and senior staff used tools such as communication books and team meetings to inform staff about changes they needed to make to working practices. This included doing things differently in response to people's feedback, advice from healthcare professionals and actions from audits and quality checks. This helped the provider to improve the quality of the service by encouraging staff to work together to make changes.

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 will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not operate effective systems to ensure compliance with requirements. They did not effectively assess, monitor and mitigate risks to people's safety or maintain accurate records about people's care. Regulation 17(1)(2)(b)(c). |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not ensure care and treatment was provided in a safe way for service users. Medicines were not managed safely. Regulation 12(1)(2)(g) |

**The enforcement action we took:**

We have served a Warning Notice on the provider for a continuing breach of Regulation 12 of the HSCA (2008) Regulated Activities Regulations 2014. They are required to comply with this regulation by 14 December 2016.