

MCCH

Beehive

Inspection report

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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

Beehive is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Beehive is a residential care home for six adults with learning disabilities or on the autistic spectrum. The service is on one floor and all areas of the home are accessible to people. At the time of our inspection six people were using the service.

At our last inspection on the 29 October 2015 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The service carried out an assessment of people's needs before they commenced using the service. However, this did not cover needs related to ethnicity, culture or sexuality and we have made a recommendation about this.

There were enough staff working at the service to meet people's needs and robust staff recruitment procedures were in place. Appropriate safeguarding procedures were in place. Risk assessments provided information about how to support people in a safe manner. Medicines were managed safely and steps had been taken to reduce the risk of the spread of infection.

Staff received on-going training and supervision to support them in their role. The service operated within the principles of the Mental Capacity Act 2005. People were able to choose what they ate and drank. People were supported to access relevant health care professionals.

We observed people were treated with respect and that staff were caring. Staff had a good understanding of how to promote people's privacy, independence and dignity.

Care plans were in place which set out how to meet people's individual needs. Care plans were subject to regular review. People were supported to engage in various activities. The service had a complaints procedure in place.

Staff and people spoke positively about the senior staff at the service. Quality assurance and monitoring systems were in place which included seeking the views of people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service remains good.

Is the service effective?

Good ●

The service remains good.

Is the service caring?

Good ●

The service remains good.

Is the service responsive?

Good ●

The service remains good.

Is the service well-led?

Good ●

The service remains good.

Beehive

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 was a comprehensive inspection. The inspection took place on the 28 February 2018 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed the information we already held about this service. This included details of its registration, previous inspection reports and notifications of significant events they had sent us. Notifications are information about important events which the service is required to send us by law. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We contacted the local authority with responsibility for commissioning care from the service to seek their views.

We were unable to speak with people using the service due to their communication needs but we observed people during our inspection and saw how they interacted with staff. We spoke with four staff, including the registered manager and three support workers. We reviewed three sets of records relating to people including care plans and risk assessments. We looked at five sets of medicine records and three sets of documents relating to staff recruitment and supervision. We examined the training records of all staff. We checked quality assurance and monitoring systems at the service and sampled policies and procedures, including the complaints, whistleblowing and safeguarding policies.

Is the service safe?

Our findings

Systems were in place to protect people from the risk of abuse. The service had safeguarding and whistleblowing procedures and staff were aware of their responsibility to report any allegations of abuse. One staff member said, "There are four things we have to do. Report it to the manager, the police, the social worker and MCCH itself [the provider]." Safeguarding allegations had been dealt with in line with the policy. Monies held on behalf of people were stored securely and records and receipts were kept of financial transactions involving people's money. This meant people were protected from the risk of financial abuse.

Risk assessments were in place for people. These identified the risks people faced and included information about how to mitigate the risks. Assessments included risks associated with accessing the kitchen, medicines, personal care, going out in the community and moving and handling.

The registered manager told us and staff confirmed that the service did not use any form of physical restraint when working with people. Where people exhibited behaviours that challenged the service behaviour support plans were in place. These identified potential triggers for behaviours that challenged the service and detailed how staff should respond. Staff had a good understanding of this guidance. This meant steps had been taken to support people in a safe manner.

The service had measures in place to help ensure the physical environment was safe. Fire alarms were tested weekly and serviced annually by a qualified person. Gas and electrical safety checks had been carried out. Risk assessments covered the physical environment and staff carried out a monthly health and safety audit to make sure the physical environment was safe.

There were enough staff to meet people's needs. We observed staff were able to respond to people in a timely and unhurried manner and staff told us they had enough time to carry out their duties. One member of staff said, "Staff levels are ok here." We saw staffing levels on the day of inspection were in line with those detailed on the staff rota.

The service had robust staff recruitment practices in place. Staff told us and records confirmed that checks were carried out on prospective staff before they commenced working at the service. These checks included criminal record checks, employment references, proof of identification and a record of previous employment. This meant the service had taken steps to employ people who were suitable to work in the care sector.

Medicines were managed safely. Medicines were stored securely in locked and designated medicine cabinets inside the office. Records were kept of medicines entering and leaving the home and audits were maintained of medicines held in stock. Medicine administration charts were in place which recorded the name, strength, dose and time of each medicine to be given. We checked these and found them to be accurate and up to date. The service had a medicines procedure in place and we observed staff administering medicines in line with the procedure.

We found the service was clean and free from offensive odour on the day of inspection. Cleaning schedules were in place which detailed which areas were to be cleaned and when, and these were signed by staff to indicate when a particular task had been completed. We observed that staff wore protective clothing including gloves and aprons when providing support to people. This meant the service had taken steps to reduce the risk of the spread of infection.

There was evidence that when things went wrong the service learned from this and put in place strategies to minimise the risk of similar occurrences. For example, it was highlighted in a medicines audit that there had been incorrect recording of some medicines entering the service. The issue was addressed with the relevant staff in their one to one meetings and staff were expected to re-take the medicines training course. Records were kept of accidents and incidents. These were reviewed and showed action was taken to lead to improvements. For example, after some recorded incidents of behaviour that challenged the service a referral was made to the psychiatry team for one person. They worked with the person and the service and incidents of such behaviours reduced significantly.

Is the service effective?

Our findings

The registered manager told us and records confirmed that the service carried out an assessment of people's needs before they moved into the service. This was to determine what the person's needs were and if the service was able to meet them. The registered manager told us, "I would carry out an initial assessment to see if we can meet their needs and if they can fit into the service." Assessments covered needs associated with communication, eating and drinking, personal hygiene, health, mobility, daily living skills and finances. However, they did not cover needs associated with equality and diversity issues such as the person's ethnicity, culture or sexuality. We discussed this with the registered manager who said they would in future cover these issues as part of the assessment process and we recommend this.

Staff were supported to develop knowledge and skills through training and supervision. Staff undertook an induction programme on commencing work at the service which included shadowing experienced staff and completing the Care Certificate, a training programme designed for staff that are new to working in the care sector. Staff told us and records confirmed that they had access to regular on-going training, including training about first aid, fire safety, the Mental Capacity Act 2005, epilepsy and infection control. Records confirmed that staff had regular one to one supervision meetings with their manager which gave the opportunity to discuss matters of importance to them. One staff member said of their supervision, "We talk about how I can develop things, if there are any issues, if I want to go further (in terms of career progression), [registered manager] tells us what to look for. Every month we have a supervision with [registered manager]."

People were able to help choose the food they ate through the weekly residents meetings. Picture cards were used to help people communicate the food they liked. We observed people enjoying their lunch on the day of inspection. Food reflected people's cultural background. One person had food related to their religion and we saw this was stored and cooked separately from other people's food. Staff were knowledgeable about people's food preferences and this information was recoded in care plans.

The service worked with other agencies to promote people's health and wellbeing. The service worked with the local authorities who commissioned care from the service who had a role in reviewing people's needs. People had access to health care professionals. Records showed these included GP's, dentists, psychiatrists, learning disability specialists, speech and language therapists and opticians. To help promote people's health, Health Action Plans were in place which set out how to promote the health of individuals. Hospital Passports were in place. These provided information about the person to hospital staff in the event of the person been admitted to hospital.

The service had been adapted to meet the needs of people. The building was all on one floor and corridors were wide enough to allow easy access for people who used wheelchairs. Handrails were situated along corridors and in bathrooms and toilets to assist people with their mobility. The premises were step free including access to the garden. The premises were well decorated and homely in appearance.

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). People at the service were subject to DoLS authorisation. The service had followed appropriate procedures in applying for DoLS authorisations and had notified the Care Quality Commission. Mental capacity assessments had been carried out to determine if people had the capacity to make specific decisions, for example, in relation to personal care, managing their finances or obtaining health care. Where they lacked capacity best interest decisions had been taken which involved staff from the service and other relevant persons.

Is the service caring?

Our findings

People were unable to tell us their views about staff but we observed people were relaxed and at ease in the company of staff. People were regularly seen to initiate contact with staff and were frequently seen smiling throughout the course of the inspection.

Staff had a good understanding of how to promote people's dignity and privacy. One staff member told us, "I do the front then cover [person] up to do the rest (when providing support with personal care)." The same staff member said, "Before I touch them I have to ask, I can't assume they are ok for me to touch them." Another staff member said, "You need to close the door if someone is in the toilet and the curtains if in the bedroom."

Care plans included information about promoting people's independence. For example, the care plan for one person stated, "[Person] cannot dress themselves at this point without prompting and encouragement. [Person] will put on their underwear and trousers if positioned in the right way for them." Staff were aware of information in care plans and told us how they promoted people's independence. For example, one member of staff said, "[Person] can put their socks on a certain way. They can't really bend down so much so I put them on over their toes and they pull them up." During the inspection we observed staff supporting people to do things for themselves, for example, with making a cup of tea or a sandwich.

The service sought to meet people's needs in relation to equality and diversity issues. Food was provided which reflected people's culture and religion. People were seen to wear clothes that reflected their culture. We saw compact discs in people's room which were in line with information about people's musical tastes detailed in their care plan, and again, reflective of people's culture. Records showed that one person was supported by staff to attend a place of worship, although at the time of inspection they had not been recently due to ill health.

Care plans included information about supporting people with communication. For example, the care plan for one person stated, "I am non-verbal but I understand when spoken to. I will get staff's attention by my gestures and facial expressions. I sometimes lead staff to what I want." Communication passports were in place for people which provided information about how they communicated and how staff should interpret and understand their communication.

Each person had their own bedroom. These were homely in appearance and contained people's personal possessions such as televisions and family photographs. Bathrooms and toilets at the home were fitted with locks that included an emergency override device. This helped to promote people's privacy in a safe way.

Is the service responsive?

Our findings

Care plans were in place which set out how to meet the needs of individuals in a personalised manner. Care plans covered needs related to health, personal care, relationships, daily living skills, communication and activities.

Care plans were subject to review which meant they were able to reflect people's needs as they changed over time. Each person had a monthly review with their keyworker. This looked at progress people were making in achieving goals set out in care plans, as well as reviewing any medical appointments and activities that took place in the month. Daily records were maintained of care provided which meant it was possible to monitor that care was delivered in line with care plans.

People were supported to engage in various activities both in-house and in the community. Although there were community based activities scheduled for the day of inspection these had been cancelled due to unexpectedly severe weather conditions which meant transport could not be arranged. Weather permitting, records showed people attended various day centres and engaged in activities organised by the service, including trips to parks, cafes, bowling and shops. We saw staff supporting people with in-house activities including puzzles and playing with toy trains which people were seen to enjoy.

The service had a complaints procedure in place. This included timescales for responding to complaints received and details of who people could complain to if they were not satisfied with the response from the service. A copy of the procedure was on display within the communal area of the home. This was in both written and pictorial form to help make it more accessible to people. The registered manager told us there had not been any complaints received since our previous inspection and we found no evidence to contradict this. Records of compliments were kept. We saw one professional had written, "The care home environment is very clean and tidy."

Although no-one was receiving end of life care at the time of our inspection, end of life care plans were in place for people. These included details about the care people wanted to receive, who they wanted involved and what after death arrangements they wanted, including details of funeral arrangements. We saw for one person the end of life care plan had not been completed. The registered manager told us they had raised this issue with the person's relative and they were seeking a meeting to discuss the issue. Records confirmed what the registered manager told us.

Is the service well-led?

Our findings

The service had a registered manager in place. Staff spoke positively about the registered manager and about the culture of the working environment at the service. One member of staff said, "[Registered manager] is approachable. They always make sure we are on top of things, with service users, paperwork. They always make sure we put service users first." Another staff member said, "As a manager they are good for service users and staff. They do all the things." They added, "We think our workplace is a good environment, good teamwork. It's like a second home, like a family."

The registered manager had a good understanding of their legal responsibilities in relation to their registration and was knowledgeable about what issues they had a legal responsibility to notify the Care Quality Commission (CQC) about. Records showed the service had notified the CQC appropriately of significant events.

The service had systems in place for monitoring and reviewing the quality and safety of care provided. Some of these systems included seeking the views of people who used the service and their relatives. For example, the service held weekly service user meetings. Minutes of these showed they included discussions about if people were happy, appointments and menus. Picture cards were used in these meetings to help people participate. Minutes showed that three monthly meetings were also held for friends and family so they were able to participate in the service. In addition, the service carried out surveys of relatives, the most recent of which was conducted in January 2018 and contained positive feedback. For example, one relative had written, "[Person] seems very happy in Beehive and regards it as their home."

Monthly team meetings were held. A staff member said, "Yes, we have team meetings. We talk about what needs improving, the service users, when birthdays are coming up." Another staff member said, "We talk about a lot of things at the team meetings. [Registered manager] brings a lot of things to talk about." Minutes of staff meetings showed they included discussions about team work, the regulator, health and safety and issues relating to people.

A senior manager working for the provider carried out six monthly audits of the service which covered staffing levels, the physical environment, training and medicines. We saw issues identified in these audits were subsequently addressed. The registered manager carried out their own monthly audit which looked at care plans, health and safety, mental capacity assessments and medicines.

The service worked with other agencies to promote people's wellbeing. For example, the supplying pharmacist carried out an annual audit of medicine practices and procedures at the service. The registered manager attended the 'Providers Forum' which was run for care providers by the local authority. The registered manager told us, "I network a lot, share ideas with managers of other homes." They also told us, "I try to read all the information that comes through from the Care Quality Commission to keep up to date with changes."