Royal Mencap Society

Royal Mencap Society - 36 Huddleston Close

Inspection report

36 Huddleston Close
Bethnal Green
London
E2 9NR

Website: www.mencap.org.uk

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14 March 2018

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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 carried out this announced inspection on 14 March 2018. At our last inspection in January 2016 we rated this service 'good'. At this inspection we found the service remained 'good'.

36 Huddleston Close is a care home for up to three people with learning disabilities which is managed by Mencap. At the time of our inspection there remained two men using the service. The service is a small purpose built home, with a large shared kitchen and lounge, a small garden, two bedrooms and two rooms for staff.

The service adjoins 34-35 Huddleston Close, which is also a service managed by Mencap and shares a registered manager, who had been in post since 2014 and jointly managed both services. 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.

Since our inspection there had been some changes to people's needs, particularly with regards to health conditions. The service worked well with other professionals in order to meet the person's needs and support them to access health appointments. There were measures in place such as communication books and hospital passports to support the person to stay in hospital when required. People were supported to eat and drink well.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. Medicines were safely managed with systems in place to protect people from mistakes.

The staff team had effective strategies for communicating with people and supporting them to express their needs. There were positive behavioural support plans which were effective in reducing incidents of behaviour which may challenge. The service promoted positive risk taking, and had risk management plans for supporting people to access activities whilst recognising the benefits to the person of doing so. People were safeguarded from abuse and poor care.

Staff received suitable training to carry out their roles and were recruited in line with safer recruitment processes. Staffing levels were adequate to meet people's needs and were reviewed as people's needs changed. There were procedures to maintain a safe environment which met people's needs.

People's needs were assessed with plans and guidelines in place to make sure people received the right support. Staff worked with people to develop their skills, independence and to encourage people to carry out meaningful activities.

Managers had a clear vision for promoting the provider's values amongst the staff team and systems in place to monitor the care people received and the quality of 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? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service was good.	**Good**
Is the service well-led? The service remains good.	**Good**

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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 which was carried out on 13 March 2018. We gave the service 48 hours' notice of the inspection visit because the location was a small care home for younger adults who are often out during the day. We needed to be sure that they would be in and to give the provider time to prepare people for our visit.

This was a routine inspection as we had rated this service 'good' 24 months ago. Since our last inspection we were aware of two potential safeguarding incidents; one concerned an assault on a person using the service by their housemate and one was regarding a serious medicines error. In both cases the provider told us how they had responded to the incident and the measures they were taking to prevent a recurrence.

The inspection was carried out by a single adult social care inspector. People using the service were not able to talk to us due to their learning disabilities, so we used other ways to understand their experiences such as observations of care. We attempted contact with two relatives and spoke with one. We also spoke with four health and social care professionals involved in planning and monitoring their care.

We looked at records of care, support and medicines records for both people using the service, and records of management of the service. This included staffing rotas, training records, audits and team meetings. We also looked at records of recruitment and supervision for four support workers. We spoke with the registered manager and two support workers.

We contacted four health and social care professionals involved in the planning of people's care and heard

back from all of them.

Good

Is the service safe?

Our findings

The service continued to safeguard people from abuse and poor treatment. Staff received training in safeguarding adults and were aware of their duties to report suspected abuse and how they could report concerns elsewhere if they were not acted on by managers. There was information on whistleblowing procedures displayed in the office. No-one we spoke with had any concerns about the safety of the service. A relative told us "My relative loves it there, he loves the people and the staff treat him great." There were processes in place for investigating incidents of concern, such as when care workers had observed unexplained bruises on a person.

The provider continued to assess risks to people using the service, including those related to behaviour which may challenge. The registered manager maintained a register of these which ensured they were reviewed regularly. Plans had clear review dates and also outlined the types of changes, such as changes in people's behaviour, which would necessitate reviewing the plan earlier. Risk management plans also highlighted the risks of not carrying out an activity and clearly documented the benefits to the person, which promoted a culture of positive risk taking.

Professionals we spoke with told us the service promptly reported incidents and worked with them to support people to reduce their behaviour which may challenge. There were positive behavioural support plans in plans which clearly detailed the possible causes of behaviour which may challenge and strategies for preventing and managing these. These were developed with the input of the person's circle of support. Care workers used Antecedent-Behaviour-Consequence (ABC) charts for recording and monitoring behaviour which may challenge. The provider told us they had observed significant reduction in this behaviour amongst the people they supported. For example, the television in the lounge no longer needed to be kept in a protective box. A plan had been updated within the last two weeks due to three incidents of a particular behaviour; this included clear guidance on how staff could respond to and prevent future incidents. Support workers we spoke with demonstrated a good understanding of the link between communication and behaviour which may challenge.

There were systems in place to ensure that the premises were safe for people. For example, there was an alarm on the front door which would alert staff if a person tried to leave the building in an unsafe manner. There were up to date personal emergency and egress plans for people, outlining the level of support a person would need to evacuate the service safely. The provider had a joint evacuation plan in place with the neighbouring service, including the need for regular fire drills. There were times when these could not be safely carried out, for example due to people's health conditions or extreme weather, which was clearly recorded with plans for future evacuation drills. Staff carried out regular checks of fire safety such as those on emergency lighting, call points, and fire safety equipment, and there were regular checks from appropriate servicing personnel on this equipment. Other checks included appropriate testing of portable appliances, gas equipment and boiler checks, and monthly checking of first aid kits and cleaning of showerheads.

Staffing levels were sufficient to meet people's needs. Staff told us they thought there were enough staff in

the service. We reviewed two weeks of rotas which showed that staffing levels were as described by the provider. These were subject to review, as one person required significant support to access hospital appointments and to stay safely in hospital with support. People using the service usually required two staff to safely support them in the community, which was detailed in risk assessments, and there was a clear guideline for staff on how to provide this whilst maintaining safe staffing levels in the building. There was out of hours support for staff from an on call service, with a clear protocol displayed on when to contact them for advice.

The provider carried out appropriate checks to ensure that potential support workers were suitable for their roles. This included obtaining proof of identity and the right to work in the UK and at least two references, which were verified by managers. Staff also received a check from the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

Medicines were safely managed. Staff received medicines management training and yearly observations of their practice. This included training around the monitored dosing system the service used, and staff signed a charter on medicines best practices. Medicines Administration Recording (MAR) charts were correctly completed and there were weekly checks of these carried out by the registered manager. There were weekly checks of stock levels, but due to the high rate of change of one person's medicines the registered manager had changed this to daily checks. A professional told us "The home has been able to be proactive and check that the client is receiving the right dosage of medication and ensured that he is given the right dose of medication." There were clear pen pictures in place for people's medicines, including what the medicines were for, the route, dose and possible side effects. Medicines guidelines were clear about how people liked to have their medicines, for example one person liked to have theirs in their yoghurt. There was a clear warning for staff on how to avoid this becoming covert administration, by making sure the person was aware of the medicines and that it was visible. There were also clear guidelines on how to manage medicines that people took on an 'as needed' (PRN) basis, which had been reviewed in the last six months.

Medicines were safely stored in locked cabinets in people's rooms, with labels showing the dates when creams and eye drops were stored. Temperatures of these cabinets were checked daily with clear guidelines for staff.

Where medicines errors had occurred, the provider had taken appropriate action to address these. Three medicines errors had occurred and the provider's investigation had shown that two of these were caused by dispensing errors. In response to this the provider had introduced a procedure for two staff to sign in all medicines, and had carried out observations of practice of all staff. The registered manager had implemented a clear checking-in procedure from ordering to receiving medicines, and then checking medicines against the previous MAR chart to make sure nothing was missing, all of which was carried out by two staff. There was a clear procedure for reporting staff medicines errors, which included looking at any problems with the medicines systems identified as a result of the error, and what support and follow up was required with the staff member.

We observed that staff observed good practice for managing the control of infection. This included wearing gloves when cooking or carrying out personal care. There were monthly checks of the safety of the water system and clear guidelines for the safe storage of food, including daily checks of fridge temperatures.

Good

Is the service effective?

Our findings

The provider conducted a detailed assessment of people's needs in a wide range of areas, including daily living tasks, communication, mobility, personal safety and domestic tasks. These were used to clearly indicate the level of support people required in each area.

New staff completed the Care Certificate as part of their induction. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Staff completed workbooks in areas such as moving people whilst maintaining their dignity, emergency first aid, safeguarding and supporting people, medicines management and fire safety. There was also a detailed programme for undergoing a local induction, which included information on people's needs and health and safety procedures within the building. The provider maintained a computer system for ensuring that staff received training and observations in line with the provider's requirements. This included yearly training in areas such as manual handling, risk assessment and safeguarding and observations of finances and medicines administration. Staff told us they were supported to develop their skills in Makaton which is a language programme using signs and symbols to help people to communicate.

Staff received quarterly appraisals of their performance, which was in line with an initiative called Shape Your Future. This included discussing staff's wellbeing and work-life balance, considering how staff wanted to develop and staff were encouraged to give examples of how they had demonstrated the provider's values, such as trustworthiness, inclusion and caring. There were additional supervision meetings with staff in order to address concerns about conduct or practice.

The provider supported people to eat and drink healthily and safely. We observed people being given choices on what they wanted to eat and approaching staff to indicate their wishes. For example, one person gestured to a cupboard which contained a box of snacks with their photograph on it. There was a daily food menu in place for each person, which showed evidence of a varied and healthy diet. Staff and the registered manager gave us examples of ways in which they tried to support people to make healthier choices. Wherever possible, people were involved in making choices about the food, for example to make choices about what to eat each day and to be involved in food shopping.

There were extensive measures to support people to maintain good health and access health services. This included the use of health action plans and hospital passports. A hospital passport is a document for health staff which contains key information on how best to support a person during a hospital stay. Staff told us "It makes such a difference, we'll show it to him and he can process he's going to see a doctor."

One person using the service had complex health needs due to an ongoing health condition, which required frequent stays in hospital. The provider was working with NHS Continuing Care to agree funding to support the person throughout their stay in hospital and had worked with community professionals to make sure that hospital staff had the right information on how to support this safely. There was also a clear protocol for managers and staff to follow in the event of a hospital admission. Staff had agreed actions with other professionals, for example the person was weighed on a daily basis in order to give early warning if the

person was suffering from fluid retention. The registered manager said "It's great to have the support of a multidisciplinary team".

Staff maintained records of regular health checks such as chiropody and eye checks to ensure these were carried out. Records were maintained of appointments, and the registered manager had introduced a book specifically for recording and monitoring actions following health appointments. Where necessary, there were regular checks taken of people's weight and bowel movements. There were guidelines on specific health conditions such as epilepsy, and actions on how to support a person if they experienced a seizure.

People were prepared for hospital appointments by being given the right information on what to expect. For example, the provider had obtained picture books from "Books Beyond Words" which demonstrated a person's hospital stay, both for planned and emergency admission, and told us that they used this prior to hospital admissions. The registered manager told us "I can't imagine having to go to hospital and not know why you're there."

There were no significant adaptations made to the design of the building, as none were required to meet people's needs. We noted that information for staff was limited, wherever possible, to the staff room, and that supplies of medicines and files were kept in cupboards which were not immediately obvious. There were pictures of people undertaking activities which were placed in a way which meant they could be used as objects of reference, and accessible signs to indicate hot surfaces. One person had a streaming service on their television which meant they could more easily watch their preferred programmes, as the provider had found DVDs to be unreliable and problems with playing them could trigger the person's behaviour. One person was provided with equipment such as a hospital bed and a recliner chair in order to meet their changing health needs.

The service continued to work in line the Mental Capacity Act (2005) (MCA). The Act 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. There was a detailed framework for assessing people's capacity, and there was evidence of discussions with other professionals and family members to demonstrate that they were working in people's best interests.

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). Both people had a valid DoLS assessment in place from the local authority, and these were reviewed yearly prior to their expiry.

Good

Is the service caring?

Our findings

A professional told us "Support staff I have come across are caring".

The service used good communication systems to make sure that people's views and wishes were acted upon. We saw care workers using clear verbal communication with people, which was backed up with the use of objects of reference and Makaton symbols where required. A relative told us "they are very good at communicating… talking to him and telling him what happened". A professional said "I have noticed that the staff try to engage and use Makaton to engage the clients. Staff [have] a calm approach."

People had one page profiles, which described people and things that were important to them, what they were great at and what they sometimes found difficult.

There were comprehensive guides in place for understanding how people would communicate their needs and wishes. This included guides to how people vocalised, signed and indicated their needs and ways in which support workers could communicate concepts. Staff had used online videos to learn words from a person's language which they said had been useful in improving the person's understanding. There were visual resource packs in place for people for particular needs such as activities and medical appointments. There was a Makaton sign of the week for staff to practice. Staff had recently worked with the Speech and Language therapist to obtain a tablet computer for one person. This was used to view videos of the person and their family and to use video chat to speak regularly with the person's family. They had also recorded how to carry out exercises recommended by a physiotherapist to support the person to engage in this. The registered manager told us "There's so much potential for activity planning."

There was an agreed protocol for communicating information to families which took into account that each family had different wishes for what and when they were informed of significant events. A relative told us "If [my relative] has got to go to the doctor's, they always inform me."

Keyworkers carried out monthly reviews of people's care. This included a review of how the person was being supported to meet their identified goals such as trips and outings, checking the person needed anything for their room and whether the person needed to be supported to try something new. These referenced each person's personal development plan, where staff had recorded areas of the person's life they wished to develop such as community involvement, and key skills such as using a toilet or eating at a table.

There was evidence that people's views were respected in a way that respected their dignity. For example one person did not like having a belt on their dressing gown, but was prompted to arrange their gown in a way which made sure they were covered. People were able to get washed and dressed at a time of their choosing and were not rushed by staff. Care plans were clear about how people demonstrated they wanted to be left alone in their rooms.

Good

Is the service responsive?

Our findings

The provider had detailed support plans in place indicating the daily support that people required. These were developed in line with the provider's programme of "What matters most", which assessed how people's needs were met in areas such as happiness, health, friendships and inclusion. Support plans contained detailed guidelines in certain areas such as supporting people with showering, shaving, exercise and maintaining good health.

We saw that plans continued to be reviewed regularly, and amended as needed. Care workers recorded the support people had received on a daily basis, and there were systems of handover in order to check that tasks such as medicines management, personal care and meal preparation had been carried out. We saw that daily logs were clear about what activities people had done and their current state of health and mood. Handover sheets recorded that people had received personal care, including oral care, but we found sometimes daily logs lacked detail about exactly what personal care people had received, such as whether they had had baths or showers.

The provider was meeting the Accessible Information Standard. People's communication needs were clearly assessed and information was given to them in a way they could understand. This included using objects of reference, pictorial support plans and accessible hospital passports and health action plans, and using videos of activities and exercises.

There were good activity programmes in place for people. One relative we spoke with told us that staff worked hard to encourage the person to go out of the house and undertake activities, but respected their choice when they chose to remain in the house. For another person, changes in their health needs meant they were not able to go out regularly to do activities, and support workers had devised an activity timetable for the person for activities they could do in the house. This included an international food night, baking and sensory activities such as "messy play". A staff member told us "When I came in, the activities were so different compared to what they're doing now, and that's due to the team and the effort they have put in".

At our last inspection, a person who liked watching cartoons was using a streaming device in their room in order to provide a wider choice and to manage the risk of frustration from damaged DVDs. At this inspection we saw that this was now a smart TV, and we saw the person regularly approaching staff when they wanted the channel changed. Care workers had a book of pictures from the person's favourite cartoons to support them to make choices about what to watch. Staff talked about how they had supported a person to be able to eat their meals at a table, rather than in bed, and how the person had benefitted from this, for example to go out for meals in the community which they had not previously been able to do. There was a strategy to encourage the person to develop their independence by using the toilet, which had been developed together with the person's community nurse.

We saw that team meetings were used for reviewing people's support plans, and staff had begun discussions about how a person's plan for meeting their future needs could look if their health needs continued to change.

The provider had a clear protocol for logging and responding to complaints, which included systems for recording the complaint that had been made and investigating it accordingly. An accessible complaints procedure was also displayed in a communal area. Since our last inspection there had not been any complaints made. A relative told us "I'd be the first one to complain if I thought things weren't right."

Good

Is the service well-led?

Our findings

Staff we spoke with told us they felt well supported in their roles. Comments included "It's a great team, good manager, we all support each other" and "[The manager] has helped me a lot."

The registered manager worked to promote their values in the service. For example, there was a vision board in the staff room with three points that the staff team had committed to achieve for each individual and for the service in general. The registered manager told us "There's so much going on, so we agreed three things that we think are most important…it's a reminder that we're committed to this." Examples of these included showing empathy and patience, developing home based activities and arranging for a person to go on holiday. The registered manager understood that recent circumstances had been challenging for the staff team, and told us they had to agree to prioritise what was most important at this time. The provider had also recognised that recent events had stretched the registered manager, and had arranged for a support worker to take on particular administrative tasks to support him.

There was an agenda for the upcoming staff meeting that staff were encouraged to add to. Staff meetings took place monthly and were used to discuss the way people's needs had changed, and how the team identified their priorities for the coming month. Managers had identified areas of practice that needed to improve, for example recording carried out by staff, and how to develop activities. Managers also had clear shift plans on what needed to be done each day, which staff used to record any outstanding tasks which needed to be carried out by the next shift with a clear written handover.

The values of the organisation were promoted throughout recruitment. For example, staff were encouraged to write a one page profile about themselves, and were required to write a 15 minute essay on what values they thought were important in supporting people with learning disabilities. Candidates had reflected on how they had promoted community inclusion and providing a safe environment, and were asked at interview about their motivations for applying for the post.

The provider had a system of audits in line with their "What Matters Most" programme. This was designed in a way that gave equal importance to areas such as friendships, activities and access to volunteers to more established areas such as health and finance. For example, it required the registered manager to indicate on a monthly basis when the person last tried a new activity, and this prompted the manager to come up with an action plan to address this. The audit system prompted managers to provide monthly data on health and safety checks, staff supervision and training, and this was reviewed by a senior manager to gauge the service's performance. The provider also had systems for recognising talented staff and encouraging them to develop through additional responsibilities and leadership training. Staff told us they were given the opportunity to work in other services to develop their knowledge and skills.

The registered manager maintained registers on the walls of the main office with a list of all the relevant documents for each person that required constant review, including when they were last reviewed and when they next needed review. There was also a "read and sign" file to ensure that documents were reviewed by care workers for any changes; we saw that all key documents relating to people's care and

support had been signed by the staff team whenever they had changed to indicate that staff understood the contents.

Representatives of the service stayed up to date with what was happening in the area and best practice by attending a local provider forum. For example, they had found a local handyperson service to help them fix the roof of the garden shed, and had learnt about useful health themed resources such as "Books without Words" by speaking with staff from other services.

The provider was meeting their responsibilities to inform the Care Quality Commission (CQC) of significant incidents which had occurred in the service, and were displaying the ratings from their previous inspection in a communal area of the building.