Sense

# SENSE - 70 Castleton Road

## Inspection report

70 Castleton Road
Walthamstow
London
E17 4AR

Tel: 02085315561
Website: www.sense.org.uk

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11 April 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

Sense Castleton Road is a six bedded care home for adults with learning disabilities and sensory impairments. The home provides personal care to people with complex needs and some have additional physical disabilities and behaviours that challenge. At the time of this inspection, there were six people using the service.

This inspection was unannounced and took place on 1, 4 and 11 April 2016. At the last inspection on 7 January 2014, the service was meeting the legal requirements.

There was a registered manager at this service. 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.

Relatives told us they thought their family members were safe. Staff were knowledgeable about the procedures for raising safeguarding concerns and for whistleblowing. Risk assessments were carried out, regularly reviewed and included management plans to reduce the risk. Building safety checks were done and were up to date. People received their medicines safely and as prescribed. Safe recruitment checks were carried out.

People were given a choice of nutritious and varied menus. Staff received regular supervision and training opportunities.

New staff followed an induction programme before working unsupervised. Staff were knowledgeable about obtaining consent before giving care. People had access to healthcare appointments as and when they needed it.

There was a calm relaxed atmosphere throughout the home. Relatives thought staff were caring and respected their privacy and dignity. Staff were knowledgeable about people's care needs, their likes and dislikes and how to promote their independence.

People had an individualised timetable of various activities within and outside the home. Staff demonstrated an understanding of what personalised care was and care plans were written in a person-centred way. Relatives knew how to make a complaint and complaints were resolved in line with the policy.

The provider and the registered manager carried out regular quality audits of the service provided. People and their relatives were asked for feedback to help improve the quality of the service. Staff meetings were held regularly so that staff could be updated on organisational issues and issues concerning 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 was safe because staff were knowledgeable about how to report concerns or abuse and how to whistleblow. There were enough staff on duty. Relevant recruitment checks were carried out for new staff and criminal record checks were up to date.

The premises were safe and there was an effective system in place to ensure safety checks were done. There were appropriate arrangements in place for the storage and administration of medicines to ensure people received their medicines as prescribed and safely.

People had risk assessments in place to ensure risks were minimised and managed. The service had an emergency on-call system for foreseeable emergencies.

### Is the service effective?

Good

The service was effective because staff had regular opportunities for training opportunities and received regular supervision. Staff were completing the Care Certificate to ensure they were competent to fulfil their role.

The registered manager was knowledgeable about the mental capacity act (2005) and deprivation of liberty safeguards (DoLS). Staff sought people's consent before delivering care.

Staff were aware of people's nutritional needs and food preferences. People had access to healthcare appointments as and when they needed it.

### Is the service caring?

Good

The service was caring because staff had developed positive relationships with people and had a good understanding of their needs. Staff were observed to spend time interacting with people and speaking with them in a caring manner.

People were encouraged to maintain their levels of independence when they were able to do things for themselves.

Staff treated people with respect and promoted their dignity and privacy.

## Is the service responsive?

Good

The service was responsive because staff understood what personalised care was. Care plans were written in a person-centred way and used pictures to help people to understand them.

Each person had their own individualised activity programme which was varied to meet people's needs and preferences.

The service had a complaints policy which staff and relatives were knowledgeable about. Complaints were responded to in line with the provider's policy.

## Is the service well-led?

Good

The service was well led and there was a registered manager in post. Staff and relatives had confidence in the manager as a leader.

Staff had regular meetings to keep up to date with future plans for the service and issues concerning people who used the service. The provider had systems in place to obtain the views of relatives and to monitor the quality of care and support in the home.

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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 inspection took place on 1, 4 and 11 April 2016. The inspection was unannounced and was carried out by one inspector.

Before the inspection, we reviewed the information we held about the service including notifications that the provider had sent us since the last inspection and the previous inspection report. We also asked the provider to complete 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.

During the inspection we spoke to the area manager, the registered manager, four care staff and three relatives. We observed care and support in communal areas and looked at care records for three people and five staff files. 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 looked at records relating to how the home was managed including medicines administration records, policies and procedures, building safety and quality assurance documentation.

Good

# Is the service safe?

## Our findings

Relatives told us they felt their family members were safe. Staff were knowledgeable about safeguarding and the procedure to follow if they had a concern. Comments from staff included, "Abuse is anything that affects the person mentally, physically, financially, sexually, neglect, any mistreatment towards the person", "Report it to next port of call, whatever it is you've witnessed. Record, date it, time, remember phone on-call manager or line manager, safeguarding or CQC." "Whistleblowing is when you notice abuse and you report it to the manager, the social worker or CQC."

The home had a recruitment policy which included involving people who used the provider's services in staff selection where feasible. There was a process in place for recruiting staff that ensured relevant checks were carried out before new staff began employment with the service. For example, we found staff had produced proof of identification, had produced confirmation of their legal entitlement to work in the UK and had been given written references. We also saw staff had criminal record checks carried out to confirm they were suitable to work with people and there was a system in place to get regular updates.

At the time of inspection there were two vacancies which were covered by regular agency staff. We reviewed the rota and saw there were four staff on duty to work with people in the morning and afternoon. At night there was one staff member who was awake at night and one staff member who slept on the premises who could be called upon if extra support was needed. The area manager and staff confirmed that staff absences were covered by permanent staff agreeing to extra hours or regular agency staff and the rota confirmed this. This meant there were enough staff to meet people's needs.

The service had a comprehensive safeguarding and whistleblowing policies which gave clear guidance to staff about what abuse was, the core issues associated with safeguarding and what action to take if they had a safeguarding concern. There was a summary guide available for relatives and a poster available for staff displayed on the noticeboard in the office. The policy included a section which listed outside agencies who staff could whistleblow to. This meant the provider had taken steps to ensure people who used the service were safeguarded.

People had comprehensive risk assessments documented in their care plans to assess their safety within the home and for activities carried out in the community. These assessments included risks associated with using the home's minibus, risk of choking when eating, medicines administration, risk of not responding in an emergency situation and support in the community. Risk assessments identified the risk and detailed actions needed to minimise and manage the risk. We saw that each assessment was divided into three parts with the first part identifying the level of risk, the second part stating what actions staff needed to take to minimise the risk and the third part giving the date of last review and a signature sheet for staff to sign once they had read it. Risk assessments were subject to regular review.

The service had an emergency folder which gave guidance to staff about how to respond to different types of emergencies. This folder included people's basic information sheets which could be given to the police in the event the person went missing and contact details for staff in case extra or additional staff were needed

at short notice. The service had an on-call system for staff to obtain managerial support outside of office hours and the rota with contact details was kept in the emergency folder. This meant staff would be prepared for foreseeable emergency situations.

The premises were safe. We saw the building safety checks had been carried out with no issues of concern identified. For example, we saw a new gas boiler had been fitted on 19 August 2015 and was due for a service in August 2016 and portable electrical testing had been done on 19 January 2015 with the next one due in 2017.

Medicines were managed safely. The provider had a comprehensive medicines policy which included clear guidance to staff about ordering, receiving and storing medicines, administration of medicines and record-keeping. We found that people's medicines were kept in a locked cabinet in people's bedrooms and surplus supplies were kept in the office until needed. The medicines administration record (MAR) sheets had been completed and signed appropriately and reasons for people not being given their medicines were clearly accounted for. We saw there were guidelines in place for people who required "pro re nata" (PRN) medicines. PRN medicines are those used as and when needed for specific situations. We found PRN medicines had been administered and signed for as prescribed. Medicines were stored safely and were safely administered.

Staff received training before they began to administer medicines. Records showed that staff were required to have a competency assessment before they were able to administer medicines unsupervised and had at least one week shadowing a competent staff member. This showed that people received their medicines from suitably qualified and skilled staff.

Good

# Is the service effective?

## Our findings

Records showed staff completed a combination of e-learning courses and face to face training. Staff confirmed this and told us training opportunities included British Sign Language to help them in their work with people who had sensory impairments. Records also showed that staff were given training in how to work effectively with behaviours that may challenge services. The service operated with a policy of not using restraint with people. The training matrix showed people were up to date with mandatory training.

We saw that staff were working towards obtaining the Care Certificate. This is a training programme of an identified set of care standards aimed at helping staff to develop their competence in this area of work. New staff were given a three week induction which included shadowing experienced staff and had to complete a six month probation period to ensure they were competent to work with people.

The provider had a policy of giving staff supervision at least every eight weeks. Records showed that people received regular supervisions and these were up to date. We saw topics that were discussed included individual staff performance, training needed and completed, and the care needs of people who used the service.

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. At the time of inspection six people were having their liberty deprived because they needed continuous staff support. Only one person had a current DoLS authorisation in place but the other five people had appropriate assessments in place and applications or renewals in process with their relevant local authorities.

Staff were knowledgeable about MCA and the need for a best interests decision involving relatives and other professionals when a decision had to be made about people's care or medical treatment. Staff told us how they gained consent from people before giving care and that they knew if a person was not consenting, for example, from their facial expression, body language or vocalisations.

We observed people at lunch and at the evening meal. One person who used the service helped to set the table. People were offered a nutritious and varied menu. Staff sat with people at mealtimes and offered them appropriate support with eating and drinking. People had sensory impairments and did not use language so staff offered people the meal from the menu explaining each food item on the plate and if they

did not like what was on offer, an alternative was prepared and offered. For example, one person did not want the sandwich that was offered to them for lunch, so staff gave them a pasty as an alternative. Staff documented what each person ate and this was in people's daily records. Staff told us they knew people's food preferences well because they had been working with them for some time but now and again people may not want what was offered so they ensured there was alternative food in the fridge and the freezer. We observed this was the case and people were given food on coloured plates and adapted cutlery where appropriate. Staff also showed us that each person had their own snack box so they could have access to snacks in between meals if they were hungry.

People had access to healthcare professionals as and when needed and this was documented in care records. For example, we observed a speech and language therapist visited one person who was having difficulties with eating and drinking to assess if they were at risk of choking and to offer guidance to staff on the best way to offer support.

Good

# Is the service caring?

## Our findings

Relatives told us staff were caring. One relative told us, "I think they look after [person] very well. They are so caring, they are lovely actually." Another relative said, "Yes the staff are okay, I don't have a problem with the staff."

Staff were knowledgeable about people's care needs and preferences. Comments about how staff got to know people included, "When they come in first, you read their care plan including likes and dislikes", "Treat them as an individual, have a duty of care, have to know their needs and when they are not happy", "Get as much information as you can from family and other services. Read up on their care notes" and "Meet the person before they move in. Get information from keyworker from last service."

The service had a 'keyworker' system. A keyworker is a staff member who is responsible for overseeing the care a person received and liaising with other professionals, relatives or representatives involved in a person's life. Records showed that keyworkers were responsible for updating people's care person centred plans on a monthly basis.

Care records gave clear guidance to staff about people's chosen communication method. Staff were knowledgeable in finding ways to enable people to make choices. For example, one staff member described how they used other forms of communication to obtain consent and said, "Show them the item, they will push away what they don't want, use pictures, photographs or if they can't see, I give them something to feel." Another staff member said, "Give as many choices as we can. They can refuse if they don't want it." A third staff member said, "One person will smell [the item] and give it back if they don't want it.

During the inspection we saw that people were treated with respect and in a kind and caring way. There was a calm and relaxed atmosphere in the home. Staff took the time to speak with people as they supported them and took care to use people's preferred method of communication.

Staff were knowledgeable about how to provide people with privacy and dignity. Comments included, "Close doors, pull blinds down, draw curtains, not sharing [private] information, not talking about them in a derogatory way", "Stand outside toilet door and wait in case they need help" and "Knock on the bedroom door, tell them your name and explain to them why you are there."

We observed that people were encouraged to carry out tasks independently. For example, one person was encouraged to make hot drinks for themselves when they wanted one and staff closely supervised the person through the process in order to keep them safe. Staff supported this person by talking to them patiently through each step of the process. People were not rushed and were offered support at a pace that suited them.

Good

# Is the service responsive?

## Our findings

Staff were knowledgeable about personalised care. For example, one staff member told us personalised care was, "Care that is built around that person. Not to assume two people are ever the same. Care plan is personalised to the person." Another staff member said, "It's individualised, not based on everybody's needs as a whole but based on that person's needs, likes and dislikes."

People's care plans were comprehensive and person centred. Pictorial aids were incorporated in care plans to assist people's understanding. Person centred information was included to help plan care that was appropriate and tailored to the individual which included people's preferences. Care records contained a profile page containing the person's photograph and a summary with the person's background and cultural information. We saw keyworkers met with the registered manager each month to discuss the person they were keyworker for, to summarise main events that occurred during the month and to identify outstanding actions or goals. Care plans were reviewed every six months by the registered manager with relatives, social services and the keyworker. People also had a separate healthcare file which detailed health needs, sensory impairment assessments and contained a hospital passport.

A relative told us their family member did not get the opportunity to go swimming as often as they used to. A member of staff confirmed this was the case and told us some staff did not have the confidence to support the person with this activity and keep them safe. The area manager told us they were working on building up staff confidence so that people could be supported safely with swimming. We saw it was documented in the March staff meeting minutes that the service was sourcing hydrotherapy sessions for people who liked water activities to participate in. Records showed that each person had a timetable of various activities and we saw on each day of our visit people went out with staff to attend activities. For example, on the third inspection day, one person went for a walk with staff in the local area and two people went cycling. Activities offered to people included using a trampoline, baking, reflexology, aromatherapy, music, park visits and art.

Relatives told us they knew how to make a complaint if they were not happy with the service provided to their family member. The service had a comprehensive complaints policy which gave guidance on the actions to take when a complaint had been received. A complaints poster was displayed visibly in the home so that relatives or visitors would know who to contact if they had a concern. This policy stated that the aim was to resolve complaints informally in the first instance. Staff were knowledgeable about the complaints procedure and said they would bring complaints or concerns to the attention of the registered manager or head office.

Records showed a relative had made a complaint in October 2015 about their family member's clothes sometimes looked creased. We saw this was responded to in a timely manner and the resolution was that ironing became a duty for night staff to complete. The relative was satisfied with the response.

During the course of the inspection, a relative visited and made a complaint to the area manager, who was covering for the registered manager on leave. This relative was unhappy because they had not been notified about an incident involving their family member the previous day. We observed this was dealt with

appropriately and suggestions from the relative to improve the service were welcomed. For example, the relative said their family member had savings which could be used to purchase a mobile phone with a camera so that photographs of activities the person was engaged in could be sent to them. A resolution was found in line with the timescales of the policy. The relative told us they were satisfied with the apology and response they had received. This showed the provider used feedback to make improve the quality of the service provided.

Good

# Is the service well-led?

## Our findings

The service had a registered manager. One relative said about the registered manager, "Yes, she's fine." Staff said they felt supported in their role by the registered manager to do their job and that the registered manager took part in the rota and would lead the shift. Comments from staff about the registered manager included, "She is quite understanding and supports staff to meet people's needs", "She does support us and tries to work around staff needs" and "I think [registered manager] is a good leader."

The provider had a system of obtaining feedback from relatives on the quality of the service provided. We reviewed the most recent feedback surveys received from relatives in October 2015. Comments on these surveys included, "[Person] is receiving excellent care service. Long may it last" and, "We are happy where [person] is and very grateful for everything you all do." We saw as a result of receiving feedback the provider had increased the variety of activities on offer and two people who used the service had been on holiday.

Staff and records confirmed staff meetings were held every two months. We reviewed the minutes of the meetings held in November 2015 and March 2016. Topics of discussion included training, activities, teamwork, staff appreciations, communication with relatives and updates on the well-being of people who used the service.

The provider had various quality assurance systems in place. The registered manager carried out a monthly self-audit of various aspects of the service including 'choice and decision-making', 'supporting staff' and 'nutrition'. These audits were checked by the area manager on completion. For example, a 'keeping safe' audit was done on 14 March 2016 which included a section on safeguarding concerns, confidentiality, finances and a team discussion on this topic. We saw the identified action was to do a risk assessment for handling information guidance to be completed by 31 April 2016. Another example was a 'management of medicines' audit was done on 16 December 2016. The identified action was for mental capacity and best interests assessments to be completed for each person with respect to them having their medicines administered to them. We saw this had been completed by the target date of 15 January 2016.

Records showed the area manager had drawn up a service plan which identified areas which could be further improved. This showed the identified improvement area, who was responsible for completion and the timescale within which the action should be completed. The area manager explained this plan was to help the service to keep improving and aim towards providing an outstanding level of service. For example, in October 2015, the action identified was to display in a visible area, actions staff needed to take in the event of someone choking. The improvement plan showed the registered manager had completed this action on 1 November 2015. The choking guidance was displayed in the office downstairs next to the dining area.

The provider had a system of the area manager visiting to carry out staff observations. We reviewed the observations report written by the area manager of the visit done on 13 October 2015. This report highlighted positive areas, for example, how staff demonstrated they knew a person well and how to communicate with them each step during an activity. The report also documented that staff had said a

detailed shift plan would be beneficial with ideas for activities. We saw this had been implemented and individual staff were allocated to each task by the shift leader.