DRS Care Homes Limited

DRS Care Home

Inspection report

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London
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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 inspected this service on 9 May 2017. The inspection was unannounced. DRS Care Home is a residential home providing care for up to four people with either a learning disability or mental health need. At the time of the inspection all four people had a learning disability and had very limited or no verbal communication.

The service is located in a terraced house, on two floors with access to an outside area at the back. There were two 'move on' supported living units located in the garden area. Support to the people living in these is provided by another DRS scheme locally. This inspection relates to the residential care service only.

At our last inspection in January 2016 the service was meeting all of the regulations, but had an overall rating of Requires Improvement.

DRS Care Home had a registered manager at the 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.

We saw staff were kind and caring to people living at the service, and this was confirmed by family members.

The staff demonstrated a good knowledge of people's care needs, significant people and events in their lives, and their daily routines and preferences. They also understood the provider's safeguarding procedures and could explain how they would protect people if they had any concerns.

Care plans were up to date and showed people's strengths as well as needs. They were person centred and gave detailed information on how exactly to support people. Risk assessments were in place and covered the majority of risks identified.

There were sufficient numbers of suitably qualified, skilled and experienced staff to care for the number of people with complex needs in the home. Staff told us they were well supported by the registered manager and could contribute their views to the way in which care was provided and the service was run. We could see regular supervision and training took place.

Safe recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

Medicines were stored and managed safely. People received their medicines as prescribed and on time.

A health and social care colleague told us the service worked closely with them to meet people's needs and manage their behaviours.

People participated in a range of activities in the local community.

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). The service was working within the principles of the MCA 2005 and DoLS.

The registered manager and deputy manager carried out quality assurance processes to ensure people received a good service and they showed they were continually working to improve the service.

The service was clean throughout, and well maintained. Essential services, for example, gas, electricity and fire safety equipment were regularly maintained. Fire drills took place regularly.

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. There were enough staff to meet people's needs.

Medicines were safely stored and managed.

Risk assessments were in place for the majority of risks identified.

The premises were clean and food was stored safely and hygienically

Is the service effective?

Good

The service was effective. Staff had received training in key areas and supervision took place regularly with staff.

Staff understood the importance of consent and there was relevant documentation in place for people deprived of their liberty.

People were supported to eat healthily, and there was a choice of meals.

The service worked in partnership with local health professionals to meet people's needs.

Is the service caring?

Good

The service was caring. We saw staff were kind and caring and family members confirmed this. Staff knew people's daily routines and preferences and showed them dignity and respect.

People were encouraged to be as independent as possible and their abilities and strengths were documented in care plans.

People's cultural needs were met.

Is the service responsive?

Good

The service was responsive. Care plans were comprehensive, up to date, and were person centred.

People were supported to take part in activities in the local community.

People knew how to make a complaint although there were no complaints formally logged in the last 12 months.

Is the service well-led?

Good

The service was well led. The registered manager provided good leadership and involved staff in the running of the service.

There were quality assurance processes in many key areas and essential services were safely maintained.

DRS Care Home

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 9 May 2017 and was unannounced. It was undertaken by an inspector for adult social care and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

Due to the communication needs of people living at the service we were unable to get answers to our questions so we observed interaction between staff and people living at the service. Three of the four people living at the service went out to the day service soon after our arrival, and returned in the afternoon. We spoke with two staff members on the day of the inspection and the registered manager.

We looked at two care records related to people's individual care needs and three staff recruitment files. We looked at two staff training records and three staff supervision records. We also looked at records associated with the management of medicines, and audited boxed medicines for three people.

We reviewed health and safety documentation and checked essential services were of a good standard including electrical, gas and fire safety equipment.

We reviewed staff meeting and residents' meeting minutes and other documentation related to the safe running of the service.

Following the inspection we spoke with three relatives and three health and social care professionals that had experience of working with people using the service.

Good

Is the service safe?

Our findings

People were not able to tell us if they felt safe living at the service, but we could see there were sufficient numbers of suitably qualified staff to keep people safe and meet their needs. Family members told us they were very happy with the care provided to their relatives.

There were five members of care staff on duty from 8am to 8pm. Three members of care staff accompanied people to external day activities and remained with them there throughout the day, returning to the service at 3.30pm. At night there were three waking night staff to ensure people were safe. The service had permanent staff in post and only rarely used bank staff but ensured they knew the people well. The provider had previously rotated staff across the services in the local area, but we were told this was no longer the case.

Staff knew how to keep people safe from abuse. The staff had all received safeguarding training as part of their induction and on-going training. Staff were able to tell us about types of potential abuse and how to report any allegations. They were also aware of whistleblowing procedures should they have any concerns.

There was a safe recruitment process in place. In one case whilst the provider waited for a second reference to be received, the care staff member undertook an induction and shadowed other staff. They were not alone with people until all checks had been completed. We saw completed application forms, proof of right to work in the UK and an in-date Disclosure and Barring Service certificate (DBS) on each record we looked at. Existing staff had their DBS status checked every three years. This meant staff were considered safe to work with people who used the service.

Individual risk assessments were up to date and in place. They covered the majority of risks identified in the care plans. They provided advice on the triggers for people's behaviours and detailed guidance for staff in the management of risks. A traffic light system was adopted to show staff how to de-escalate each behaviour before it reached crisis point. When a person's behaviour had reached crisis point information for staff was clear. For example "Never hold onto him and get out of the way, he is strong" was written in one risk assessment. Risk assessments for activities outside the service were in place to support staff. We noted that two aspects of one person's health conditions were not included in their risk assessment. We discussed this with the registered manager who undertook to review all the risk assessments to ensure they covered all identified risks.

Food was stored hygienically and the service was clean throughout. The service had been awarded a five star rating by the Food Standards Agency for hygiene in 2016. Medicines were safely stored and were administered in line with good practice. Medicine administration records had photographs of people and contained details of people's allergies and any other relevant information.

Accidents and incidents at the home were recorded appropriately. Copies of incidents were sent to the local learning disability team for review and advice in relation to behaviour management. The registered manager also reviewed these regularly and any learning was discussed in team or handover meetings.

Essential services, for example, gas, electricity and fire safety equipment were routinely maintained. Fire drills took place regularly and there was a recent fire risk assessment undertaken as the needs of the people moving into the service had changed significantly in the last year.

Good

Is the service effective?

Our findings

Family members told us they thought the care staff had the skills and experience to care for their relatives, all of whom had complex needs. One family member told us the night staff were as skilled as the day staff in managing behaviours for their relative, and that staff "absolutely have the skills" to care for their family member and "were brilliant."

The make-up of people living at the service had changed significantly over the past year due to people moving onto supported living schemes and people with higher levels of support moving into the service. One health and social care professional told us they thought care staff's skills had improved over the last 12 months and this was positive for all.

New care staff received a period of induction which included shadowing experienced staff and covered key areas of knowledge required including safeguarding, food hygiene, health and safety and fire safety at the service. Staff received training in a range of subjects including moving and handling, medicines administration, breakaway and safe escape techniques and first aid. Although staff were able to tell us what they would do if a person had a seizure they had not received any formal training in this area. The registered manager could show us the new training plan would include this area training and a course was due to be run in June 2017. Staff had also had limited Makaton training from members of the learning disability team, but this course was also to be included in the training regime for 2017. It was important these courses were available to staff to enable them to most effectively meet the needs of the people living at the service. The service was using the Care Certificate for induction purposes at the time of the inspection and planned to extend its use in the coming year.

Alongside formal training care staff had support and guidance from the learning disability team in managing people's specific behaviours. This was helpful as it meant different approaches were adopted for individuals. A recent audit into medicines given 'as required' had resulted in the giving of some medicines prior to an event taking place to minimise crises occurring.

Care staff told us they felt supported by the registered manager, and if there was an incident or they experienced a particularly difficult shift, they could talk it through with them and other staff. We saw that staff had supervision on a regular basis and records showed discussions were in depth and addressed training needs.

People were supported to eat healthy meals; care records documented suggested healthy eating plans. Where weight management was an issue records were kept of people's weight on a monthly basis. People were supported to take part in exercise classes which was positive as this, alongside a healthy menu, were key elements to support weight management at 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). The service was working within the principles of the MCA and had applied for DoLS for all the people living at the service.

Staff understood the importance of consent and could tell us what they would do if a person did not want care or didn't want to eat, at a particular time. They were aware that despite being assessed as not having formal capacity to make significant decisions people had the right to accept or refuse care and support. A best interest meeting had taken place recently to decide the best course of action for one person who required medical intervention but who was reluctant to have it.

There was evidence that people accessed a range of health professionals including their GP and local health professionals. Speech and language therapist (SALT) guidelines were in place to provide staff with guidance in how to ensure a person ate safely, for example, by cutting up their food into bite size pieces and using a thickener for drinks. SALT guidelines also provided advice on how to communicate with people, for example speak advising staff to speak in short, simple sentences.

There were photos of health and social care professionals who worked with people living at the service to assist care staff in explaining what was happening, when and with whom. There was a positive behaviour plan on file for one person. The registered manager told us that due to the success of the service in supporting one person in particular, the local specialist intervention team were withdrawing their support as it was no longer needed. Health and social care professionals told us the staff were working within a 'Positive Behaviour Support' model of care, which promoted and reinforced appropriate behaviour. This was positive for the person and staff as it provided guidance for management of behaviours and a structured response for continuity of approach for the person.

Family members told us their relatives were supported with health care and they were kept informed if there were any specific issues of concern. Health action plans had been drawn up and we saw documents were available to accompany people should they need to be admitted to hospital. These outlined their needs, behaviours and methods of communication.

The garden was shared between people living at the service and the people in the 'move on' units. There was a shared covered smoking area as well as a table and chairs for use by all.

Good

Is the service caring?

Our findings

Care records showed that staff understood what activities people could do for themselves and what activities they needed support with. For example, we saw in one care plan "Do not do this [task] for him." People living at the service were encouraged to shower themselves, help with laundry, help with making tea and do other self-care tasks. This was positive as all the people living there were encouraged to be as independent as possible.

We could see staff were caring and kind to people living at the service and family members confirmed this. People's like and dislikes were well documented. For example, one care plan said "[Person's name] does not like eggs, biscuits or cakes, sandwich fillers that are wet or cheese."

People's background and information regarding key family members and friends were available to help staff to understand people's personal histories. Cultural and religious needs were met by the service. We saw one person's care plans had key words in Turkish to aid communication. The service had also employed a number of Turkish speaking care staff, this was positive for one person living at the service. Another family member told us they had asked staff in the week following the inspection, to take their relative to the mosque on a regular basis. The service intended to trial this this new activity.

People were shown dignity and respect in a number of ways; by ensuring curtains were drawn and doors kept shut when care was being provided; by consent always being obtained when providing care; by staff understanding people's routines and preferences. As a number of people living at the service preferred set routines when carrying out tasks this was important, and by complying with these a calmer atmosphere was encouraged.

Family members told us they were involved in decision making as people living at the service lacked formal capacity to make key decisions and family and friends were made welcome at the service.

People's rooms were homely and had personal effects. The service had creatively solved one person's behaviour of writing on the walls by painting one wall in black chalk paint so it became a huge blackboard.

People's birthdays and festivals were celebrated by the service.

Key workers had had discussions with people and their families to understand and document their end of life wishes.

Good

Is the service responsive?

Our findings

Care plans were up to date and comprehensive. Care plans gave guidance to staff in how to assist people and included personal care, dressing, handling money, shopping, transport requirements and health needs.

A step by step pictorial guide was in place to help staff understand how to support people. Care plans were person centred and had numerous pictures to show what people could do and how they preferred to be supported. As routines were important for people living at the service these were well documented with reminders to staff "Let [person's name] get their toiletries." And "Do not rush him."

People also had Person Centred Plans which indicated the activities which would contribute to 'My best weekend' or 'My best weekday'. These helped staff to understand a person's holistic needs and wishes.

People were supported to attend a range of activities in the local community. Some people attended the day centre run by the provider. Exercise classes including Zumba and belly dancing took place at the centre to encourage fitness and mobility. People also went bowling, attended a gym, occasionally went cycling and ate out at restaurants. People were encouraged to go out with family members and visit their family home. Each person had an individual activity plan.

There was a complaints policy in place but there were no complaints logged within the last 12 months. Family members told us they felt confident any complaints they had would be dealt with, and confirmed any minor issues they raised had been addressed by the registered manager. To aid good communication the registered manager was available to meet family members on a regular basis if this was considered helpful. One family member told us they felt treated with respect and friendship by the registered manager which was very positive for them. Health and social care professionals told us the registered manager was responsive if issues were raised with them.

The registered manager had held meetings for people living at the service in the past, but he told us given the complex needs of people who lived there, in his view this was not necessarily the most effective way of getting people's views. As a result, in consultation with the local learning disability team, the registered manager had introduced a pictorial questionnaire that key workers completed with individual people each month that asked them simple questions regarding the service. People were able to use these simple methods to give their views. The registered manager also told us people's behaviours were affected if they were not happy so there was also continual feedback in this way.

Good

Is the service well-led?

Our findings

There was a welcome pack for new people joining the service with easy to read information relating to transport links, local leisure activities including libraries and gyms, cinemas and parks. This helped to orientate new people and their family to the service.

We could see the service was well led in a number of ways. Staff told us they felt supported in their caring role. They were able to contribute ideas to how the service was run and how people were supported, through supervision and team meetings. Team meetings took place on a monthly basis. The registered manager used new technology via a mobile phone 'app' to share non confidential information. For example, to remind staff to read new policies or procedures or team meeting minutes or to give prompts for staff for actions required.

The registered manager was able to recognise the challenges of the caring role and understood how important it was to thank staff and offer support when there had been a difficult shift or an incident had taken place. The registered manger also shared out management tasks which were rotated within the team to encourage team responsibility in the running of the service, and to aid learning for individuals. Staff told us they were encouraged to complete national vocational qualifications which would benefit their career progression. An example of this was a member of the care staff had recently been promoted to deputy manager. New staff were 'buddied' by more experienced staff to assist them in settling into their new role. These were examples of the registered manager operating in an open and transparent way valuing all staff members' contribution to the service.

Family carers were unanimous in their praise of the service. One relative told us they thought the service "was fantastic" and their family member had experienced a "complete turnaround for the first time in five years." Family members praised the leadership of the service and all said they would definitely recommend the service to other people.

We saw that systems were in place to prompt management actions. For example, there was a list of when essential services were due to be checked; DoLS were up to date and applied for in advance of their expiry date and medicines audits took place on a weekly basis. Files were checked regularly to ensure care plans were up to date and a building audit took place each month to ensure the service was safely maintained.

The registered manager attended the local provider forum as part of a rota with other DRS managers locally. As a qualified social worker the registered manager was part of a scheme to mentor newly qualified social workers, and his management style was to value reflective practice for all care staff.

The provider ensured there was management of the service in the absence of the registered manager by utilising the skills of other managers of schemes locally. At the last inspection we had noted that some care staff worked very long shifts, and we were concerned this may affect the quality of the service. At this inspection we found this was no longer the case. Staff were recruited to work either in the day or night, and were attached to a particular service so they could get to know the needs of those people well.

The provider had recently opened up a day service as part of a project to reduce social exclusion for local people with complex needs.