The Royal National Institute for Deaf People

RNID Action on Hearing Loss Brondesbury Road

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

RNID – Action on Hearing Loss Brondesbury Road is a service for six people who are deaf, have hearing loss or tinnitus. Some people are deaf/blind and some people display behaviours that may challenge. The service is spacious and provides accommodation on the first and second floor. RNID Action for Hearing Loss Brondesbury Road is located close to Queens Park and Kilburn High Street; both areas provide good transport links and shopping facilities.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection, in January 2016 the service was rated Good.

At this inspection we found the service remained Good.

There was a system to ensure that people were safe and protected from abuse. Staff knew how to recognise abuse and how to report allegations and incidents of abuse. Recruitment of staff was safe and robust. We saw that pre-employment checks had been completed before staff could commence work. There were sufficient numbers of staff to support people to stay safe. Risks to people's safety and welfare had been assessed and action taken to minimise the risk. Accident and incident information was analysed to identify trends and where changes were required to prevent future reoccurrences. Regular safety checks were carried out to ensure the premises and equipment were safe for people. We also saw there were systems in place to protect people and staff from infection. There were suitable arrangements for the recording, administration and disposal of medicines.

People were supported to have maximum choice and control of their lives. People confirmed they were involved in planning their care. We saw that their care was person centred. Their care records showed relevant health and social care professionals were involved in their care. The service was working within the principles of the Mental Capacity Act 2005 (MCA) We saw that people's mental capacity to make decisions about their care had been considered as part of the initial care assessment. Their human rights were protected because the requirements of Deprivation of Liberty (DoLS) were being followed, which meant they were not deprived of their liberty. There were arrangements to ensure that people's nutritional needs were met. We also saw that people's dietary requirements, likes and dislikes were assessed and known to staff. Staff had been trained to meet people's care and support needs.

People were treated with kindness, respect and compassion by staff. Staff were consistently described as kind and caring. Staff understood the need to protect and respect people's human rights. We saw they had received training in equality and diversity. People's spiritual or cultural wishes were respected. People told us and we saw that care staff promoted their independence. People were supported to maintain friendships

and important relationships, which minimised risk of isolation.

People received person centred care. Their communication needs were met in relation to the Accessible Information Standard (AIS). The service had made reasonable adjustments to make sure that communication was made as easy as possible for people using the service. People's support plans reflected their social needs. They were supported to take part in meaningful activities that were socially and culturally relevant and appropriate to them. People knew how to complain. They told us they could discuss any concerns they had with the registered manager and were confident any issues raised would be dealt with.

The service was well managed and well-led. There were effective quality assurance systems to monitor the quality of service being delivered. The service regularly sought feedback from people and their relatives to help them monitor the quality of care provided. There were also regular audits of care and safety issues. This showed how the management team ensured the service was safe and provided good quality care.

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 remained safe.	**Good**
Is the service effective? The service remained effective.	**Good**
Is the service caring? The service remained caring.	**Good**
Is the service responsive? The service remained responsive.	**Good**
Is the service well-led? The service remained well-led.	**Good**

RNID Action on Hearing Loss Brondesbury Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 unannounced inspection took place on 27 February and 13 March 2018. The inspection was carried out by one inspector, with support from a BSL interpreter.

Prior to the inspection we looked at information about the service including notifications and any other information received from other agencies. Notifications are information about specific important events the service is legally required to report to us. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

During the inspection we spoke with four people using the service to obtain feedback about their experiences of the service. We also spoke with two relatives of two people using the service. We spoke with the registered manager, and five care workers. We examined four people's care records. We also looked at personnel records of five staff, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including quality assurance processes, to see how the home was run.

Good

Is the service safe?

Our findings

We asked people if they felt safe in the care of staff. One person said, "I am safe here. I can speak to staff if I have any concerns." Another person said, "I feel safe with staff. I have no worries." People's relatives also felt their family members were well looked after. They told us that they had no concerns about people's safety.

There was a system to ensure that people were safe and protected from abuse. A safeguarding policy and procedure was in place. Staff had been provided with safeguarding training. They knew how to recognise abuse and how to report allegations and incidents of abuse. They were also aware they could notify other agencies such as the local authority, the Commission and the police when needed. Staff were confident the registered manager would act if they were made aware of any concerns about people's safety.

Recruitment was safe and robust. Pre-employment checks had been completed before staff could commence work. This included Disclosure and Barring Service (DBS) checks. DBS checks help employers make safer decisions and help to prevent unsuitable people from working with people receiving care. References had also been obtained from previous employers to help ensure staff were suitable and of good character. People using the service also participated in the recruitment process, which meant that they could have an influence on the selection of staff.

There were sufficient numbers of staff to support people to stay safe. There was a minimum of two staff during the day with two at night, including a sleep-in staff. Where people required one to one care and support this was provided. When we reviewed previous rotas, we saw that this was normally the case. The service also used regular agency staff who were familiar with the service and could be called to cover any gaps on the rota. People felt there were sufficient staffing levels to ensure they received care when they needed it. One person said, "There is always staff around to support me." Another person said, "There is always staff, including a BSL interpreter to support my needs."

Risks to people's safety and welfare had been assessed and action taken to minimise the risk. Risk assessments covered a range of areas, including nutrition, medical conditions and environmental safety. Staff understood the needs of people and the approaches which had been agreed to protect them from harm. For instance, where people displayed behaviours which challenged the service, management plans were in place. This ensured staff had the guidance they needed to provide safe care.

The home also took the least restrictive action in reducing risks. This enabled people to be more independent. For example, one person was at risk of sustaining burns from ironing. Rather than the home taking over, instead staff supervised the person as they carried out the activity by themselves. The risk assessments had been regularly reviewed and kept up to date.

There was a system to record accidents and incidents to ensure people remained safe. We saw action had been taken in relation to previous incidents. The information was analysed to identify trends and where changes were required to prevent future reoccurrences.

There was a record of essential maintenance. The home had a contract with the owners of the building, who arranged for safety checks on equipment and the premises to ensure this was safe. This included regular testing and monitoring of water temperatures, portable appliances and electrical installations.

Personal Emergency Evacuation Plans (PEEPS) had been completed for each person. PEEPS give staff or the emergency services detailed instructions about the level of support a person would require in an emergency such as a fire evacuation.

There were systems in place to protect people and staff from infection. Staff had completed infection prevention and control training and they understood the importance of infection control measures. They used personal protective equipment such as vinyl gloves and other protective measures when handling food or completing personal care tasks. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care.

People's medicines were handled safely. The home had a medicines policy and procedure, which it followed. There were suitable arrangements for the recording, administration and disposal of medicines. The temperature of the room and the fridge where medicines were stored was monitored daily and was within the recommended ranges. We looked at four medicines administration records (MAR) charts and found no gaps in the recording of medicines administered. The home had a system for auditing medicines. There was no protocol for the administration of paracetamol. This was put in place whilst we were still inspecting.

Good

Is the service effective?

Our findings

People were supported to have maximum choice and control of their lives and they were supported in the least restrictive way possible. People confirmed they were involved in planning their care. Their support plans showed assessments in many areas including communication, medical history, medicines, dietary needs and activities. We saw that care in these areas was person centred.

People's care records showed relevant health and social care professionals were involved in their care. They were supported to attend regular health appointments and if they were unwell the service sought advice from their GP in good time. Health Action Plans (HAP) were in place. A HAP is a personal plan about what a person can do to be healthy. Each HAP listed details of people's needs and professionals involved. There was evidence of recent appointments with healthcare professionals such as people's psychiatrist and GP. This ensured staff had current and relevant information to follow in meeting people's health needs.

One person said, "I used to be overweight. Staff have encouraged me to eat healthily and to take exercise on the bike. Now I have lost weight and I am much happier." Another person said, "Staff arrange for me go and see my GP." A third person said, "I have just returned from having eye surgery. I can see a lot better." This shows the service was meeting people's health needs.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible and legally authorised under the MCA.

We saw that people's mental capacity to make decisions about their care had been considered as part of the initial care assessment. People told us staff always sought their consent before providing their support. People's support plans included a record that confirmed they had consented to care and treatment. Consent was reviewed regularly, and consent forms updated. Records also included a 'decision making agreement' between the home and the person. This stated that people had the final decision in any matters relating to their care.

People's human rights were protected because the requirements of Deprivation of Liberty (DoLS) were being followed. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The authorisation procedures for this in care homes and hospitals are called DoLS. We saw that no one living at the home was subject to a DoLS authorisation. We observed that people had free access of all the areas of the building and the community when they wished to.

We also saw where people were subject to treatment orders that were near continuous supervision, the

home was proactive in ensuring these only remained in place where necessary. For instance, some people were subject to Community Treatment Orders (CTO). A CTO allows a person with mental health problems to leave hospital and be treated safely in the community rather than hospital. The home continued to review the orders to ensure that once it was safe for people to be discharged this was carried out on time. This meant people did not continue living under the CTOs, where this would have amounted to unnecessary restriction. We saw one example, where the home had worked persistently to support a person who was eventually discharged from a CTO.

Staff had been trained to meet people's care and support needs. Training records showed staff had received essential training in areas such as safeguarding, Mental Capacity Act 2005, medicines management and health and safety. Where people presented with specific health conditions, such as behaviours that challenged the service, staff had received training around this. For instance, staff had completed BSL (British Sign Language) and MAPA (Management of Actual and Potential Aggression) training. These were bespoke courses, specific to the needs of people who lived at the home. This meant the service recognised people's diversity and ensured staff were trained to support them effectively. Training was provided to staff through a mixture of E-Learning and face to face taught courses. Staff competency was then assessed to ensure they carried out their roles effectively. Staff confirmed that they had access to the training they required to meet people's individual needs.

New staff were supported to undertake an induction. The induction followed the Care Certificate induction standards. The Care Certificate sets out the learning competencies and standards of behaviour expected of care workers new to care. The induction comprised awareness organisational policies and procedures, values of the organisation and completion of essential training. New staff also worked alongside more experienced staff for a period until they were ready to work with people.

Staff confirmed they received regular supervision and a yearly appraisal of their performance. One staff member said, "We receive regular supervision and appraisals." This reflected the feedback from all other staff we spoke with. We looked at four records and saw supervision meetings provided staff with an opportunity to discuss their training and support needs. Appraisals were also an opportunity to review and set targets to motivate staff.

There were arrangements to ensure that people's nutritional needs were met. People's dietary requirements, likes and dislikes were assessed and known to staff. The home provided a variety of healthy foods and home-cooked meals for people to choose from. Records showed that pictures of food and meals were available to support people with choosing meals. Drinks and snacks were available on request throughout the day.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion by staff. Staff were consistently described as kind and caring. One person told us, "Staff are very caring. I was worried about moving here but staff have supported me. I am well settled." Another person said, "Staff ask me for permission before entering my room."

Staff understood the need to protect and respect people's human rights. We saw they had received training in equality and diversity. The service had a policy and procedure to guide staff around ensuring people were not discriminated against on the grounds of diversity. People's spiritual or cultural wishes were respected. Two people were supported with their religious observances, including visits to church. The registered manager told us the other people living at the home did not have particular beliefs they followed.

People told us care staff promoted their independence. People felt encouraged to participate in day to day chores at the home. We saw that one person who lost their sight whilst at the home continued to be supported to be as independent as possible. This person could do their laundry and prepared meals with minimal support. Equipment remained in familiar locations for the person so the person could carry on as they would have previously done.

People were supported to maintain friendships and important relationships. We spoke with relatives of some people and they confirmed what people had told us. People's feedback demonstrated they enjoyed being in touch with those that mattered to them. Their feedback included, 'my relative visited me. I really enjoy spending time with my relative' and 'I had my birthday party and my relatives came'. Relatives also confirmed they were supported by the service to spend time with their family members. Their comments included, "I can visit my relative any time I want to. He also visits us", "The home is very proactive since they have had the new manager. At times they ask me to visit the home" and "I have a lot of contact with the manager."

People were given choices. For example, we saw that information was made available on the activities and the menu choices for the day. People could choose the staff to support them based on shared interest and where possible we saw this was supported by the service using a staff matching tool. For example, one person was matched with a staff member based on their interest of movies, cinema, supporting the same football club and computer games. This ensured people had a choice and could build meaningful relationships with staff.

People were treated with privacy, dignity and respect. Staff knocked and waited for a response before they entered people's rooms. Staff spoke with people in a friendly manner. They also respected people's right to confidentiality. We noted that information was kept confidential. Care records and staff files were stored securely, both in the office and electronically. The service had started to plan for the new General Data Protection Regulation (GDPR) law coming into effect on 25 May 2018. The GDPR is Europe's new framework for data protection laws – it replaces the previous 1995 data protection directive. Previous UK law was based upon this directive.

Good

Is the service responsive?

Our findings

The provider's website states that their purpose is to 'help people confronting deafness and hearing loss to live the life they choose and to enable them to take control of their lives and remove the barriers in their way'. There was evidence the service was serving its purpose. People received personalised care and support which was specific and responsive to their changing needs. This was supported by several policies and initiatives. For instance, Action on Hearing Loss had signed up to declare their commitment to personalising care. Making it Real is a sector wide commitment to transform adult social care through personalisation and community-based support. It sets out what people who use services expect to see and experience if support services are truly personalised.

During our inspection we saw evidence that the service had embedded Making it Real in their Involvement Standards. Included in the Standards is the service's commitment to provide person centred care. We looked at how this was being promoted. People told us they received individualised care and support which met their needs. One person told us, "The staff always make arrangements for a BSL interpreter to be available." Another person said, "Staff are aware of my needs and they can communicate with me."

The support plans reflected protected characteristics under the Equality Act 2010. People living at the home are profoundly deaf or deaf/blind. The Equality Act protects people against unfair treatment (discrimination). We looked at how the service was protecting people from discrimination in relation to communication. In particular, we looked at how the service was meeting the requirements of Accessible Information Standard (AIS). As of 1 August 2016, providers of publicly-funded adult social care must follow the AIS in full. Services are required meet people's information and communication needs.

We saw that the service met the requirements of AIS. Support plans contained clear communication guidelines explaining how each person communicated. This ensured staff were aware of the aids people needed to help them stay involved. Assessments completed were based on AIS categories such as the preferred methods of communication, information format, and preferred contact method. For instance, one person's preferred method of communication was British Sign Language (BSL), preferred information format was verbal and easy read, and the chosen contact method was by letter. This person told us, "I can communicate because I get help when I need it." During the inspection the service could demonstrate that they were meeting these standards. We also saw that the communication needs of the other five people using the service were being met.

The service had made reasonable adjustments to make sure that communication was made as easy as possible for people using the service. This was also in keeping with the Equality Act. The Act places a legal obligation on organisations to provide reasonable adjustments to ensure that people with disabilities are not disadvantaged in service provision. We observed several good equalities practice. People using the service required aids or equipment and other services to ensure information was in a way they could understand. These are referred to as auxiliary aids and services by the Equality Act. There were several auxiliary aids on site, such as a portable loop for people with hearing aids, tactile devices, alerting devices, BSL interpreters and provision of information in alternative formats. Some of these aids were required

because people had problems in being alerted to sounds such as doorbells, smoke alarms, and telephones. As a result, the service had provided solutions in the form of vibrating and flashing alerts installed in people's rooms.

We saw that the service continuously met people's communication needs. Prior to our inspection the service arranged for people to have BSL interpreters available. The registered manager understood that people's first language was BSL and therefore she made sure that she had booked an interpreter to facilitate our communication with people. This meant the service was aware that if they did not provide interpreters, this would place people at substantial disadvantage.

People's support plans reflected their social needs. They were supported to take part in meaningful activities that were socially and culturally relevant and appropriate to them. People attended a variety of activities and spent time in the local community. They visited libraries, cinemas, restaurants, shopping centres, and other reactional facilities. This gave people an opportunity to mix with others socially and reduce the risk of social isolation. We saw one person was being supported to undertake new skills and hobbies to prepare them for independent living. As part of day to day chores, this person's care plan showed they made their bed daily, took a bath and brushed teeth, prepared lunch and dinner, emptied bins and did laundry. We observed these activities were taking place. This was also true of others living in the home.

There was a complaints policy and procedure in place. Each person had a copy of the complaints policy. This was in easy read plain English and was also presented visually, to make it accessible to people. The complaints procedure included details of who people could complain to if they were not satisfied with the care. People were regularly asked how they felt and if they had any concerns. They told us they could discuss any concerns they had with the registered manager and were confident any issues raised would be dealt with. One person told us, "I have raised a concern with the registered manager and this has been sorted." There were no active complaints at the time of our inspection.

Good

Is the service well-led?

Our findings

At the last inspection, we found the service was well managed and well-led. At this inspection we saw this had been sustained. People gave positive feedback about how the service was managed. They described the service as, 'well-managed' and 'organised'. Their relatives were also complimentary. They said the management team was supportive, flexible and approachable.

The service had clear lines of responsibility and accountability. The registered manager was supported by the head of service and support workers in the running of the service. She also worked closely with the service manager, who had a regular presence at the home. Staff confirmed they were clear about their roles, responsibilities and the reporting structures in place, including for out of hours. The management team were experienced and familiar with the needs of the people they supported. They shared a commitment with staff of providing people with the best care they could, which was person centred, inclusive and open. The registered manager told us, "The culture at this home is very person centred. It is very much in tune with Making it Real."

The vision and values of Action on Hearing Loss centred on those people they supported. The organisation's vision is 'a world where deafness, tinnitus and hearing loss do not limit or label people, and where people value their hearing'. This vision was reflected in the organisation's strategy. We saw that this strategy had been translated into actions at the service level. For example, there were benchmarks for services to demonstrate commitment to personalisation. The benchmarks included, a commitment to ensure people had access to information about their care; activities and receiving support that was responsive to their needs. Staff at RNID Action on Hearing Loss Brondesbury Road had a clear understanding of the provider's vision for the service. People living at the home received care that was centred on them.

The service organised several meetings to give people, their relatives and staff an opportunity to share opinions about how the service was delivered. People told us this gave them an opportunity to discuss issues that mattered to them and how the service was supporting them toward their goals. For example, one person wanted to move to independent living. This was discussed in meetings, and we saw action had been taken to support this person to achieve their goal. Equally, staff were asked for their views and opinions and were confident of raising concerns and making suggestions. They told us further opportunities to provide feedback were provided via staff supervisions and appraisals.

There were effective quality assurance systems to monitor the quality of service being delivered. The service regularly sought feedback from people and their relatives to help them monitor the quality of care provided. There were also regular audits of care and safety issues. For example, there was evidence of regular audits on medicines, care records and health and safety. These audits ensured high standards were maintained and improvements made where appropriate. Planned improvements included refurbishments to the shower room, pager monitoring system, painting of the house and guttering. This showed how the management team ensured the service was safe and provided good quality care.

The service also drove improvements by learning from mistakes and other events. There was a system for

managing accidents and incidents, safeguarding concerns and complaints. These records were reported to the registered manager who logged them centrally. This provided oversight for accident and incidents. This meant the management team could keep track of any emerging trends and help keep people safe.