MacIntyre Care

Anvil Close

Inspection report

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Date of inspection visit:
25 January 2017
27 January 2017

Date of publication:
01 March 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

This inspection took place on 25 and 27 January 2017 and was unannounced. At our previous inspection on 10 and 15 September 2015 we found the provider was meeting the regulations we inspected.

There was 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.

Anvil Close provides care for up to 12 adults with a range of learning disabilities. There are two flats on the ground floor and two flats on the top floor each with three bedrooms. At the time of the inspection, there were 11 people using the service.

We were only able to have limited conversation with people using the service as most people using the service had limited verbal communication. However, relatives we spoke with felt that their family members were happy living at the service and had no concerns. We observed care workers interacting with people in a friendly manner. They were also familiar with people's individual communication needs and were clear about how they sought consent from them in relation to everyday tasks.

Relatives that we spoke with told us they were confident that their family members were happy and settled living at the service. They said that staff were in regular contact with them and kept them informed about any changes to their care or health needs. They also said they would not hesitate to raise any concerns, either formally or informally if they had any.

Staff were recruited after undergoing appropriate recruitment checks and thereafter received training in a number of areas which helped them to carry out their roles. However, we found that their medicines training was not always renewed annually to ensure that they remained competent to administer people's medicines safely. We also found that not all the care workers received regular supervision to support them in their role.

There were records in place in relation to people's health and nutrition. These included records of upcoming health appointments, details of people's previous contact with health professionals, health passports and prescribed food and fluid plans.

Risks to people were identified and steps that staff had to take to mitigate any risks were also identified. Appropriate environmental risk assessments and checks such as fire, electrical and gas safety were carried out.

Some records relating to medicines for one person, such as medicine administration records (MAR) and stock checks of medicines were not completed correctly.

We also found that not all of the care plans were updated. This had been identified as an area of improvement during a previous inspection.

Regular audits were undertaken in relation to a number of areas. We found that these were effective in identifying the areas of improvement that were identified during this inspection. There were action plans in place to make improvements to the service.

We found a breach of the regulations in relation to person-centred care. You can see what action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe in all aspects.

Accurate records were not always kept in relation to medicine administration records and stock levels of medicines.

Each person had an individual risk assessment in place which had been overseen and signed off by the registered manager and care workers.

Staff were able to identify abuse and also what steps they would take to protect people if they suspected it was occurring.

There were sufficient numbers of staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not effective in all aspects.

Staff received training which helped them to support people, however they did not always receive regular supervision to support them in their role.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). Where people did not have the capacity to understand decisions related to their care, care plans were written in their best interests.

People's dietary and healthcare needs were being managed appropriately.

Is the service caring?

Good

The service was caring.

Relatives told us that care workers were kind and approachable.

People's privacy was respected.

Care plans were written in a person centred way and included ways in which care workers could communicate with people more effectively.

Is the service responsive?

Requires Improvement

The service was not responsive in all aspects.

Care plans were not always up to date and therefore did not accurately reflect people's individual needs.

People attended day centres and were also encouraged to maintain relationships that were important to them..

Where complaints had been made action was taken to resolve them.

Is the service well-led?

Good

The service was well-led.

The provider sought the views of people using the service and their relatives.

There were a number of quality assurance audits which took place at regular intervals. These were effective in identifying some of the concerns we picked up.

Anvil Close

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 checked 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.

We undertook this comprehensive inspection on 25 and 27 January 2017. The first day of the inspection was unannounced, the provider knew we would be returning for a second day.

The inspection was carried out by one inspector.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

We spoke with two people using the service and carried out observations as some people were unable to communicate with us verbally. We contacted four relatives and spoke with seven staff members including the registered manager and care workers. We looked at five care records, training records, four staff records, complaints and audits related to the management of the service.

After the inspection, we contacted 17 health and social care professionals and heard back from three of them.

Requires Improvement

Is the service safe?

Our findings

Relatives of people using the service told us their families were safe and they had no concerns about their safety. Some of their comments included, "Yes, I believe they are safe" and "I don't have any worries."

A safeguarding assessment was completed for people using the service. The purpose of this was to assess the person's vulnerability to abuse and identify suitable measures to safeguard them. It included a checklist of factors to consider and whether additional safeguards were required.

Staff were able to identify the different types of abuse and who to contact if they had any concerns.

We received notifications from the provider where safeguarding concerns had been raised. There was evidence that the provider worked with the local authority in investigating these concerns and took appropriate action in response to them.

Risk assessments were in place for people. The provider used a 'risk assessment list' to identify potential risks that people were susceptible to. These covered a range of overarching areas such as personal care, physical support, medical and health support, safeguarding, finance, going out and domestic/life skills. Contained within these areas were specific risks, for example personal care was further split into care of skin/nails, bathing, toileting and continence. The risk assessment list was reviewed annually by the registered manager which helped to ensure that all risks were appropriately identified and addressed.

Each identified risk was given a score based on the likelihood and severity of it and the steps needed to mitigate the risk were identified. The provider also identified extra action that could be taken to further mitigate the risk. The registered manager quality checked these records were signed by staff indicating they understood them. In our conversations with care workers, it was evident that they were aware of risks to particular individuals and how to manage these.

People with moving and handling support needs were supported appropriately. They had ceiling hoists in their rooms which connected to a bathroom, making it easier for staff to transfer people. Baths were appropriate; people had comfortable chairs and pressure relieving mattresses where required. A senior care worker was responsible for ensuring that all staff were competent in carrying out correct moving and handling techniques, this was done through three shadowing observations per year for each care worker.

There was an emergency information sheet in place for each person using the service and also a Personal Emergency Evacuation Plan (PEEP) for both the daytime and night-time, which had been reviewed in October 2016 to ensure these still met people's needs. A fire evacuation plan with steps for each night staff to undertake was also seen.

A risk assessment for the fire control and fire prevention had recently been carried out in May 2016.
Up to date certificates were seen for Portable Appliance Testing (PAT), fire inspection and testing and gas safety.

This meant that people were supported appropriately in relation to any risks to their safety which help prevent any avoidable harm.

People had medicines profiles, these had been signed by the registered manager and care workers indicating they understood the medicines requirements of people using the service.

We checked the medicines administration records (MAR) for four people using the service. In one MAR chart there were gaps in recording where care workers did not record whether the person had taken their medicine. Some of the medicines stock checks for this person were also inaccurate. Care workers had recorded that 56 sachets of one medicine had been delivered when the actual quantity delivered was 60. The recording of this medicine was not accurate either, 60 tablets had been signed in on a particular day and there had been 15 occasions according to the MAR chart when it had not been administered to the person, however there were none left in stock when we checked the medicine on the first day of our inspection when according to the records there should have been some left.

The area manager had conducted a medicines audit in which the issue of stock checks was identified and an action plan was in place to make improvements.

We found pre-employment recruitment checks were appropriate and there were sufficient care workers employed to meet people's needs.

Staff files included a checklist of pre-employment checks that were carried out. This confirmed that identity checks, references, Disclosure and Barring Service (DBS) checks and health assessments were all seen and were appropriate. The DBS check assists employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people and includes criminal record checks. Staff also completed an annual criminal records declaration.

Staff were deployed according to the needs of people using the service. There were six care workers on the rota during the day, two assigned to each of the flats on the ground floor and one to each of the flats on the first floor. People on the ground floor needed support with moving and handling and there were more care workers deployed to these flats than those on the first floor.

The registered manager told us that the usual staffing levels during the day were six care workers, but the minimum level they could safely work with were four, 1 care worker per flat. They sometimes had seven people during the day to support people with any extra appointments. At night there were two waking care workers, one sleep-in care worker and an additional care worker for one to one support for one person using the service.

We reviewed the staff rota for the months of December 2016 and January 2017 and saw the staffing levels were as stated by the registered manager.

Requires Improvement

Is the service effective?

Our findings

People were supported by care workers who had the skills and knowledge to meet their needs effectively. However, formal support systems for care workers such as regular supervision were not always operated effectively. Care workers told us they received regular training which helped them to keep up to date with their development, however staff did not always receive suitable supervision from supervisors.

New care workers completed a corporate induction. The provider's policy was that those with no previous experience of working in a care environment completed the Care Certificate. The Care Certificate is the new minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. The registered manager said no new employees had undertaken this as they all had some relevant experience. New staff were assigned a mentor who supported them throughout their probationary period.

New care workers completed 3 stages of training called safe, competent and skilled. "Safe" was where a care worker was considered to be safe working with people unsupervised. "Competent" was when they had completed the required mandatory training within their probationary period and "skilled" referred to a programme of ongoing training for experienced care workers.

Training was a mixture of e-learning and face to face training and observations where appropriate. A sheet of upcoming training was posted in the staff office and staff had signed up to courses which included autism, first aid and manual handling training.

We found that some of the training was difficult to track as the registered manager said it was not possible to produce an up to date list of all the e-learning that had been completed by staff without going into their individual records. However, she said that all training was discussed and looked at during supervision and any expired training was scheduled in to be completed. We could not verify this as not all the supervision records were up to date. She also said they were looking to create a matrix of all training completed.

We asked for a record of all medicines training that had been completed by staff. Medicines training consisted of e-learning and three separate observations completed by three senior care workers before they were allowed to administer medicines unsupervised. Thereafter, the registered manager said annual reviews of medicines competency took place. The records given to us on the day of the inspection showed that not all of the staff who administered medicines had undergone an annual review to ensure they remained competent to administer people's medicines.

Staff were supervised, however there were significant gaps in some of the records we saw. Where supervision had been carried out, the records included discussions about progress against actions from previous meetings, training and how care workers were managing in their role. Out of five staff files that we saw, two had insufficient supervision sessions recorded. One care worker had a formal supervision the week of the inspection, however their previous recorded supervision was from February 2014. In a second staff file that we saw, the last recorded supervision was September 2015. We asked the registered manager about

some of the gaps in the supervision records we saw and they acknowledged these and said some of the staff assigned to do supervisions were not doing them at the required frequency. After the inspection, the registered manager sent us confirmation that senior support workers had been booked onto supervision training on 7 March to improve their performance.

The registered manager sent us a copy of the supervision and appraisal policy which did not make reference to the frequency of supervision, stating 'Supervision will take place at regular intervals throughout the appraisal year. The regularity will be determined and agreed according to the needs of each service.' However, it was apparent that not all staff were receiving supervision during each appraisal year as stated.

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 are called the Deprivation of Liberty Safeguards (DoLS).

Care workers were aware of the importance of offering people a choice in how they wanted to be supported and to make decisions for themselves wherever possible. They said, "If I ask them would you like to go shopping they will laugh or frown" and "You can put objects such as cereals or clothes in front of [a person] and they choose, their hands or eyes will go towards one or the other."

People with up to date care plans had records about 'choice and control' giving details about the type of decisions they could make independently, those that they could make with some support and those they needed full support with. This demonstrated that the provider sought to empower people to make decisions related to their care.

Where people did not have the capacity to consent to their care planning, these records were completed in their best interests with input from family members where appropriate and other professionals.

Eight people using the service were subject to a DoLS authorisation, this was because they needed supervision and were not able to leave the service independently for their own safety. A DoLS restrictions checklist was in place to consider restrictive practices such as locked doors, alarms, wheelchair belts, bedrails and whether these amounted to a deprivation of someone's liberty.

Relatives told us they were satisfied with the support their family members received in relation to their diet. Care workers were familiar with people's preferences and needs with respect to their food choices. One care worker said, "[Person] has dysphagia, you have to puree the food."

Weekly menus were on display in each flat, these were all different and based on the individual preferences of people in each flat. Specific guidelines were also displayed for people that required specialist input. These included snack suggestions for people that needed to put on weight, prescribed food and fluid plans for people with dysphagia (the medical term for the symptom of difficulty in swallowing). Some people required the use of specialist cutlery to aid them to eat and we confirmed these items were in place to help people to maintain their independence at mealtimes.

We observed people being supported to attend health appointments on both days of our inspection. A health appointment diary was kept for each person with dates of appointments. Staff also completed a

health information sheet after each visit, recording the purpose of the visits, what happened and any updates. Specialist care plans, for example epilepsy care plans were in place where appropriate. This included an epilepsy risk assessment.

We saw healthcare passports for all the people using the service. The healthcare passport is a resource for people with autism or learning disabilities who might need hospital treatment. The passport is designed to help people to communicate their needs to doctors, nurses and other healthcare professionals. These contained person-centred information such as 'things you need to know about me', 'things important to me', likes and dislikes. It also included contact numbers of professionals involved in their care and their medical history, how people communicated, personal care needs, their diet preferences and their toileting needs.

Good

Is the service caring?

Our findings

Relatives of people using the service told us that staff were caring and treated their family members well. They said, "Yes, they are all lovely people", "I visit regularly and never seen any bad attitude" and "[My family member] tells me s/he is happy."

We observed staff speaking to people in a kind and friendly manner. They also made sure people's privacy was respected and pressed the doorbell before entering people's flats. One care worker said, "When doing personal care, we close the doors. You always tell them before helping them wash." People lived in single bedrooms, which were either ensuite or had direct access to a shared bathroom connecting two bedrooms.

Some care workers acted as link workers for individuals. They were familiar with the needs of the people they supported and knew how to communicate with them effectively. One care worker told us, "[Person] has their own special way of communicating. They understand but cannot verbalise. They use their hands and their eyes." This was reflected in the person's communication profile. Another care worker said, "You can put objects such as cereals or clothes in front of [person] and they choose, their hands or eyes will go towards one or the other."

Some people had their communication profiles displayed in their bedrooms. There were also records entitled 'helpful hints to improve communication' in some records that we saw. This gave accessible information to care workers on the best way of communicating with people.

People were encouraged to maintain relationships that were important to them, including regular visits to see family and friends. One relative said, "[My family member] comes here (home) every week and stays with me for a few hours." Another said, "[My family member] comes for visit."

People had a person centred care plan in place. These had been reviewed recently. They gave staff person centred information such as how to communicate effectively with people, their life history, their religious and cultural needs and how to support their independence.

Requires Improvement

Is the service responsive?

Our findings

People's care records were not always kept up to date to ensure that the information about how to meet their needs was current and accurate. Some of the care records we saw were out of date. For example, in one person's care records their communication profile was last reviewed in March 2010, their personal health profile was last updated in February 2009, and a document called 'My Health' was dated January 2009. We spoke with the registered manager about these and she told us these were historic records and the information was being transferred into a new style of person centred plans.

We saw one example of the new support plan but this was from 2014, which a care worker told us was not up to date. The care worker printed a new, updated version which had been reviewed in April 2016. However, even this care plan was not fully up to date and contained notes asking for more detail or information to be included.

The registered manager confirmed to us that three out of the eleven care plans had still not been updated to the new style at the time of our inspection. This was an area of improvement that was identified at our last inspection in September 2015 and it still had not been fully completed.

There was also a lack of outcomes and identified goals that could be monitored to ensure that people were supported to improve and maintain their independent living skills. This was highlighted in a quality assurance review undertaken by the area manager, there was a plan in place for the registered manager to action this but this was not reflected in the records we saw.

The registered manager told us that previously, link worker meetings were being held every three months but they had decided to hold them monthly from January 2017. She acknowledged that they had not been carried out as regularly as expected. We asked to see link worker meeting records for all the people using the service and we saw that the meetings were not held every three months for any person using the service apart from one person who had regular link worker meetings at the stated intervals of three months. In one case, we only saw one link worker meeting record. In another there were two records one dated March 2016 and the second April 2016. In a third example, there were two records, one dated January 2017 and another dated January 2016.

These identified issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person had individual care records in place. Care records included personal details, care plans, risk assessments, Deprivation of Liberty Safeguards (DoLS) records, service agreements, letters and correspondence.

The new support plans that we saw were person centred and included people's support needs in relation to religious/cultural needs, supporting independence, behavioural support, people's daily routines, health details, medicines and skills that they were developing.

Some link worker meeting records were in place, these included a review of actions that were assigned. Other topics of discussion included health and medicines, home/tenancy issues, money, whether people were happy or sad, communication, community activities and family life.

The majority of people using the service went to a variety of local day centres during the week for differing periods of time depending on people's needs and preferences. There were two people using the service who did not go to any day centres and they were supported to take part in activities in the service.

A social group called 'London Cats' had been set up by the provider for people using the service and those from another local service operated by the same provider. People from both services got together once a month to participate in a range of activities of their choosing. They held a planning meeting in January 2016 and planned an evening of activities for every month of the year. For example, the February 2016 meeting was based around Valentine's Day and March 2016 around Easter. Other themes included movie night, crafts, music, cooking, games and Christmas. Records were kept of each event and photos taken of the people enjoying their activities and spending time with their friends.

Relatives of people using the service told us they didn't have any major complaints. They said, staff kept them up to date about any important changes and that they were able to pick up the phone and speak with the registered manager if they wanted.

There had been two recorded complaints in the past year. They were both documented and the action taken in response was recorded on a complaint management form. These complaints were both resolved at stage one by the registered manager without the need to progress to stage two with the area manager. People were given details of how and who to complain to in an easy read format displayed outside the flat on the first floor.

Good

Is the service well-led?

Our findings

Relatives of people using the service said they were generally happy with how the service was managed. One relative said, "I visit often, and they always keep me up to date." Another said, "I don't see [the registered manager] often but I speak to [the senior support worker] whenever I go there."

Staff that we spoke with did not raise any major concerns about how the service was run. Comments included "Things are OK", "[The registered manager] is around if we need to speak with her." There were four senior care workers, each was given responsibility for one flat. Their responsibilities included making sure all appointments were kept, shopping was ordered, checks carried out and also to supervise the link workers for each person living there.

Staff meetings were held monthly and we saw the minutes for the meetings held from August 2016 up to December 2016. Staff discussed each person using the service and issues relating to health and safety, medicines, hoists and other health and safety checks and staffing issues.

People using the service and their relative's views were sought by the provider. People were asked 35 questions based on their experience of living in the service, people were supported to complete these either by their link worker or relatives. Seven out of the 11 people using the service had responded and feedback was provided to people following the survey in an accessible format. We reviewed the responses to the survey and also the feedback the provider gave in response. The feedback was generally positive.

Checks were completed by care workers, the registered manager and also the regional manager to monitor the quality of service.

Waking night staff carried out hourly checks on people and completed observation sheets. The area manager carried out a hoist audit in November 2016. The only concerns identified in this were around visual inspection of equipment.

A medicines and financial audit had been carried out by the area manager in December 2016 as a result of some concerns that had been raised by the Care Quality Commission (CQC). Issues identified with the medicines audit included consent not always being clearly recorded and some medicines profiles not being up to date. The financial audit did not pick up any major errors. For each audit, there was an action plan and a deadline for making improvements. As a result, the medicines and financial procedure had been updated and shared with staff.

A health and safety audit was completed every two years by the area manager, this was last completed in November 2015. This was comprehensive and covered 10 different areas such as policies, emergency planning, incidents/accidents, inspections, audits and reviews.

A quality self-assessment tool was completed every quarter, looking at staff, wellbeing/engagement, leadership and people using the service. We saw from the results from the most recent one that these were

effective in identifying areas of improvement that we found during this inspection.

For each audit carried out, a rating was given for each assessed area based on the level of compliance from either full compliance to non-compliance. There was an action plan in place to support improvement in those areas identified as not fully meeting the standard of full compliance.

The identified actions included, 'not good at recording outcomes for people' in relation to care plans and staff supervisions not being carried out as regularly as required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care or treatment with a view to achieving service users' preferences and ensuring their needs are met was not always in place. Regulation 9 (3) (b).