Harrow Council

Harrow Council - 14-15 Kenton Road

Inspection report

14-15 Kenton Road
Harrow
Middlesex
HA1 2BW

Tel: 02084237484

Date of inspection visit:
26 February 2018

Date of publication:
22 August 2018

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

Harrow Council - 14/15 Kenton Road is a care home providing personal care and accommodation for people with mental health needs. It is a service run by Harrow Council, located in Harrow on the Hill and accommodates up to 14 people.

At the last inspection, in December 2015 the service was rated Good.
At this inspection we found the service remained Good.

A registered manager was employed at the service and had been in the role since 2015. 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.

There was a system to ensure that people were safe and protected from abuse. Staff were able to describe to us the different ways that people might experience abuse and the correct steps to take if they were concerned that abuse had taken place. Recruitment records showed that relevant checks had been completed. References had been obtained from previous employers as part of the process to help ensure staff were suitable and of good character. There were sufficient numbers of staff deployed to support people to stay safe and to meet their needs. Risks to people's safety and welfare had been assessed and measures put in place to mitigate these risks. People's medicines were safely managed. There were clear policies and procedures in the safe handling and administration of medicines.

People's health needs were met. They had their needs assessed across a wide range of areas, including their medical and mental health needs. Individual plans were in place for these areas and specialist input from other professionals had been obtained. The home was working in accordance with the Mental Capacity Act 2005 (MCA). People's capacity to make specific decisions had been assessed. They were offered external support from agencies such as independent mental capacity advocates (IMCA) to support them if required. Staff had completed essential training. Where people had specific diagnosis, additional training was provided.

People told us staff were caring in their approach. We observed staff spoke with people in an appropriate way throughout the inspection. The home had a policy on ensuring equality and valuing diversity. This reminded staff to respect people's preferences regardless of their background. People were supported to be as independent as possible, and where possible, staff assisted people to increase their independence skills. Individual communication needs were assessed. However, the registered manager acknowledged improvements were required in relation to Accessible Information Standard.

People told us they received personalised care. People at the home were on Care Programme Approach (CPA). CPA is a package of care for people with mental health problems. Each person at the home had a care

coordinator, who ensured people received care that met their needs. Care plans were regularly reviewed. This helped to monitor whether they were up to date and reflected people's current needs.

People felt the service was well run. Equally, staff were satisfied with the leadership of the home. There were effective systems to assess, monitor and improve the quality of the service provided. A range of quality assurance processes, including staff meetings, surveys, audits, management of accidents and incidents, management of complaints had been used continuously to drive improvements.

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

Harrow Council - 14-15 Kenton 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 26 February 2018. The inspection was carried out by one inspector.

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 spoke with the registered manager, and five care workers. We examined four people's care records. We also looked at personnel records of seven care workers, 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

People felt safe. They said they were well looked after. One person told us, "I receive round the clock care and I feel safe." Another person said, "I feel safe. The environment is homely." This reflected the views of other people we spoke with.

There was a system to ensure that people were safe and protected from abuse. A safeguarding policy and procedure was in place. Staff were able to describe to us the different ways that people might experience abuse and the correct steps to take if they were concerned that abuse had taken place. They were also aware they could report allegations of abuse to the local authority safeguarding team and the Commission if management had taken no action in response to relevant information.

Staff had been recruited with care. Their personnel records showed that pre-employment checks had been carried out. The Disclosure and Barring Service checks (DBS) had been undertaken prior to them commencing work. DBS checks help employers make safer decisions and help to prevent unsuitable people from working with people receiving care. Other checks comprised evidence of identity, permission to work in the UK and a minimum of two references.

There were sufficient numbers of suitable staff to support people to stay safe. The staffing levels consisted of the registered manager, the team leader and two staff during the day shift and two staff during the night shift. There was evidence additional staff were booked to provide assistance or escort for outings or appointments. We observed that when people requested support this was provided on time.

Risks to people's safety and welfare had been assessed and measures put in place to mitigate these risks. Highlighted risks included those associated with nutrition, mental health, going out into the community and medicines. These were regularly reviewed. For instance, risk assessments were in place for people who took medicines independently. As people's mental health needs changed, the service ensured their ability to take medicines was regularly ascertained. This meant staff had up to date and accurate information on how to keep people safe.

There was a record of essential maintenance. The home had a contract with external services who undertook safety checks on equipment and the premises to ensure this was safe. Regular safety checks were carried out to ensure the premises and equipment were safe for people. This included regular testing and monitoring of water temperatures, portable appliances and electrical installations.

There was a business continuity plan in place to ensure people would continue to receive care in the event of an emergency. 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 situation such as a fire evacuation. The building was connected to Harrow fire Brigade. This meant, there was an immediate response should there be a fire.

Accidents and incidents were monitored. All accidents were recorded to ensure on going monitoring and

identification of recurrent themes. There was evidence of discussions around any incidents and learning being shared. We saw action being taken following incidents. Learning derived from these incidents had been documented and discussed in the supervision of staff and in meetings.

People's medicines were safely managed. There were clear policies and procedures in the safe handling and administration of medicines. All prescribed medicines were available at the home and were stored securely in a locked cabinet. This assured us that medicines were available at the point of need. Some people were on controlled medicines and this was administered from the GP's practice.

People received their medicines as prescribed. We looked at six Medication Administration Records (MAR) charts and found no gaps in the recording of medicines administered. This provided a level of assurance that people were receiving their medicines safely, consistently and as prescribed.

People were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. Their behaviours were not controlled by excessive or inappropriate use of medicines. For example, we saw mood stabilizing medicines. There were appropriate, up to date protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine did not have its intended benefit.

Good

Is the service effective?

Our findings

People felt the service was effective. They said staff understood their needs and had the skills to meet them. One person told us, "Since I have been here, my health and well-being has improved." This was also a view shared by other people we spoke with.

People's health needs were met. They had their needs assessed across a wide range of areas, including their medical and mental health needs. Their care records detailed how their needs were met. Individual care plans were in place for relevant areas. Guidance obtained from the external healthcare professionals was included in people's care plans. Therefore staff had current and relevant information to follow to support people in meeting their health needs.

The home was working in accordance with the Mental Capacity Act 2005 (MCA). The Act provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

Staff had received training in relation to protecting people's rights. They were aware of the need to assess people's capacity to make specific decisions. People's care plans contained assessments of their capacity to make certain decisions. These included the capacity of people to consent to care and support. All people at the home had been determined to have capacity to make their decisions. However, the registered manager was aware of the requirements of the MCA 2005, in case they needed to support people to make decisions. External support from agencies such as independent mental capacity advocates (IMCA) was on offer if required.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA 2005. All people at the home had consented to the arrangements made for the provision of their care or treatment. They had free access of all areas of the building, including the lounge, kitchen and dining room when they wanted to. This showed that people had independence and the freedom to move around without undue restriction on their liberty.

Even though some people displayed behaviours that challenged the service from time to time, their risk assessments were managed thoughtfully, taking into consideration the least restrictive approaches and interventions. The home was aware of the balance needed to be struck between risk and the protection of people's rights. The registered manager told us physical interventions were applied as a last resort and risk assessments had been completed.

Staff had relevant training and experience to meet people's needs. Newly recruited staff completed an induction programme in accordance with the Care Certificate. The Care Certificate assesses staff against a specific set of standards. Additionally, new staff worked with experienced staff until they were confident they could work independently with people. Staff received regular supervision. Those who had been at the home

for longer than 12 months also received an annual appraisal. This ensured they were supported to set personal goals for development and allowed the managers to monitor their competence.

A training record showed staff had completed essential training including, safeguarding, MCA 2005, medicines management, equality and diversity and nutrition and hydration. Where people had specific diagnosis additional training was provided, comprising of diabetes awareness, mental health, and pro-active behavioural intervention such as CALM (crisis, aggression, limitation, management). This meant the service recognised people's unique needs and so ensured staff were trained effectively to support people's needs.

People were supported to have sufficient amounts to eat and drink. They were given choices about what they ate and were offered varied types of meals. We also looked at what the home had put in place to address people's religious needs. There were people from Muslim, Hindu, Afro-Caribbean and English backgrounds. Their care plans reflected their preferences in relation to these backgrounds. The same applied to those on special diets due to medical conditions.

Good

Is the service caring?

Our findings

Staff were caring in their approach. People receiving care told us their dignity was respected. One person told us, "Staff are respectful and polite." Another person said, "Staff are always polite in conversations." A third person confirmed, "I speak to staff and they listen to me. Privacy and dignity are always respected." Staff described to us how they protected people's privacy and dignity. They told us they made sure doors were closed and curtains drawn when undertaking personal care. We observed that they knocked and waited for a response before they entered people's rooms. They spoke with people in an appropriate way throughout the inspection.

The service had a policy on ensuring equality and valuing diversity. This reminded staff to respect people's preferences regardless of their background. There were practical arrangements to support the individual differences and beliefs of people. People were supported with their religious observances, including visits to church, temple, and mosque. One person told us, "I go to mosque on Fridays and staff remind me." Another person said, "I am Muslim. I pray at home in my room."

Individual communication needs were assessed. There was a communication access policy. This reminded staff that 'irrespective of their particular needs, all clients must be treated with dignity and all communication must demonstrate respect and be open and non-judgemental'. People's methods of communication were clearly noted in care plans. This enabled staff to communicate with them in the way they needed to. Despite that, this had not been tailored to the specific 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. The registered manager acknowledged improvements were required in this area.

People were supported to be as independent as possible, and where possible, staff assisted people to increase their independence skills. Care plans recognised people's choices and independence. People told us about how staff took time to support them to participate as fully as they could. For instance, the home encouraged self-administration of medicines to people who were able to manage this independently. This was important to people living at the home as they were being prepared for eventual transition to move to more independent living. Two people had been risk assessed to self-administer. Both kept medicines in their rooms, whilst staff provided the required checks and support to ensure safety. In so doing the home promoted this people's independence.

People were supported to maintain friendships and important relationships. People's care plans contained details of the people who were important to them. People told us friends and family visited them and were always made welcome. This is important as it meant people were not socially isolated, and also gave a level of reassurance that if there were concerns these could be easily noticed.

People's right to confidentiality was respected. We noted that information was kept confidential. Care records and staff files were stored securely, both in the office and electronically. Any information, which was kept electronically, was password protected. Record keeping and confidentiality was part of the induction

training for all staff. Staff told us that they maintained people's confidentiality, which meant they did not discuss information with those not privileged to know.

Good

Is the service responsive?

Our findings

People told us they received personalised care. They were all on the Care Programme Approach (CPA). A CPA is a programme that supports people to recover from mental illness. The programme places weight on involving people in their care. Each person at the home had a care coordinator, who worked with other professionals and staff at the home to ensure people received care that met their needs. People's views were that this programme supported them with their recovery goals, treatment, activities as well as training and employment. One person said, "Everything is good about this place. There are staff all day and all night to support us." Another person said, "I have always wanted to live on my own. Today I am moving to my own flat."

The requirements of the CPA programme were that assessments were completed prior to people moving to the home. This was important to ensure the home could meet their needs. The home was part of a single point referral system (SPOR). This is a seven-day-a-week service that offers quick and easy access to integrated short-term health and care services to prevent hospital admissions. Thus, prior to people moving to the home, relevant professionals would have met with the person to carry out an assessment to determine if their needs could be met. We saw evidence that this had been carried out before people moved in.

People or their relatives were involved in developing their care plans. Information in support plans identified people's personal and healthcare needs. All the information that staff would need to know about people's care and support needs was written in easy to follow format. For example, a care plan of one person showed that they wanted to lose weight. Action to be taken to achieve this goal was available in easy to read step by step format. Staff were aware of this and this was being followed. This was true of other people who also had individual support plans.

Care plans were regularly reviewed. This helped to monitor whether they were up to date and reflected people's current needs. This was important so that any necessary changes could be identified and acted on at an early stage. Care plans covered mental health needs as well as, physical health, social and emotional needs, education, employment and activities. Any changes to people's care were updated in their care records to ensure that staff had up to date information. Staff always ensured that relatives were kept informed of any changes to their family member care needs.

Also, central to the CPA process was the need for continuity of care. We saw from care plans that there were teams across professional boundaries that were involved even when people moved across services. Within the home, continuity of care was supported by means of handovers at the end of every shift. This ensured any changes to people's needs were discussed with staff working the next shift. The home also used a log book system for staff to refer to where there had been any changes to people's care. For example, one log book entry alerted the incoming staff of the deterioration involving one person experiencing mental health problems. This showed the home was concerned with quality of care over time.

The home worked resourcefully with other agencies to support people to take control of their lives. People

were encouraged to take part in activities, leisure activities, sporting activities, and develop careers. For example, one person was seeking employment and the service supported the person to seek support from a vocational support worker to achieve this goal. We saw relevant support was also given to others who wished to pursue their own individual goals.

There was a complaints procedure. This was on display in the communal area of the home which helped 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 told us they could discuss any concerns they had with the registered manager and were confident any issues raised would be dealt with. There were no active complaints at the time of our inspection.

Good

Is the service well-led?

Our findings

People felt the service was well run. We spent some time speaking with the registered manager. As in previous inspections, we found him to be knowledgeable about the service. People spoke in complimentary terms about his leadership. One person told us, "The manager is very good. He is good at his job." Another person said, "The manager is a good person. He is always there for us." These views were also shared by staff. They described the registered manager as, "very competent", "very supportive", "professional, caring and fair."

The registered manager understood his role and responsibilities and had ensured CQC were kept informed of all notifiable incidents. These were documented and had been regularly monitored to ensure any trends were identified and addressed. The results were shared with staff to raise awareness of risk within the service.

People were regularly asked for their views on the quality of the service. They told us that their views were listened to and that they had in the past been asked to complete surveys. We read minutes of bi-weekly keyworker meetings. These covered a range of topics, including mental health, any worries or concerns, any upcoming appointments and if people were in contact with families or friends. These meetings were considered an effective way to seek the views of the people living at the home as this enabled staff to respond promptly and in a person-centred way.

Regular checks were carried out on the care that people received. There was evidence quality checks were carried out on a number of areas including, care records, medicines management, staff practice, staff training and development, health and safety checks and accidents and incidents. Where improvements had been identified we saw that there was an action plan. To cite an example, some refurbishments work were planned to be carried out.

The home received regular quality checks from the local authority. All previous reports had been positive. Where improvements had been suggested the home had taken appropriate action. We spoke with the local authority lead, who gave us positive feedback about the quality of the service provided at the home.

There was an open and inclusive approach to the running of the service. Regular staff meetings took place and staff were free to express their views. A staff member told us, "The manager always asks for our opinion. He takes things on board." We looked at a sample of staff meeting minutes and saw that they covered numerous topics for discussions, relevant to the care of people and operational aspects of the home. We saw from the minutes that staff could make suggestions for improvement and were acted on.

Care records contained essential information such as updates on people's health and details of care reviews. We saw that these were up to date. There was a record of visits made to people by social and healthcare professionals. There was a range of policies and procedures to ensure that staff was provided with appropriate guidance to meet the needs of people. These addressed topics such as infection control, safeguarding, Mental capacity Act 2005, and health and safety.