

Family Mosaic Housing

148 Hornsey Lane

Inspection report

148 Hornsey Lane
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London
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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement

Summary of findings

Overall summary

At the last unannounced inspection on 2 and 3 December 2014, we found that the provider was not meeting the regulation with regards to staffing levels. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach.

We undertook this focused inspection to check that they had followed their plan and to confirm if they now met the legal requirement. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

148 Hornsey Lane provides accommodation and support with personal care for up to 12 older men and women with mental health needs. At the time of our inspection there were 11 people living at the home.

A registered manager was in place at the time of the inspection. 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 found that there had been improvements made in staffing levels. A tool and other information had been used to assess the dependency levels of people at the service and to ensure adequate staff were supporting people. However, we also found the lift was out of order and risk assessments to access the ground floor safely had not been completed for people that lived on the first and second floor. This meant that the risk of potential risk of harm to people had not been identified and steps had not been taken to minimise such risks. We identified a breach of regulations relating to safe care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

We found that action had been taken to assess people's changing needs through regular reviews of care plans and care programme approach review plans.

Disturbances at night had been significantly reduced. Hydraulic door hinges had been fitted to all doors in communal areas to minimise noise from closing doors. There was a noise book that recorded any disturbances and we saw minimal reports, for example one of the noises came from radiators and another about people talking in lounges.

A joint working protocol had been agreed with the local mental health team to ensure that appropriate strategies were implemented when a change in a person's need was identified and extra resources, including more staffing input could be deployed to support people if the need arose.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Whilst the provider had taken action to improve safety in relation to a previous breach of legal requirements, we identified a new area where the provider was breaching legal requirements. Risks were not always identified appropriately and management plans were not in place to identify the steps to take to minimise the risks.

There has been an improvement in the staffing levels to support people. People who required extra assistance had support provided via an external care package on a regular basis to meet their needs.

Dependency levels had been assessed using a tool and other information to ensure sufficient numbers of staff were in place to meet people's needs.

We could not improve the rating for this key question from requires improvement because we found that legal requirements relating to the safe and treatment of people were still being breached. We will check this during our next planned comprehensive inspection.

Requires Improvement ●

148 Hornsey Lane

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.

This inspection took place on 28 January 2016 and was unannounced. It was carried out by a single inspector. This was a focused inspection that was carried out to check if improvements had been made to meet the legal requirements planned by the provider after our comprehensive inspection on 2 and 3 December 2014.

We inspected the service against one of the five questions we ask about services: is the service safe? This is because the service was not meeting a legal requirement in relation to this key question.

We spoke with three people who used the service and four staff members including the area manager. We also gained feedback from a local commissioner and a health and a social care professionals involved with the service. We looked at three care records as well as policies, procedures and protocols relating to care planning and risk assessments.

Is the service safe?

Our findings

During this inspection, we found the lift in the building was not working. This meant people on the first and second floor had to use the stairs. Staff told us that the lift had not been in use since 27 January 2016. However, we did not see that an assessment of the risks to people living on the first and second floor had been undertaken in relation to how they might access support from staff based on the ground floor if this was required. One person we saw had been unwell for some time and used a walking frame to mobilise. Staff told us they had not been coming downstairs during the period of their recent illness and were unsure how they would be able to ask for assistance particularly during the night as the staff member who slept in was based downstairs. There was no call bell system in place although we were told that a pendant call system had been acquired but had not been set up. It was later confirmed that the pendant system was not for the person but for someone else. This meant that an assessment of risk to people around accessing support when needed and to ensure their needs were met had not been undertaken and steps had not been put in place to minimise such risks. We discussed this with the area manager as the registered manager was on leave. They assured us that risks assessments would be carried out and agreed to commission an extra staff member to work during the night whilst the lift was out of action to ensure the person's needs were met and to reduce the risk of harm. They also confirmed that the situation would be kept under constant review.

The above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection of this service on 2 and 3 December 2014 we found that some aspects of the service were not safe. There were long period of time where one staff member was working alone to support up to 13 people at the service. There were regular disturbances during the night and the staff member that slept in was often disturbed and therefore unable to complete their shift the next day which led to staff shortages. Changes in people's needs were not being routinely assessed therefore the service could not provide sufficient evidence that staffing levels matched people needs. The provider sent an action plan setting out how they were going to meet the regulations breached, including regularly assessing people's dependency levels and requesting extra resources to meet individual needs. Also addressing issues around disturbances at night time to ensure there was adequate staffing to cover all shifts.

We saw evidence from the rotas and heard from staff that two people had support provided via an external care package on a regular basis to meet their changing needs. We also saw that a report had been written by the provider's compliance officer in regards to dependency levels and the level of staff required to ensure the service had adequate staff available to support people. A tool had been used to assess the amount of hours required for each person at the service to assure the provider that staffing numbers were correct. The area manager confirmed that from this piece of work and other actions they had completed that there were sufficient staff to meet people's needs. We saw that people's needs were being regularly assessed through reviews of care plans and care programme approach review plans, where information had been added regarding people's changing needs. Despite the assurance of staffing numbers the area manager confirmed and we saw from a written proposal that the service had submitted a request in October 2015 for extra staff

resources, particularly to assist people with attending appointments and to pursue external activities, which was being considered by commissioners.

We saw that disturbances at night had been significantly reduced. There had been a review of people's support needs since the previous inspection following reports from staff that people were often unsettled during the night. This led to people's individual needs being met more appropriately and people being more settled during the night. Hydraulic door hinges had also been fitted to all doors in communal areas to minimise noise from closing doors. People we spoke with told us it was quiet at night and they were happy with their support. One person said, "It's lovely here, I love it." Staff we spoke with confirmed there had been significant improvements and fewer disturbances at night and that the issue of disturbance and staffing cover were regularly discussed at staff meetings. They also reported that people and staff were satisfied that staff resources were adequately deployed at the right times. One staff member told us that people usually go to their rooms after their evening meals to watch their television or pursue their own interests therefore only minimal staff was needed at this time and during the night. Individual care plans and risk assessments reflected this. Another said "We do get extra staff for people at night if we need to".

The area manager told us that a joint working protocol had been agreed with the local trust to ensure that appropriate strategies were implemented when a change in a person's needs were identified and extra resources could be deployed to support people if needed. We saw evidence that the protocol had been signed and dated by all parties.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not ensured that risks to the health and safety of service users were appropriately assessed so that they could do all that was reasonably practicable to mitigate any such risks.</p> <p>Regulation 12(1)(2)(a)(b)</p>