

# First Choice Care Limited

## Mosaic House

### Inspection report

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### Ratings

#### Overall rating for this service

Requires improvement



Is the service safe?

Good



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Good



### Overall summary

This inspection took place on 29 January 2015 and was unannounced.

During our last inspection of Mosaic House on 29 July 2013 we found no breaches of the regulations assessed.

Mosaic House is a home situated in North Wembley and is registered to provide accommodation and personal care to five people who have mental health needs. At the time of our inspection the home had no vacancies. The registered provider was also the registered manager, as they had previously provided direct management to the home. However, at the time of our inspection a new manager had been appointed and they were undergoing the process of becoming the registered manager for the

home. 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.

People we spoke with told us that they felt safe living at the home. They were positive about the care that they received and told us that staff members respected their privacy and dignity.

People were protected from the risk of abuse. The provider had taken reasonable steps to identify potential

# Summary of findings

areas of concern and prevent abuse from happening. Staff members demonstrated that they understood how to safeguard the people whom they were supporting. People living at Mosaic House told us that they felt safe.

Written risk assessments were in place for people living at Mosaic House. These were up to date and reflected identified needs.

Medicines at the home were well managed and people told us that they received these on time.

The physical environment at the home was suitable for the people who lived there and was clean and well maintained. Regular safety checks took place and we saw that these were up to date.

Staff recruitment processes were in place to ensure that workers employed at the home were suitable. Staffing rotas met the current support needs of people, and we saw that additional staff were provided to support activities where required.

Staff members received regular supervision, team meetings took place each month, and staff felt that they were well supported.

People's dietary needs were met by the home, and there was evidence that people were enabled to make choices about the food and drink that they received.

Other health and social care professionals were involved with people's treatment and support.

Quality assurance monitoring took place regularly and records of this were in place. Policies and procedures were in place that generally met requirements. However, we did not see a policy in respect of the Mental Capacity Act, although there was one in relation to Deprivation of Liberty that required updating to encompass recent guidance.

There was limited evidence to show that people who used the service had been involved in making decisions about their care. Care documents were not always signed to show consent, and some people told us that they had not been involved in the process. We discussed our concerns with the manager and were assured that this would be addressed.

Staff training was generally good and met national standards for staff working in social care organisations. A number of staff members had achieved a relevant qualification. However, Mental Capacity Act training had not been updated to reflect recent developments to the Deprivation of Liberty Safeguards.

We have made a recommendation about staff training on The Mental Capacity Act and Deprivation of Liberty Safeguards.

The care plans maintained by the home lacked detail about people's needs and did not provide guidance in respect of how support should be provided by staff.

The new manager told us that they had already identified some of our concerns, and we saw evidence that these had been discussed with staff and that action had commenced to improve the quality of care plans.

We have made a recommendation about the development of care plans.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Risk assessments were in place for people that were up to date and reflected people's needs.

Staff we spoke with understood the principles of safeguarding vulnerable adults, how to recognise the signs of abuse, and what to do if they had any concerns.

Medicines were well managed and recorded.

Good



### Is the service effective?

People were not always involved in planning and agreeing their care. Care plans were not always signed to confirm consent and some people told us that they were not fully involved in the process.

Staff members received regular training and supervision, and team meetings were held regularly. However training on The Mental Capacity Act and Deprivation of Liberty Safeguards was out of date.

People who used the service told us that they were happy with the support that they received.

Requires improvement



### Is the service caring?

The service was caring. Staff members interacted with people in a respectful and positive way.

When people required support this was responded to quickly and in a way that respected people's privacy and dignity.

Good



### Is the service responsive?

Aspects of the service were not responsive. Care plans lacked detail of how people should be supported, and did not include guidance for staff on their role in the process.

People met regularly with their key worker and said that they valued this.

Records showed that issues arising for people on a day to day basis were recorded along with actions taken.

People who used the service knew how to make a complaint if they needed to, but felt that their complaints were not always listened to.

Requires improvement



### Is the service well-led?

The service was well led. A new manager and deputy manager had been recently appointed, and action had commenced ensure that the manager was registered with CQC.

Good



# Summary of findings

There was evidence that the new management team had identified many of the issues raised during this inspection, and had already discussed improvement plans with the staff team.

People who used the service and staff members were positive about the management of the service.

# Mosaic House

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 January 2015 and was unannounced.

The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed our records about the service, including previous inspection reports, statutory notifications and enquiries.

We used a range of methods to help us to understand the experiences of people living at the home. We spoke with four people who used the service, one member of the care team, the deputy manager and the new home manager. We observed activities within the home and interactions between staff and people who used the service. We looked at four care plans and associated care documentation including risk assessments, medicines administration records and procedures, and a range of other documents maintained by the service. These included policies and procedures, staffing records, training records, complaints records, accident and incident reports, staff rotas, menus, activity records and quality assurance documentation.

# Is the service safe?

## Our findings

People who used the service confirmed that they felt safe living at the home. One person told us, “this is the best place that I have been at.” Another person said, “I feel very safe here.”

Risk assessments were in place for people who used the service and we saw that these had been updated within the previous six months. Risk management plans were in place. Risk assessments included information about risks associated with, for example, behaviours, risks outside the home, and use of finances. Risk management plans were in place that identified indicators and provided guidance for staff.

One person living at the home was subject to a Home Office licence. This meant that there were restrictions placed upon them for some activities. These were clearly indicated in their care plans and risk assessments. Other people at the home were not subject to restrictions in respect of their access to the local community. However one person told us that, “I have to arrange things in advance. I cannot go out 24/7, and I do not have a key to the front door.” This person had capacity and we saw that their risk assessment and care plan identified that staff should be aware when they were going out, but they did not specify what staff on shift should do if they did not return home. The deputy manager told us that they recognised that the risk management plan was unclear, and referred us to other information within the person’s care file. We were told by the deputy manager and another staff member that there were no restrictions on this person’s activities, but it was important for the service to know when they were out as there were risks associated with their use of the community and if they had not returned within an agreed period of time, the service would need to alert, for example, the police or the local adult safeguarding team.

Staff members that we spoke with demonstrated that they understood the principles of safeguarding of vulnerable adults, and were able to describe different types of abuse and provide examples of indicators that abuse might be taking place. They referred to the home’s safeguarding policy and procedures and their responsibilities in immediately reporting and recording any concerns. We saw evidence that training in safeguarding had been received by all staff members.

A staff rota was displayed on the office wall. We saw that on a typical day there was one member of staff on shift between 7am and 10pm with one worker sleeping in at the home overnight. The manager and deputy covered some shifts. Although there was no evidence of concerns that might result in consideration of an increased staffing ratio, we asked about risk in relation to ensuring that there were enough staff members available to support people. The manager told us that additional staff were provided to support planned activities where required, and we saw, for example, that arrangements had been made to accompany a person to view a prospective supported living placement during our inspection.., The manager told us that if any particular risk was identified for a person who used the service, staffing levels would be reviewed.

We looked at four staff files. Staff recruitment records included copies of identification documents, evidence of eligibility to work in the UK, two written references, application forms and criminal record checks. Staff files also contained recruitment details, training certificates and supervision records. Policies and procedures were in place in relation to staff recruitment and the records showed that these had been followed.

We looked at the storage, administration and recording of medicines. Medicines were stored appropriately. We were told that medicines were ordered and received on a monthly basis and saw records in relation to this. We did not see medicines being administered but people that we spoke with told us that knew when they were due to receive medicines, and had no concerns about how or when these were received. The medicine administration records that we saw showed that receipt of medicine by the person was accurately recorded.

The communal areas were well furnished, clean and well maintained. A cleaning rota was displayed on the office wall. An up to date risk assessment was in place in respect of safety of the building, and this included information about risks associated with people who used the service. Records maintained at the home showed that safety checks, for example in relation to gas, electricity, fire equipment, and portable electrical appliances, were up to date.

Accident and incident information was appropriately recorded. Staff members described emergency procedures at the home, and we saw evidence that fire drills and fire

## Is the service safe?

safety checks took place regularly. People who used the service told us that they were aware of fire safety procedures and confirmed that they had participated in regular fire drills.

An emergency 'on call' service was in place. This was provided by the manager and deputy manager who alternated on call weeks between them.

# Is the service effective?

## Our findings

People that we spoke with were generally positive about the support that they received from staff members. One person told us that, “they support me with my treatment,” and another said that, “they are supportive.”

We had concerns about the involvement of people in consenting to the support that they received. Some of the care plans and risk assessments that we viewed were not signed by the person to indicate that they agreed with them. One person told us, “I do not have a care plan,” and another said, “I sign my care plan but I do not write it or contribute to it much.”

People who used the service had capacity to make decisions about in relation to decision making. This meant that they were not subject to any restrictions in relation to the Deprivation of Liberty Safeguards that are part of the Mental Capacity Act 2005. The Deprivation of Liberty Safeguards require services to seek authorisation where restrictions are put in place for a person who is assessed as lacking capacity in order to keep them safe in their best interests.

We did not see any policies or procedures that related to The Mental Capacity Act, but there was a policy on The Deprivation of Liberty Safeguards. This was limited and did not refer to the Supreme Court Judgement on Deprivation of Liberty of 19 March 2014. Staff members had received training on the Mental Capacity Act in November 2010, and this would not have included information about the new requirements in respect of Deprivation of Liberty. The manager and deputy manager at the home demonstrated that they understood the requirements, and we were informed that training and policies and procedures would be updated and that training would be put in place to ensure that staff members are aware of these and able to address them should a person who used the service lose capacity in any area of decision making.

The staff members that we spoke with felt that they received the support and information that they required to carry out their duties effectively. Training records were up to date and we saw that staff members had received some training in, for example, Mental Health, Dementia and Epilepsy Awareness, in addition to induction training that met the national Common Induction Standards set by Skills For Care. These set out the minimum training

standards for staff members working in social care services and include, for example, principles of care, safeguarding, and equality and inclusion. We did not ask about the home’s approach to the new Care Certificate for staff members working in social care services, but we saw that the current training programme addressed the outcomes of the certificate.

Staffing records for the service showed that staff had received regular supervision sessions with a manager. There was also recorded evidence of monthly team meetings, and we saw from the recent team meeting minutes that discussions had taken place regarding the quality of care plans, risk assessments and key working records, and how these could be improved. A staff member that we spoke with confirmed that they were aware of the plans to improve the quality of care documentation, and that they would be having an individual meeting with the deputy manager of the service to discuss their role in supporting this.

People were provided with food that met their dietary requirements. One person that we spoke with told us that, “staff support me with my dietary needs.” We saw a menu that showed that people had access to a variety of foods. Breakfast and lunch meals were generally cooked by people who used the service and we saw that a range of foods were available for people to help themselves to within the kitchen area. Evening meals were generally cooked by a member of staff, although some people cooked for themselves. The menus at the home showed that there was a variety of meals provided for evening meals. There was also a record of meals eaten that showed that people had been provided with other choices. People who used the service told us that they liked the food that they were provided with and that they were able to choose when and what they ate. This was confirmed by our observations of people during lunch time.

The kitchen was closed to people who used the service between 10.00pm and 7.00am. We were told that this was due to a specific risk identified for a person and we saw that this information was included in the care plan and risk assessment. However there was no recorded evidence that other people who used the service had been asked for their consent to this. One person told us that they would like to be able to access the kitchen at night to make drinks and snacks. We discussed access to the kitchen at night and the



## Is the service effective?

impact on other people who used the service with the deputy manager for the home. They told us that this was this arrangement would be reviewed to ensure that other people's rights were not unduly restricted.

The care records for people who used the service showed evidence that relevant health and social care professionals were involved in their support. The staff members that we spoke with referred to input from external health and social care professionals. We saw recorded evidence that people had been supported to attend appointments with, for example, psychiatrists, general practitioners, and at local hospitals. There was evidence that members of the local

community mental health team had been involved in meetings about people's care. People who used the service told us that they were supported to make and attend appointments with relevant health professionals. This showed that people were supported to maintain good health, have access to healthcare services and receive on-going healthcare support.

**We recommend that the service finds out more about training for staff, based on current best practice, in relation to The Mental Capacity Act and Deprivation of Liberty Safeguards.**

# Is the service caring?

## Our findings

People that we spoke with were generally positive about the care and support that they received from the staff team. Two people told us that they rated the service “ten out of ten. Staff members communicated with people who used the service in a friendly, respectful and professional way. People who wished to speak with the staff member on shift were given time to discuss their needs.

” for dignity, privacy, respect and care. We were told that, “staff are respectful,” and, “I talk with staff at least three times a day.” People referred to particular staff members that they liked.

We observed that discussions about people’s interests and activities took place and staff members proactively engaged with people when they returned to the home or came into the office. Where the staff member on shift was busy, we saw that they explained this to people and agreed a time when they would be able to talk with them. Staff addressed people in a respectful way and included them in conversations. We were introduced to people and staff members explained why we were at the service and what we were doing.

Three people we spoke with were positive about the information that they received from staff at the home. The fourth person that we spoke told us that they thought that more information could be provided.

People told us that regular residents meetings took place, where people could share their views about the service. We saw notes of these meetings that showed that these were well attended, and that people were consulted about, for example, menus, activities and maintenance issues at the home.

People that we spoke with told us that their privacy and dignity was respected. The privacy and dignity of people were respected. We saw, for example, that people were encouraged to discuss concerns that they had in a place away from interruptions.

Care plans referred to people’s religious and cultural needs. The people we spoke with told us that they felt that these needs were met by the service. For example, one person told us that they were supported to attend a local church, and another informed us that their cultural dietary requirements were supported. We saw that the care plans for these people reflected this.

# Is the service responsive?

## Our findings

We viewed the care documentation for four people. These had been up-dated within the previous six months. Although the care plans provided some assessment information and listed a range of supports to be provided by staff members, there was no detail in relation to how and when these supports should be provided. For example, one person's plan listed referred to a number of activities that they should be doing, but did specify why, nor provide detail of how they would be supported or monitored in achieving these. Another person's care plan specified a risk in relation to their access to the community. However, although it indicated that staff members needed to be aware of when the person was going out, it did not specify the reasons for the risk, nor provide staff with information on what to do if the person did not arrive home.

There was limited evidence of involvement from people in agreeing their care plans. Some plans had not been signed by the person.

We discussed our concerns with the manager and deputy manager and they assured us that actions were in place to improve the quality of care plans. The deputy manager showed us an example of a care plan that he was updating, and we saw that this was clear in relation to activities and outcomes, and provided information about how staff members should support people with these. However this had not yet been agreed with the person, and was not available to staff members.

We noted from the minutes of the most recent staff team meetings that the new manager had identified these issues and had discussed with the staff team ways of improving care plans and making them more person centred. The manager told us that the individual meetings were planned with members of the staff team to discuss the new support planning process, and a staff member that we spoke with confirmed that this was the case.

The home had a complaints procedure, but some people that we spoke with told us that they were unsure of what this was, but they knew who the manager was and would

complain if they needed to. However, we were told that complaints had been made about the fact that the kitchen door was locked from 10pm, and nothing had changed. We did not see recorded evidence of these complaints.

People participated in a range of activities outside the home. Two people did voluntary work and one person went swimming on a regular basis. We were also told of visits to the cinema and to play snooker, although one person told us that they used to go out to activities with staff members, but, "this doesn't happen now." The records of activities held at the home did not accurately reflect what people told us about their activities. For example, a number of activities were recorded as "outing" and there was no further evidence to suggest whether this mean, for example, a trip to the shops or a leisure activity that was relevant to the person's interests. The manager acknowledged that recording of activities was poor and that they would ensure that this would improve in the future.

We saw that people had met regularly with their key worker, and people that we spoke with confirmed this. Most key worker meeting notes indicated a list of activities and tasks that people were required to do, for example in relation to self-care and independent living skills such as cooking, shopping and laundry. However, the notes provided no indication of how they were involved in this process, or whether or not measurable outcomes had been set in relation to these activities. We also noted that key worker meeting notes were not always signed by the person to confirm their agreement with these. People were generally positive about their key worker sessions, but indicated that they would like these meetings to be planned and structured.

Daily care notes were kept and these provided sufficient detail about people issues arising for people on a day to day basis, and how these had been supported.

**We recommend that the provider seeks guidance from a reputable source regarding good practice in the development and recording of care plans, and of involving people in this process.**

# Is the service well-led?

## Our findings

The home had recently appointed a new manager and deputy manager. At the time of our inspection the provider was the registered manager. The new manager told us that they had commenced the process of application to become the registered manager for the home.

We reviewed the policies and procedures in place at the home. Most had been updated in October 2013. The manager told us that these would be updated to ensure that they met current legislation and guidance. We saw that staff members had signed to show that they had read the policies and procedures.

The staff members that we spoke with told us that they felt that the new manager was supportive and approachable. People who used the service felt that the home was well managed. We saw that the manager, deputy manager and provider communicated positively with both people who used the service and the member of staff who were on shift. For example, when people came into the office, we saw that they stopped what they were doing, and spent time talking to the person.

We saw from recent notes of team meetings that the new manager had raised concerns about the quality of care documentation within the home and had discussed plans to ensure that there was a more person centred approach to care and support. They told us that they had concerns

about the lack of detail and guidance contained within care plans and risk assessments. They also informed us that they would be working with team members to develop systems that were more detailed and outcomes based, with the intention of improving the quality of care provided by the service. Meetings had been set up with individual team members to discuss improvements, and we saw that the home had started to amend care plans to reflect these.

The service provider visited the home on a regular basis. We saw that quality assurance processes were in place. These included recorded monthly evaluations of care, environmental and health and health and safety issues. The minutes of the previous two team meetings showed that that quality issues had been discussed, and that actions to address concerns were agreed within the staff team.

The home has accreditation with Investors in People and the staff members that we spoke with were positive about the support and development that they received.

We saw recorded evidence that the home liaised regularly with relevant professionals, including relevant mental health professionals, general practitioners and commissioning authorities. There was recent evidence that the new manager had made contact with relevant social services teams regarding reviews for people who used the service, and that some of these reviews had already taken place..