Turning Point

Turning Point - Hazel House

Inspection report

67 Warwick Road
London
SW5 9HB

Tel: 02072447533
Website: www.turning-point.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Hazel House provides accommodation and support for up to 10 people with mental health needs. The home is situated in Earl's Court and close to community facilities. People are provided with a room and the home is laid out over three floors with shared communal bathrooms, kitchen and an accessible garden. There is no lift and CCTV is installed on the premises. At the time of our inspection there were eight people living in the home.

At the last inspection, the service was rated Good. During this inspection we found the service remained Good. The service remained good because effective care was carried out by staff and the management team who had the skills and knowledge to ensure people received safe care. Health care services were accessed to regularly monitor people's well being and they were supported by staff that provided personalised care and support.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

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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 a comprehensive inspection of Hazel House on 11 and 12 April 2017. The inspection was unannounced and carried out by one inspector.
Before the inspection, we checked information that the Care Quality Commission (CQC) held about the service, which included the previous inspection reports and notifications sent to CQC by the provider before the inspection. The notifications provide us with information about changes to the service and any significant concerns reported by the provider.

During the inspection, we held a house meeting and spoke with five people. We also spoke with a relative and reviewed the records in relation to five people's care. We observed how people received their medicines and how staff handed over their duties to each other after their shifts. We reviewed four staff files, minutes of meetings, quality assurance audits and some of the records relating to the management of the home. We had discussions with the cook, three support workers, the team manager, the senior operations manager and the registered manager.
After the inspection, we contacted the placing authority and obtained information from a health professional about how the provider delivered their service to people in the borough.

Good

Is the service safe?

Our findings

People told us they felt safe living in the home. They commented, "It's good I can go out when I want, I like it here", "I have a mobile phone which helps me a lot I have a few friends I phone" and "I am safe because there is always staff about." Staff understood how to protect people from harm. There was a safeguarding notice board that contained information and advice on how to protect people from abuse and report workplace concerns. This included information on the Mental Health Act to ensure this was applied if people were at risk to themselves or others. Safeguarding was added as an agenda item during staff team meetings and one to one discussions had taken place with people to raise awareness about recognising and reporting any concerns about their safety.

Risk management plans were robust and contained specific guidance about potential risks in relation to people's care and these were kept under review. Plans comprised of information that related to their sexual health, physical and mental well being, medicines, nutrition and their home environment. Existing and new control measures were identified based on the impact of risks and these were followed to reduce the likelihood of harm. For example, staff had assessed a person's mobility needs in relation to their ability to climb the stairs and noted that staff were to monitor their balance and notify the GP if this risk increased.

Recruitment procedures were followed by the provider to ensure thorough backgrounds checks were carried out on staff before they commenced employment. There was sufficient staff to meet people's needs and the people we spoke with confirmed this. Where staff were unavailable due to planned or unplanned leave their shifts were covered by the providers bank staff.

Systems were in place for the safe administration and disposal of medicines. People's medicine records were completed accurately by staff to demonstrate when they had taken their medicines and who administered them. Clear instructions were in place for staff to follow to ensure the safe management of medicines, for example, by ensuring people completed the course of their prescribed medicines. Protocols were followed in the event of medicines errors such as access to the medicines helpline and recording incidents via the providers centralised reporting system. However, we found that temperature checks of the medicines storage were not completed daily to ensure that these were appropriate to maintain the effectiveness of medicines. Temperature checks had been documented in the monthly audit and these were within an acceptable range but there were no records to evidence this was checked daily. We recommend that the provider review their current practice for monitoring and ensuring that medicines are stored safely at an appropriate temperature.

Staff followed the providers infection control procedures to ensure people were safe from harm. We observed staff using personal protective equipment (PPE) when handling people's medicines, and records noted where staff had contacted infection control nursing staff to seek advice on how to best to manage a person's health condition. Areas of the home were clean and free from malodours and information was displayed in reference to the importance of maintaining good infection control. However, we found that the Control of Substances Hazardous to Health (COSSH) cupboard was not locked during our walk around the home. A COSSH cupboard is designed to store items to limit the risk posed by hazardous chemicals. We

asked the staff member to lock this and this was done.

Environmental checks had been carried out in the home to include, legionella testing, room checks and fire evacuation drills. Where people had not responded to fire drills this was recorded and discussed with people to support their understanding of the importance of emergency fire procedures. Water temperature checks were routinely carried out however we found these temperatures had fluctuated above and below the recommended temperature in certain rooms in the home over a period of three months. The registered manager told us they had previously followed this up with an external contractor and agreed to contact them again.

Good

Is the service effective?

Our findings

People were supported by staff who had the skills and knowledge to meet their needs effectively. Records showed there was an induction and training programme for new and existing staff to ensure they were competent and effective in their roles. Systems highlighted where staff were compliant with their training and when this had expired. Training comprised of face to face and e-learning that was reflective of the needs of people who lived in the home. For example, staff received training in topics such as medicines, MCA and DoLS awareness, safeguarding, first aid and positive behaviour support. Staff told us their training was effective because they received clinical supervision to reflect on their practice and skills. Evaluations of staff performance were carried out by the management team and feedback was provided to staff during their annual appraisals.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The management and staff expressed a good understanding of the MCA and were able tell us about people's capacity to make day to day decisions about the care they received. At the time of our inspection no one living at the home was subject to a DoLS authorisation. Best interests meetings had been held with health professionals to determine the best course of action where people were unable to make decisions about aspects of their care. We found for one person a Lasting Power of Attorney (LPA) was sought in relation to their health and welfare. For another person, we found their capacity was assessed regarding their ability to receive care due to the decline in their mental health and we were told the outcome of this. People signed consent forms to agree to community professionals accessing their records when this was deemed appropriate.

People were escorted by staff to access healthcare services. The mode of transportation people used to travel to their health appointments was recorded along with their attendance to visits to the GPs, psychiatrists, nurses and dentists. This was to show how people felt most comfortable accessing the community and how often they accessed healthcare services. The provider had good links with health professionals and specialist organisations that were located within close proximity to the home. Staff explained that where people had refused to attend their GP appointments, they had arranged for the GP to visit them in the home to ensure they received effective healthcare. Where one person required intervention to support them with their personal care, frequent safety checks were carried out by the waking night staff to support them with this.

People were involved in the planning of the menu for their choice of meals. Meals prepared by the cook were homemade, nutritious and served in sufficient quantities. People described the food they preferred to eat and what they disliked. One person told us, "The roast lamb on Sunday I'm always up that for that definitely, when I am here." Some people required support with cooking and other people chose to purchase and prepare their own foods. The kitchen was accessible for people to prepare snacks and use the facilities to cook their own dishes. We checked how food was store, prepared and disposed of and found that good food hygiene practices were adhered to.

Good

Is the service caring?

Our findings

People told us staff were "helpful", said they felt "listened" to and received support when this was needed. Staff knew people well and described how people verbalised their feelings and their responses to this if they were emotionally distressed or chose to spend time on their own. Before attendance at a health appointment we observed that one person became anxious and a staff member explained the reasons why they were anxious before their health care appointment. They commented, "I observe people's moods and understanding of different challenges they have, and what is triggering that mood, it's knowing when to step in and being person centred, it's more than looking at the person's mental health."

People's privacy was respected but not in all areas of their care. There was separate room for staff to support people with their medicines and we observed this was carried out safely but not in a way that respected people's privacy. For example, on three occasions we saw that people entered the room to sit and wait for their medicines whilst the staff member administered each person their medicines. We addressed this with the staff and the registered manager who agreed to discuss this with people to obtain their views about how they would like to receive their medicines. We recommend that the provider review their current practice for administering medicines.

Before we were introduced to people we observed that staff knocked before entering their rooms and on two occasions we saw that staff gave people time to answer questions and respected their decisions. For example, staff asked people if they wished to speak with us during our visit. People were provided with their own key and we saw them enter and leave the building as they wished. Records showed the provider followed the NHS code of practice regarding the retention of documents and people's confidential records were stored securely on the premises.

The importance of people's environment and the positive affect this could have on people's well-being was considered. One person had moved rooms after they requested this to meet their health needs. The registered manager explained that this overlooked the garden and was also one of the bigger rooms, which was beneficial in meeting their health need. One person commented, "I have a nice room with a great view, you could say I like it here." We spoke with one person who was disoriented in the home, and we saw signs had been placed to guide the person to the location of their room and their records documented the reasons for this.

Care plans noted what was most important to people in their lives, such as significant others, relatives and friends and how they chose to spend their day. People's birthdays were highlighted on the staff notice board to remind them of the significant event and how this would be celebrated. One person had made an advanced statement of wishes in relation to their end of life care needs. We spoke with a relative who visited the home and they spoke positively about the support their family member had received before their death.

Good

Is the service responsive?

Our findings

A pre-admission assessment of people's needs was carried out and included the information from the initial referral received from the placing authority. Care plans were detailed and contained personalised information about what people wanted to achieved, what they could do for themselves, and the best person to support them with this. One to one meetings were held weekly with people to check their progress towards meeting their goals. Outcomes showed how people had been supported with their budgeting skills, purchasing new clothes and trips to local attractions. Records noted people's personal histories such as their educational and employment history, current interests, leisurely pursuits they enjoyed and their resettlement needs. On person commented, "I like to relax half the time but I also love a good meal."

People's diverse needs were met. We received information from a health professional about how the provider positively supported a person who lead a transient lifestyle and refused to engage with healthcare services. The provider had worked with the person to engage them in accessing services and subsequently empowered them to make an informed decision to return to their country of origin where they would have greater access to health and social care services to meet their needs.

Staff reminded people to attend their Care Plan Approach (CPA) meetings to discuss matters regarding their mental and physical health in consultation with health professionals. During these meetings people's medicines had been reviewed. Risks were considered before changing people's medicines to ensure this was appropriate. For instance, if there was a history of disengagement or non-attendance at health appointments.

When people moved into the home they were provided with information about their rights and how to access services if they felt their rights were not protected. A service user 'civil rights from' provided information to people about how to make a complaint, the role of the CQC, the frequency of house meetings and how they could access advocacy support, if they wanted to challenge any decisions about their care.

Easy read versions of the provider's procedures were available for people to access if they required this to meet their diverse needs. Notice boards provided information in pictorial formats of events people could be involved with.

People told us they had no complaints about how the service was run and knew who to speak to if they needed to raise any concerns, and felt confident these would be addressed. Systems were in place to monitor and respond to complaints and the procedure was visible on the noticeboard for people to read. The management team told us they had not received any complaints and described how they would resolve concerns if they arose.

Good

Is the service well-led?

Our findings

Audits were carried out by the provider which identified improvements that were needed but these did not identify the shortfalls we found during the inspection in respect of temperature checks of medicines storage and medicines administration procedures. We recommend that the provider seek advice from a reputable source to ensure that more thorough quality monitoring takes place. We observed during the staff handover daily checks and scrutiny of people's medicines and finances were undertaken to reduce any discrepancies or errors.

People told us they liked living at the home and said, "I have not been here long, but I'm quite content "and "I think it's good I can go out when I chose to." There was a registered manager in post who was available during both days of the inspection. They spoke with us about people's needs, what they required and how they were working to achieve this.

We found there were clear lines of accountability and the management team listened to suggestions people and staff had about the service. House meetings were held for people to obtain their suggestions, ideas and keep them informed about matters affecting the home. Surveys had been conducted by a representative of the NHS and the provider told us they were awaiting the outcome of this.

Team Meetings were held regularly and staff were able to voice their opinions in relation to people's responsibilities, and their designated caseloads and duties. Staff told us they felt supported by a management team who were knowledgeable about the type of care people needed. They commented, "I love everything about the place I am definitely well supported and I know who to go to, to ask for advice" and "I think the management are great they look at the resident's needs, what they want, they have an insight to working with people with mental health needs, and a lot more."

A robust central reporting system was used to manage incidents and accidents and drive quality improvements. For example, after a recent death in the service details of the incident were uploaded onto the system. The management teams across the provider's different localities had responded by email to raise questions and make suggestions about how the incident was managed to ensure staff had considered and covered every possible outcome. This included the response from us after the provider had notified the CQC of the incident. The team manger explained the information would be collated and used as evidence to form a clear case review and lessons learned from the death and commented, "Quality control is based on what CQC expects, we are working towards that standard."

The team manager showed us their business continuity plan they had written in preparation for a future meeting to be held with the placing authority. This demonstrated how the service planned to make improvements in areas such as the recruitment and training of staff, their IT systems and the quality of care people received.