M D Homes

Mountview

Inspection report

Rickmansworth Road
Northwood
Middlesex
HA6 2RD

Tel: 01923824826
Website: www.mdhomes.co.uk

Date of inspection visit:
05 April 2016

Date of publication:
03 May 2016

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

The inspection took place on 5 April 2016 and was unannounced.

The last inspection of the service was on 9 September 2013 when we found no breaches of Regulation.

Mountview is a care home for up to ten adults with mental health needs. At the time of our inspection there were ten people living at the service with a range of different needs. The home is owned and managed by MD Homes Limited, a private organisation providing care and nursing homes in Northwest London.

There was a manager in post who has started working at the home one month before the inspection visit. They had not applied to be registered with the Care Quality Commission but told us they were in the process of making the application. 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 and associated Regulations about how the service is run.

People felt safe. Risks to their safety and wellbeing had been assessed and there were action plans in place to minimise the likelihood of harm.

People received their medicines as prescribed and in a safe way.

There were procedures to safeguard people from abuse, which were being followed.

There were enough staff to meet people's needs and they had been suitably recruited.

People's capacity to consent had been assessed and recorded.

People were cared for by staff who were supported, trained and had the information they needed for their role and responsibilities.

People were given the support they needed with regards to their physical and mental health.

People's nutritional needs were being met.

People were treated with respect, kindness and consideration. They had positive relationships with the staff who were caring for them.

People's privacy and dignity was respected.

People's individual needs and preferences were recorded and met.

People knew how to make a complaint and felt their concerns were responded to.

The manager had been recruited shortly before the inspection. The staff found the manager supportive and approachable. The manager had ideas for improving the service which included updating records and the record keeping system.

The provider, staff and manager carried out audits and checks to make sure people were receiving a quality service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe. Risks to their safety and wellbeing had been assessed and there were plans to minimise the likelihood of harm.

People received their medicines as prescribed and in a safe way.

There were procedures to safeguard people from abuse.

There were enough staff and they had been suitably recruited.

Is the service effective?

Good

The service was effective.

People's capacity to consent had been assessed and recorded.

People were cared for by staff who were supported, trained and had the information they needed for their role and responsibilities.

People were given the support they needed with regards to their physical and mental health.

People's nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were treated with respect, kindness and consideration. They had positive relationships with the staff who were caring for them.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People's individual needs and preferences were recorded and met.

People knew how to make a complaint and felt their concerns were responded to.

Is the service well-led?

Good

The service was well-led.

The manager had been recruited shortly before the inspection. The staff found the manager supportive and approachable. The manager had ideas for improving the service which included updating records and the record keeping system.

The provider, staff and manager carried out audits and checks to make sure people were receiving a quality service.

Mountview

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 5 April 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection visit we looked at all the information we held about the provider, including notifications of significant events.

During the inspection visit we met six of the people who lived at the service. We also spoke with the manager, operations director, two care workers, the deputy manager and the chef. We observed how people were being cared for and supported. We looked at the records relating to the care of three people, the recruitment, support and training records for five members of staff, how medicines were stored, administered and recorded and other records the provider used for managing the service.

Good

Is the service safe?

Our findings

People felt safe and secure at the service. One person told us, ''The staff all look after me and reassure me when I am scared. I feel safe when I have spoken with them.''

People received their medicines as prescribed in a safe way. Medicines were stored securely, however, the cabinets used to store medicines were small and cramped and were hard to access because they were positioned behind a door to the room they were in. The manager told us that they had plans to relocate the medicines to another area of the home and in a larger cabinet.

The manager told us that they were in the process of reviewing medicines management at the service. There was an action plan outlining improvements they had identified. Improvements in records relating to medicines were being made. However, we identified a number of areas where there was a risk of problems. For example, there was information about each person's medicines and why they needed to take these, however some of this information needed to be updated. Some people were prescribed PRN (as required) medicines and the information about when these should be administered was not clearly recorded in the person's care plan. The staff told us they counted and checked the number of each type of medicine held at the service each day, but there was no record of this. The manager had also identified these areas of risk and told us the action that was taking place to address these, which included updating records and introducing a recorded tablet count each day.

There were clear and accurate records to show how and when medicines had been administered. People told us the staff helped them to take the medicines they needed.

There was an appropriate procedure for safeguarding vulnerable adults. The staff were aware of this and had undertaken training in this area. They were able to tell us about different types of abuse and what they would do if they suspected someone was at risk. The manager told us that all staff were taking part in an update of safeguarding training shortly after our inspection. This training had been booked and was being provided by an external training company. There was evidence the provider had responded appropriately when people had been placed at risk. For example, within the previous few months there had been an incident where someone had been placed at risk of abuse by someone outside of the service. The staff had reported this to the local safeguarding authority, Care Quality Commission and police. They had supported the person to find out what they wanted to do to keep themselves safe and they had put in place a plan to help prevent further risks of abuse.

The risks to people's safety and wellbeing had been assessed and there were plans to reduce these risks. The identified risks included situations which may occur in the service and in the community. There were also risks associated with people's physical and mental health needs. We saw clearly recorded plans to help manage these risks and support the person. People had been consulted about these plans and, where they had wished to, they had signed their agreement to these. There were safety measures at the service, such as securing sharp knives, which people were aware of and had agreed with. The manager was in the process of updating care plan information, which included risk assessments. Everyone's assessments had been

reviewed in the past month, however the tool the staff used to determine which areas of risk to assess for each person had not been updated since 2012 in some cases. The manager told us that these were being reviewed as part of the review of all records.

We observed the staff supporting people to move safely around the home. For example, the staff supported people using wheelchairs and walking frames. They allowed the person to move at their own pace, removed obstacles and offered support which met their individual mobility need and kept the person safe.

The staff kept a record of accidents and incidents which had occurred at the service. The records included information about what happened directly after the incident and whether the manager and provider were aware. There was also information about whether the incident could have been prevented and any lessons learnt.

The environment was safely maintained. There were emergency call bells available in each room and these were easily accessible. Hazards had been identified and there was appropriate signage where needed. Chemical products were stored securely. The staff conducted daily checks on health and safety, the environment and equipment. There was also evidence of checks by external companies on electrical items, electrical wiring, water and gas safety. There was an up to date fire procedure and risk assessment, regular recorded fire drills and checks on fire safety equipment. Recommendations made by the fire safety officer in November 2015 had been met.

There were enough staff employed to keep people safe and meet their needs. During the day there were two or three care assistants on duty, depending on planned activities for the day. There was also a chef on duty throughout the day and the manager told us that they worked there for part of most days. The manager was also employed to work at one of the provider's other services, which was a short distance from Mountview. The staff told us the manager and provider's senior managers were able to be at the service within a few minutes if emergency support was needed. The staff were aware of emergency procedures and told us they felt well supported if they needed to contact a manager. There was one waking and one sleeping (on call) staff member on duty at night. The manager told us that this level was safe, but that they were hoping to increase the staffing to two waking members of staff because many of the service users stayed up late or rose early and they felt more support could be offered by two waking members of staff. The manager told us that they did not currently use agency staff. They were advertising to employ bank (peripatetic) staff so that staff absences and holidays could be covered by a familiar and consistent team.

The provider had an appropriate procedure for recruiting staff. This included an interview with the manager at the service. The manager told us they had recently interviewed a number of potential staff. The provider's head office carried out checks on staff suitability, including references from previous employers, criminal record checks, identification and eligibility to work in the United Kingdom. We saw evidence of staff interviews and recruitment checks in the staff files we viewed.

Good

Is the service effective?

Our findings

People's capacity to consent had been assessed and recorded. Care plans and risk assessments had been discussed with the person they were about and people had signed their agreement to these. Where people had agreed but refused to sign this had been recorded. Some of the assessments and records of consent had not been updated or reviewed for over a year, therefore if there had been a change in people's needs and care plan there was no record of the person's consent to these changes. The manager told us they were in the process of updating this information and we saw that some assessments had been updated and people had been asked to consent to new care plans.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

One person had been assessed as lacking capacity to make specific decisions. There had been a DoLS authorisation made in the past, however this had expired. The previous manager had applied for further authorisation to restrict the person's freedoms in October 2015 because they had assessed this remained in the person's best interests. However, they had not received authorisation from the appropriate authority. The manager agreed to follow this up, find out why there had been a delay and obtain the authorisation needed.

Other people living at the service had been assessed as having capacity to make decisions about their care. For one person we saw that some restrictions were in place, for example the staff looked after the person's cigarettes and controlled the number of these the person was allowed each day. The staff explained that this was to support the person to manage their finances as they could only afford a certain number of cigarettes each day. However, there was no written agreement to this restriction, and although the staff told us the person was happy with the arrangement, there was no evidence of this. The manager acknowledged that the restriction should not have been put on the person without their consent and that this needed to be recorded. They agreed to rectify this immediately. The service was a recovery unit for people with mental health needs and as part of their recovery it was sometimes necessary to agree certain rules which might have a restrictive nature. Some of these were recorded in risk assessments and care plans. However, the manager told us that recorded information needed to be updated so that staff were aware that these restrictions were only lawful if the person agreed to them and that they had the right to change their minds.

The staff had received training regarding the Mental Capacity Act 2005 and were able to tell us about this. The manager had organised for further training for the staff which was due to take place the week after our inspection.

People were cared for by staff who were supported, trained and had the information they needed for their role and responsibilities. The staff told us they felt supported and worked well as a team. The manager had been in post for four weeks and the staff told us they felt supported by them. They told us there was good informal support and the manager had met with them all as a team. However, there were no recorded individual staff supervision records or appraisals of staff performance since 2014. The manager showed us they had a plan to ensure they met with all staff individually every other month, and held an annual appraisal of their work. They also planned regular team meetings. The staff told us they could approach the manager and deputy manager with any questions or concerns. There was a daily handover of information for all the staff to discuss people's needs and any changes at the service.

New staff were expected to undertake a range of training, which included classrooms and computer based training. The training included assessments of the staff member's learning. There was an induction workbook which included information about the service and the provider's policies and procedures. New staff completed this with the manager or senior staff. There was evidence all staff had received training in safeguarding adults, health and safety, infection control, safe manual handling, food hygiene and the Mental Capacity Act 2005. The manager told us that additional training had been organised in some areas to refresh staff knowledge and this was taking place shortly after the inspection. The provider was supporting senior staff to become qualified manual handling trainers so they could train and support other staff. The staff told us they had found the training valuable. However, they said they had not received training about different mental health conditions and the specific needs of people who lived at the service. We discussed this with the manager who told us the local Community Mental Health team would be providing some of this training for the staff in the future and they were in the process of organising this.

People were given the support they needed with regards to their physical and mental health. People told us they had the support they needed. Their healthcare needs had been assessed and were recorded in care plans. There was evidence individual needs were reviewed regularly. People were supported to attend healthcare appointments with other professionals. However, the records of these were not always clear and therefore it was difficult for the staff to see if other professionals had recommended any changes to people's care and support.

People's nutritional needs were met. People told us they liked the food and were given choices. The provider employed a chef who prepared the majority of meals. They told us they met with each person and discussed the menu they would like each week. We saw evidence of this. There were a range of photographs to help people make choices about meals and photographs of the meals on the day's menu were on display. The chef had a good awareness of people's individual preferences and dietary needs. There was a choice of food at each meal and the chef gave us examples about how they catered for individual tastes. We saw this was the case during the lunch time meal.

People were supported to prepare their own drinks and snacks. The staff told us some people liked making meals and baking. People were offered hot and cold drinks and snacks throughout the day and were provided with food when they asked for anything.

Individual nutritional needs had been assessed and these were reviewed monthly.

Good

Is the service caring?

Our findings

People told us the staff were kind and caring. They said they helped them and reassured them whenever they needed. We saw that people living at the service had good relationships with the staff. They shared discussions about common interests and jokes. The staff checked on people's wellbeing and offered them comfort and support when they needed.

The staff knew people's needs well. They spoke positively about people and showed genuine affection towards them. The atmosphere at the service was calm and relaxed. People were able to spend time together or on their own. The staff were aware of people who appeared distressed and responded appropriately to this.

People's privacy was respected. Everyone had their own bedroom with en suite facilities. The staff knocked on people's doors and waited for an answer before entering. People were called by their preferred names and the staff showed them respect when addressing them.

People were supported to gain knew skills and to be independent where they were able. For example, one person told us they washed their own clothes. People were supported to understand their finances, to budget and plan for their own needs. They were able to use the kitchen to make themselves food and drink. Care plans identified where people wanted to be independent and we saw these were followed.

People were supported to pursue their cultural and religious needs. For example, cultural dietary preferences were respected.

Care plans included information about people's wishes for care and support at the end of their lives. These included evidence of discussion with the person and their agreement to the plan.

Good

Is the service responsive?

Our findings

People told us they had been consulted and involved in planning their own care. The staff had created care plans for each person which included information about their wishes, preferences and individual needs. The care plans details about the support each person needed from the staff. Care plans had been reviewed and updated monthly. However, some information was not always clearly recorded and presented. Where there had been changes in people's needs, information about past and present needs was not always clearly separated. The manager was in the process of reviewing the information and updating all care plans in a new format which was clearer and easier to understand.

People's needs were met by the staff. They were given support which was person centred and reflected their preferences. People were given support to learn new skills and the manager told us they wanted to support people further in this area. Some people had voluntary jobs in the community and the staff were supporting others to investigate the possibility of work or voluntary jobs.

The staff supported people to participate in individual and group activities. During our inspection the staff supported different people with leisure activities, such as card and board games, playing music and spending time discussing their interests. The staff supported people to pursue activities they were interested in.

There was an appropriate complaints procedure and people told us they knew how to make a complaint and felt confident these would be responded to. There had not been any formal complaints at the service.

Good

Is the service well-led?

Our findings

The manager had been in post since the beginning of March 2016. He was in the process of applying to be registered with the Care Quality Commission. People living at the service and the staff told us they felt the manager was approachable and supportive.

People told us they were able to contribute their ideas and opinions. The manager said that they wished to invite relatives to a meeting so their opinions and views could be considered. The manager also planned to improve the service's involvement with the local community. They had made contact with some local charities and were hoping people living at the service could be involved in fundraising for and volunteering with these.

The manager told us they had invited the local Community Mental Health team to visit the service and meet with staff, to provide guidance, training and to discuss the specific needs of people who lived there.

The service was managed and run by MD Homes Limited, a private company who ran five residential and nursing homes in Northwest London. People living at the service and the staff told us the provider was supportive and they felt the service was well managed. The staff told us they could ask for assistance, equipment or support from the provider and they felt listened to and valued.

The records at the service included information required by the Regulations and these were up to date. However, some information was not clearly recorded and old information had not always been archived. Therefore it was not always easy to distinguish old information from newer guidance and care plans. The manager had already identified this issue and was in the process of updating all records and reorganising record keeping at the service, so that information would be easier to access and clearer in the future.

The provider, manager and staff undertook a range of audits and checks on the service. These included checks on the safety of the environments and equipment, audits of care plans, audits of medicines. There was a record of audits and action had been taken where concerns were identified. The provider had responded to requirements and checks made by other agencies. For example, there had been requirements as a result of the most recent visit to the service by the environmental health officer and fire officer. The provider had taken the required action and updated these agencies with the improvements they had made.

Notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required.