Instant Care Solutions Limited

Great West Lodge

Inspection report

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Hounslow
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Tel: 02085819313

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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

The inspection took place on 27 March 2018 and was unannounced. This was the first inspection of the service since it had been registered in May 2017.

The home is one of two care homes owned by Instant Care Solutions that supports people with mental health needs. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection seven out of a maximum capacity of nine people were living at the service.

There was a registered manager in post. 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.

During the inspection we found the provider had procedures in place to protect people from abuse. Staff we spoke with knew how to respond to safeguarding concerns. People had risk assessments and management plans in place to minimise risks.

Medicines were managed safely and staff had appropriate training. As the service had only been open a year, all staff had medicines competency testing within the last year when they were trained and inducted, but any medicines competency testing since the training had not been written down even though the registered manager told us they were undertaking this task. They agreed to keep written records of competency testing and observations in future. Weekly medicines audits indicated that people were receiving their medicines safely and as prescribed.

Staff had completed training in infection control and food hygiene so they could reduce infections and cross contamination.

Staff had up to date relevant training, supervision and annual appraisals to develop the necessary skills to support people using the service. Safe recruitment procedures were followed to ensure staff were suitable to work with people and we saw there were enough staff to meet the needs of people using the service.

People's dietary and health needs had been assessed and recorded so any dietary or nutritional needs could be met.

The service worked well with other professionals and we saw evidence that people were supported to maintain healthier lives and access healthcare services appropriately.

People were supported to have maximum choice and control of their lives and staff were responsive to

individual needs and preferences.

We observed people were treated with respect, were involved in planning their care and made their own day to day decisions. Care plans contained the required information to give staff guidelines to effectively care for people in their preferred manner.

There was a complaints procedure in place, however the service had not had any complaints in the last year.

Feedback indicated the service fostered an open culture and positive communication. People using the service and staff told us the registered manager was available and listened to them.

The service had a number of systems in place to monitor, manage and improve service delivery to improve the care and support provided to people. This included a complaints system, service audits and satisfaction surveys.

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.

Safeguarding and whistle blowing policies were up to date. Saff followed these and knew how to respond to safeguarding concerns.

People had risk assessments and risk management plans to minimise the risk of harm and knew how to respond to incidents and accidents.

Safe recruitment procedures were followed to ensure staff were suitable to work with people using the service.

The provider ensured staff had the relevant training, and had audits in place for the safe management of medicines.

The provider had infection control procedures in place which were followed by staff.

Is the service effective?

Good

The service was effective.

The provider acted in accordance with the requirements of the Mental Capacity Act (2005) to promote people's rights.

People's physical, mental health and social needs were assessed prior to their move to the home.

Staff were supported to develop professionally through, training, supervision and appraisals.

People's dietary and health needs had been assessed and recorded and were monitored.

Is the service caring?

Good

The service was caring.

People using the service said they were treated kindly and with respect.

Care plans identified people's needs and preferences and provided staff with guidelines to effectively care for people in a way that met people's needs.

People were able to express their views and be involved in day to day decision making.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care. Care plans included people's preferences and guidance on how to support them. Reviews were held regularly.

The service had a complaints procedure and people knew how to make a complaint if they wished to.

People had their advanced wishes for end of life care recorded so staff were aware of these and were prepared to meet these if they developed.

Is the service well-led?

Good

The service was well led.

People using the service and staff had the opportunity to provide feedback to improve service delivery.

The provider had a number of data management and audit systems in place to monitor the quality of the care provided.

People and staff were able to approach the registered manager to discuss any aspects of their work and felt supported.

Great West Lodge

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.

The inspection took place on 27 March 2018 and was unannounced. The inspection was carried out by one inspector.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We contacted the local authority's safeguarding and commissioning teams to gather information about their views of the service and received feedback from the clinical commissioning group (CCG).

During the inspection we spoke with five people using the service, the registered manager and two care workers. We observed the care and support being delivered to help us understand people's experiences of using the service. We viewed the care records of four people using the service and six staff files that included recruitment and training records. We also looked at medicines management for one person who used the service and records relating to the management of the service including service checks and audits. After the inspection we received feedback from two healthcare professionals.

Good

Is the service safe?

Our findings

People using the service told us they felt safe. Their comments included, "I definitely feel safe ever since I moved in and it's been a nice journey over a difficult period", "It's a safe place", "I feel safe here. I have a door lock and keys but I trust the people here. I could lock the bedroom door but I don't. Staff knock on my door and say [name]" and "It's safe here. My bedroom is locked from inside."

We saw there were systems in place to help safeguard people from abuse. Safeguarding policies and the whistleblowing policy were up to date and people's resident information packs had contact information for the local authority's safeguarding team. Support workers we spoke with had attended safeguarding adults training, were able to identify the types of abuse and knew how to respond. A social care professional told us, "Regarding service users placed at Great West Lodge we have not had any concerns regarding any safeguarding issues. The [care home] communicates promptly by telephone if they have any concerns otherwise we have a handover prior to seeing the service user and after seeing the service user."

Where there were risks to people's safety and wellbeing, these had been assessed. People's risk management plans recorded how people might respond if they were unwell and what strategies had and had not been helpful to them in the past, so staff had clear guidance on how to support people and minimise risks. Risk assessments were summed up in a tick list with additional fully completed risk assessments and risk management plans. These included areas such as neglect, suicidal ideation, self-catering and aggression. Triggers and indicators were noted for staff to be aware of and agreed responses were recorded to try and deescalate the situation.

The provider had an incident and accident file but had not had any incidents and accidents. Any incidents of behaviour that challenged were recorded separately on line. These records included the person's behaviour, the action taken and/or action planned and how the situation was resolved. This meant the provider could see patterns and take preventative action.

The provider had checks in place to ensure the environment was safe. These included monthly health and safety checks and a health and safety audit. A copy of the fire escape plan was kept in people's rooms and each person had a personal emergency evacuation plan (PEEP). The provider had a smoking policy and people smoked in the identified smoking area only. On person said, "We can't smoke in the house so we have a gazebo to smoke in so we stay dry in the rain." A health professional said that an example of the provider's good practice was, "Maintaining a consistent zero tolerance to alcohol and illicit substance misuse within the premises including no smoking within the building apart from the designated areas."

We looked at six staff files and saw the provider had systems in place to ensure support workers were suitable to work with people using the service. The files contained checks and records including applications, interview records, two references, identification documents with proof of permission to work in the UK if required and Disclosure and Barring Service criminal record checks.

There were a sufficient number of staff deployed with the right skills to meet people's needs. A support

worker and senior staff were always on shift and the registered manager spent time at the service each day. If a person required support to an appointment, an additional member of staff was rostered to escort them and an activity co-ordinator came in several times a week or met people in the community. A health care professional said it was helpful "having regular staff on duty".

Each person's medicines were kept in a locked cabinet in their room and no one was self-administering medicines. However we did see people's independence in this area was being promoted as some people were responsible for alerting staff to when they were due their medicines.

Medicines were on a 28 day cycle and we saw a record of medicines received and stock checks completed. Medicines administration records (MAR) were filled out correctly and included a photograph, allergy information, a list of each medicine with any specific administration instructions and a review date. The provider had an up to date medicines policy which included PRN (as required medicines) guidelines. No one was currently receiving PRN medicines but we saw old records that had detailed guidance.

Staff had completed annual medicines training on line and then had one month of observations with the team leader. Additionally the local pharmacist had provided medicines work books for staff to complete and planned to follow this up with face to face training.

The registered manager said he undertook regular medicines competency assessments but was not writing them down. He agreed in future he would keep a written record of all assessments and not just the ones completed after training. However, as the service was newly opened and staff had medicines training and competency testing as part of their initial training with the service within the last year, we found that medicines were being administered safely.

The provider had an infection control policy in place to help protect people from the risk of infection. Support workers undertook the appropriate training in infection control and food hygiene safety and used appropriate protective equipment as required. The home was clean and well-kept. Social care and health professionals said, "The hostel has a high standard of cleanliness and amenities at residents disposal" and that they have "high standards of hygiene."

The registered manager was open to learning and told us there had been a learning curve regarding people smoking. When the service opened they tried to implement a no smoking policy and did not have a smoking area. However the registered manager noted that "residents should be able to express what they want to do" and after talking with people in residents' meetings, the provider built a gazebo in the garden to accommodate people smoking.

If issues arose with people using the service, the provider was proactive in liaising with other professionals to improve or resolve the situation as quickly as possible. A health professional told us, "We have seen some remarkable improvements including longer gaps between admissions, reduction in harmful or anti-social behaviour and increased independence - with some clients able to step down to less highly staffed settings."

Good

Is the service effective?

Our findings

People's needs were assessed prior to moving to the home. People had been involved in their assessment and it included communication, medicines, mental health needs, food and diet requirements, mobility and personal care needs. People using the service had been placed by local authorities or clinical commissioning groups (CCG) which also provided background information and assessments as part of the provider's assessment process to ensure the service could meet the needs of the people being referred to them.

All staff had completed a number of relevant courses identified as mandatory by the provider which helped to provide staff with the skills and knowledge required to deliver effective care. This included medicines administration, health and safety, infection control, food hygiene, safeguarding and Mental Capacity Act 2005 (MCA). Staff completed an induction that included training and shadowing and then began completing their care certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to care workers roles and responsibilities within a care setting. Staff also undertook training that was specific to the people they were supporting and told us they had completed drug and alcohol training and had started work books for a mental health course they were undertaking. Staff were supported to develop professionally through supervisions and appraisals. Some staff member's files had competency assessments that covered all areas of their practice. However, not all staff had them and of those who did, not all were signed off. The registered manager told us they planned to complete these for all staff on an annual basis.

People's dietary needs were identified and food preferences discussed so people could be supported to eat and drink enough to maintain a balanced diet. We observed people going to the kitchen and helping themselves and staff cooking fresh meals. Fruit and meats were purchased daily. One staff member said, "We cook freshly every day and we tell staff in handover if [people] don't eat and we check weight monthly. At residents' meetings we talk about the menu." People using the service were generally happy with the menus and told us, "They put on a week's menu that they think will be suitable for us so a meat dish and a vegetarian dish. We do have a say in what we eat. [Person] doesn't eat fish or pasta, so they cook him something else. It's flexible", "They've got some good chefs here. Every time I eat, it's a real experience. It's really nice and I enjoy it with others. We can [eat] later if we want to", and "The food is okay here. We have house meetings and talk about food." One person said, "I don't really like the food. They said I could cook for myself." When we fed this back to the registered manger they said they would discuss this with the person. Staff met with people using the service every quarter to design a new menu and we saw that the seven out of ten food satisfaction surveys that had been completed rated the food 'good' to 'very good'.

The staff team was small and worked well together. Staff had a handover once a day and kept a written record of it, so all staff could see what had happened that day. Feedback from other health and social care professionals was very positive about communication and included, "When there have been incidents or problems with a placement they have been extremely proactive in keeping us informed and asking for our involvement where necessary. They also maintain good contact on an ongoing basis and are quick to respond to referrals or other requests from our side" and "Communication is made by telephone when there

are urgent issues to be communicated and addressed. Emails are used for appointments and feedback. Face to face contact is made when reviews have been arranged. In all meetings the clients are supported by their key worker and more often accompanied by the manager. Communication is quite effective."

We saw evidence that people's day-to-day health needs were being met and that they had access to various healthcare professionals in a timely manner. One healthcare professional said," If anything, the level of monitoring and support identifies any changes in clients' presentation which is recorded and reported to the respective community mental health teams. Urgent reviews have been organised for such cases with some medication adjustments and care plan reviews taking place. It is pleasing to note that none of the cases who have shown signs of deterioration in their mental health have been supported intensively without being readmitted into hospital." Where required, we saw evidence of blood pressure, weight, pulse and blood sugar monitoring records. People were supported to appointments and one person said, "Here they take you where you want to go in the car; to the doctor, dentist, chiropodist or psychiatrist."

People using the service all had en-suite rooms which were decorated to their tastes. The communal rooms were well kept and there was a large enclosed garden.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We found signed records of consent to various activities that included use of photographs and involvement in care plans. No one using the service required a DoLS authorisation and people were making their own choices about day to day activities. One person said, "I can make my own choice about when I get up." Staff members received training in MCA and demonstrated an understanding of the principles of the Act. One staff member told us, "Everyone has a right to take their own decisions. We have to asses if people have capacity. If we do assess and they don't have capacity, we go to DoLS." We saw people were asked what they would like and consent was sought, for example around what activities people wanted to participate in. Through care plans and one to one key working sessions there was evidence that people were consulted about their care and support.

Good

Is the service caring?

Our findings

People were treated with care and kindness and staff were available. People using the service were happy with the care and support they received from staff and told us, "They cater for all our needs. They look out for us and show compassion and caring by making sure all our needs are met", "Everyone is really respectful here", "It's all right. The staff are reasonable", "I'm so pleased to be here. We're used to the support workers. They seem quite jolly and happy. They put things right that are wrong. They explain things", "Staff are nice. They help us. They're like angels" and "It's not that bad. Staff are okay here. They cook and clean for us."

People we spoke with indicated they were able to express their views and were involved in planning their care. One person said, "I go to any of the staff. I approach who seems available. They do listen and take notice." A staff member said, "People communicate to us what they like and don't like and we observe what they like, for example what time they get up. Most of them set their own routine. The care plan also says what the person prefers and once a month we do a one to one with them." The registered manager talked with us about changing activities to suit people's preferences and said, "It's about them. They don't live in our workplace, we work in their house and we're happy to try [new] things." A healthcare professional said, "There is clear evidence of working collaboratively with clients and supporting them to understand the impact of substance misuse including escorting them to their reviews. [Staff] treat all residents with dignity and respect and support them in taking ownership of their premises."

In addition to one to one key working sessions, the provider had residents' meetings. People commented, "We have residents meetings once a month. They're pretty good. We talk about health and safety and fire exits" and "We have house meetings. They ask everyone about the help they need." This was confirmed when we saw meeting minutes that included discussions around health and safety, healthy eating, activities and sharing ideas for improvement.

Care plans had information about people's preferences and included any cultural or religious needs. People using the service were fairly independent and one staff member observed, "Most people have relatives to be in touch with their cultural events. We celebrate English holidays because we are all from different places."

We observed interactions between people using the service and staff were respectful and were aware of people's interests and needs. People told us that their privacy was respected and that staff knocked on their doors prior to entering. People showed us they had keys to their rooms so they could lock them if they chose to.

Relatives were welcome to the service and people had access to advocacy services to help them with making decisions if this was needed. The resident information pack had the complaints procedure and provided contact information for two local advocacy services. Other contact numbers included safeguarding teams, the police and CQC. This meant people had access to external agencies to help keep them safe and promote their interests.

Good

Is the service responsive?

Our findings

People told us they were involved in the development of their care plans and reviews. We saw copies of care plans in people's rooms and one person said, "I have a care plan in my room. We reviewed it about six months ago and went over the basics." A social care professional said, The service they provide reflects the care plan. Staff are always supporting the service user in what he wishes to do and in fact go the extra mile in helping. [For example],the service user has had lessons from staff on using the computer to access emails and basic use of the computer."

The care plans we viewed were all comprehensive, person centred and regularly reviewed with the person whose care plan it was. Each care plan had an aim and an objective with short and long term goals. The goals were clearly set out with steps on how to achieve them and who should be involved in achieving them. The care plans were developed using information from people using the service and other professionals involved in their care. In addition a daily log was completed by staff that was mostly task orientated but indicated people were receiving support in line with their care plans.

The service had an activity co-ordinator who supported people to access activities of their choosing. Activities included going shopping or to a café, playing football and basketball in the garden, going to the gym, swimming or playing board games in the home. The provider was planning to have a vegetable plot this summer as one of the people using the service liked to garden. Additionally people were supported to access community services and work programmes. As people were able to go out independently they generally felt the amount of activities were sufficient. Comments included, "We are all looking for employment or studies and that falls to [the activity co-ordinator]. She found me volunteer employment [locally]", "We're free to do what we want pretty much all day", "On Wednesday we go to the cinema or bowling. On Monday, I can go to exercise. I go out three times a day walking" and "We have in house activities like cinema and dominos." A health care professional commented, "The progress that most of the very challenging clients have made since moving into Great West Road Lodge is remarkable. They have turned around from being non engaging, neglecting themselves, smoking and taking illicit substance mostly to being active, interactive and participating in a variety of activities both indoors and outdoors."

The service had a complaints procedure but had not had any complaints. People we spoke with knew how to make a complaint, which was included in the resident information packs. Comments included, "They [staff] told us how to make a complaint. We get a complaint form from the office", "If I wanted to make a complaint, I ask one of the staff", "There is a complaints procedure in a file and on the wall in my bedroom. I would tell them [staff] rather than write it" and "If I have a complaint, I speak to [registered manager] or staff. It's a good place."

The service did not provide palliative care, but the care plan included an advanced statement from people using the service so staff were aware of these and could work with people should they develop any end of life care needs. We discussed making this more detailed, which the registered manager agreed to do.

Good

Is the service well-led?

Our findings

The culture of the service was positive and promoted open, honest communication. The staff team and registered manger were available to people using the service and the feedback we had from people was that they were approachable and listened. Comments included, "[Registered manager] is around quite a lot. He's always got an open ear. Very friendly guy. He's been supportive the whole time I've been here. All members of staff are good" and "[Registered manager] is around. He'll work out things for you. [He] is a smashing chap."

Staff also found the registered manager approachable and told us, "[The home] is small so we are always working with the manager. He is very good and very understanding. Any problem we can contact him. There's good teamwork" and "They're open and they let me know how things are done. [For example] I have been to an assessment with [the registered manager], so I am learning from the start here."

The provider had a number of data management systems in place to monitor service delivery. Audits included medicines and fire equipment and daily checks included cleaning checklists and fridge and freezer temperatures. In November 2017, the provider completed a quality assurance audit of all aspects of the service that included the environment, staff training, menus and recorded information including people's care plans. The monthly health and safety check covered all areas of the home and had an action plan to improve the service. For example to check the smoking area twice a day to ensure it was clean. The registered manager also used a training data base on a traffic light system to record completed staff training and when new training was due. The audits and checks provided the registered manager with an overview of the service so they could respond to issues, minimise risks and improve service delivery.

The provider received feedback and shared information through monthly team meetings and residents' meetings. We viewed the minutes and saw that items discussed included sharing ideas, healthy eating, health and safety checks and learning and development. They also used completed service satisfaction surveys from people using the service, staff and other professionals to gain feedback. Seven out of ten people using the service completed the survey and indicated they were happy with the service provided, as did care staff and one social worker who completed a survey.

Policies and procedures had been reviewed in the last year and contained relevant legislation and guidance for good practice. The registered manager notified the Care Quality Commission of specific incidents as required. The registered manager kept up to date with good practice through reading a number of social care magazines and received emails from the local authority and the NHS with updated guidance.

The provider worked closely with the mental health team and other professionals such as social workers, GPs and the police who were very positive about the care and treatment provided by the service. A clinical commissioning group (CCG) professional said, "They are working effectively with some of our most complex and challenging clients - some of whom have had multiple failed placements elsewhere and for whom this is the first service to succeed in engaging them or supporting their recovery."