Social Care Aspirations Ltd

Grosvenor House

Inspection report

29 Grosvenor Road
Hounslow
Middlesex
TW3 3ER

Tel: 02085695147
Website: www.socialcareaspirations.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 31 January 2017 and was unannounced. The previous inspection took place on 24 March 2015 at which time the service was meeting all regulatory requirements.

Grosvenor House is a care home for up to six people with learning disabilities registered to provide accommodation and personal care. The service has never accommodated more than four people in residence. Prior to our inspection, there had been three people using the service, however on the morning of our inspection one of the three people moved out, leaving only two people currently using the service. We have therefore attempted to protect people's anonymity as far as possible.

The nominated individual and owner was on site daily and the registered manager had been in post since March 2014. 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.

During the inspection we saw the service did not always have robust risk assessments in place to minimise harm and safeguard people using the service.

The principles of the Mental Capacity Act 2005 were not always followed, as the registered manager did not renew a Deprivation of Liberty Safeguards (DoLS) authorisation in a timely manner.

There were a number of service checks carried out to ensure the environment was safe. However, audits were not in place to monitor training and DoLS applications effectively. Additionally, the service had failed to raise a safeguarding notification as required by the Care Quality Commission.

Safe recruitment procedures were initially followed but one care worker had a Disclosure and Barring Service (DBS) check from 2012, which meant we could not be sure they were suitable to work with people using the service. However, after the inspection, the registered manager provided evidence of an up to date check.

The service had not undertaken refresher training on mandatory training or completed ongoing competency assessments to ensure care workers had the skills required to support people using the service. However, after the inspection, the registered manager provided evidence that care workers had completed up to date training. Supervisions and appraisals were up to date which contributed to the development of care workers' skills and enabled them to carry out their duties.

People received their medicines in a safe way.

People using the service were supported to access activities both inside and outside the home.

Care workers knew how to respond if they suspected abuse and there were enough care workers to support and meet people's needs.

People were supported to have enough to eat and drink and were offered refreshments throughout the day.

People had access to health care services and the service worked with other community based agencies.

We observed care workers were kind, respected people's dignity and privacy and were aware of people's individual needs and preferences.

An appropriate complaints procedure was available.

Relatives and care workers indicated they could speak to the registered manager about concerns.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding safe care and treatment, staffing, the need for consent and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk management plans were not robust enough and therefore harm to people using the service was not effectively minimised. However, care workers knew how to respond if they suspected abuse.

Safe recruitment procedures were initially followed but during the inspection we saw an out of date Disclosure and Barring Service (DBS) check. After the inspection, the registered manager provided evidence of an updated check.

There were systems in place to manage people's monies safely.

A number of health and safety checks were completed.

There were enough care workers to meet the needs of people using the service.

Medicines were managed in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 were not always followed as the registered manager did not renew a Deprivation of Liberty Safeguards (DoLS) authorisation in a timely manner.

During the inspection, we did not see refresher training or competency testing being undertaken which meant we could not be sure care workers' skills were up to date and competency maintained. However, after the inspection the registered manager provided evidence of up to date training.

Care workers had a good understanding of the needs of the people using the service and had the opportunity to develop their skills through inductions, supervisions and appraisals.

People were supported with food and drink to meet their individual needs.

People's healthcare needs were met and we saw evidence of involvement with relevant healthcare professionals.

Is the service caring?

Good

The service was caring.

People using the service had developed positive relationships with care workers.

People's privacy and dignity were respected.

People were supported to maintain relationships with family and friends and relatives were informed about changes to people's health and wellbeing.

Is the service responsive?

Good

The service was responsive.

Care workers were aware of people's individual needs and they were able to identify the routines and preferences of people living in the service.

We saw evidence that people using the service and their relatives were involved in planning people's care and were present at care plan reviews which were held annually.

People using the service were supported to access activities both inside and outside the home.

There was a complaints procedure. Care workers and relatives said they would speak with the registered manager about concerns they had.

Is the service well-led?

Requires Improvement

The service was not always well led as the provider's audits had not identified training or the need to renew a DoLS application. In addition, the service had failed to raise an incident notification as required by the Care Quality Commission.

The service had some systems to monitor the quality of the service delivered and service checks were carried out to ensure the environment was safe.

All stakeholders felt able to raise concerns with the registered manager.

Grosvenor 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 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 31 January 2017. It was unannounced and conducted by a single inspector.

Prior to the inspection, we looked at all the information we held on the service including the last inspection report, 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 also contacted the local authority's Commissioning Team and Safeguarding Team.

Of the two people using the service on the day of the inspection, one person did not want to talk with us and stayed in their bedroom and the other person was not able to give us feedback about how they felt about the service because of their disabilities. We spoke with the registered manager, the nominated individual who was also the owner and two care workers. Following the inspection, we received feedback from two relatives, a health care proffessional and two social care professionals.

We looked at the care plans for both people using the service. We also saw files for four care workers which included recruitment records, supervisions, appraisals and training records.

We looked at medicines management for people who used the service. Additionally we looked at the environment, maintenance, servicing checks and audits.

Requires Improvement

Is the service safe?

Our findings

We saw each person had up to date risk assessments but for one person the risk management plan was not robust enough. The plan said (person) was "advised to refrain from going out on his own" and we could see there were concerns recorded regarding road safety awareness. However, we also saw that the person did not have any restrictions on leaving the premises and did go to the local shop alone. The registered manager told us when the person went out, they informed care workers and action would be taken if the person did not return in a reasonable amount of time. This was not clearly recorded, and the lack of guidance meant risk was not adequately minimised to keep the person safe from harm. Furthermore, although the service considered the person able to go out without supervision, the social worker had requested that the registered manager make an application to deprive the person of their liberty and restrict their movement. Consequently, it was not clear what the person's level of ability was and if it was reasonable for them to leave the home unaccompanied. After the inspection the registered manager provided us with evidence of an updated risk management plan stating the person would be accompanied when they went out. However, it did not indicate how to manage the risk if the person did not want to be accompanied, as this was something they had indicated in the past. Therefore, the risk management plan was not robust enough to effectively manage the risks associated with the person going into the community.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives of the people using the service told us, "He's safe there. He has good supervision with the care workers" and "The welfare and safeguarding are good." We saw evidence that safeguarding and whistleblowing had been raised in team meetings in the last year. Care workers we spoke with had undertaken safeguarding training, were able to identify various types of abuse and knew how to respond. One care worker explained the types of abuse and said if they saw a change in behaviour, that could be an indicator of abuse. Another said, "If I suspected a service user being abused I would discuss with my senior person and if they were not available, talk to the manager."

The service followed safe recruitment procedures to ensure care workers were suitable to work with people using the service. There was evidence care workers had two references, Disclosure and Barring Service (DBS) checks, proof of identity and had the right to work in the UK. However, we saw one care worker's DBS was dated from April 2012, which meant we could not be sure people using the service were supported by suitable staff. The registered manager said they would immediately apply for a new DBS and after the inspection, they provided us with evidence that a new DBS had been received 14 March 2017.

The service had a finance policy and systems were in place for the safe management of people's personal finances. We saw receipts for purchases were kept and reconciled with people's individual records. The registered manager carried out weekly checks to ensure the correct procedures were being followed to manage people's money safely. There was evidence that when a safeguarding concern around finances had arisen, the registered manager reported it to the local authority's safeguarding team.

In May 2016, the London Fire and Emergency Planning Service served an enforcement notice on the property listing a number of areas requiring action. In September 2016, the Fire Service confirmed to the Care Quality Commission they had revisited the premises and the service was now compliant with all of the requirements on the enforcement notice. We saw a new fire alarm panel had been installed in July 2016 and an external company serviced the system in January 2017. The service had a fire evacuation plan that gave guidance on what action to take in the event of a fire and where equipment was located. Individual fire risk assessments on how to support people using the service to leave the building were also included. The fire evacuation plan was part of the induction process. Fire extinguishers, lights and automatic door releases were checked monthly and there was a weekly fire alarm check. This indicated the service had taken steps to ensure the safety of people using the service.

People's health and safety was promoted. The service undertook monthly infection control, health and safety and Control of Substances Hazardous to Health (COSHH) checks. We saw that where actions had been recorded, these had been followed up. Fridge and freezer temperatures were recorded daily. We saw an up to date gas safety certificate, portable appliance testing (PAT) and legionella testing. The cleaning list indicated what had to be done daily and included deep cleaning at the weekend. Additionally, there were maintenance records confirming wheelchairs and hoists had been assessed. The registered manager also undertook a quarterly quality audit which covered all areas and aspects of the service, provided an overview of how safety was maintained and identified areas that needed to be improved upon.

Care workers had a shift plan which included a list of tasks to be completed during their shift including medicines administration, meal preparation and one to one time with people using the service. Care workers signed the tasks as completed at each handover.

Incidents and accidents were recorded and there was a policy and procedure in place. However, the service had very few incident and accidents and the last one recorded was in November 2015. Care workers said if there was an incident they would, "make sure the service user is safe and talk to the manager. Contact the hospital. Have to fill out a form for the accident and incident." As there were only two to three people using the service the registered manager had a good understanding of each person's individual needs.

During our inspection we saw there were enough care workers to meet the needs of the people using the service. The nominated individual, registered manager and two care workers were on site daily.

We saw evidence that medicines were managed and administered safely. Each person's medicines administration record (MAR) included their photograph and had clear PRN (as required) protocols for when and how to administer PRN medicines. We saw care workers' signatures if they administered medicines. Medicines were kept securely in a locked cupboard in a locked room. Controlled drugs were kept in a locked medicine cabinet and the controlled drug book was signed by two authorised staff. The medicines stock we counted was correct and reconciled to the MAR charts. This reassured us people were receiving their medicines as prescribed. Medicines audits were completed monthly by the registered manager and stock was reconciled weekly. A pharmacy had audited the service in June 2016 and we saw the service had actioned the recommendations.

Requires Improvement

Is the service effective?

Our findings

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.

People's care plans included a section to discuss DoLS and appointeeships and we saw decision support assessments completed by other healthcare agencies. The service had made a DoLS application for one person using the service and this was corroborated by the person's social worker. However, we noted that the person had a previous DoLS authorisation which expired in December 2015 and the registered manager had not made a new application for DoLS until he was requested to do so by the social worker. The registered manager said this was because the person's circumstances had changed and they no longer required a DoLS authorisation, however there was not a record of discussion of this with the social worker and a new application was made as requested by the social worker. This indicated the registered manager was not fully compliant with MCA principles as he had not recognised the person lacked the capacity to keep themselves safe and had not made a new DoLS application when the old DoLS authorisation expired.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The training matrix indicated all care workers had received Mental Capacity Act 2005 (MCA) training but the care workers we spoke with did not have a clear understanding of the MCA. However, in practice they were aware of choice and consent and told us, "We show them things we are going to use. Show her two foods, show her two dresses and if she wants to wear one, she will look over there" and "I will give them a choice about their needs and they can choose what they would like." A relative told us, "He can make choices about what he wants to do. Mostly he wants to go out. He gets things in his mind and care workers will help him to get it."

One care worker told us that it would be good to have more training because, "there's always new stuff coming out and it's good to be up to date." Training was done predominantly on line and recorded by the registered manager. Training the registered manager considered mandatory included adult safeguarding, medicines awareness, fire awareness, infection control and person centred care. All care workers had completed this initial training, however, we saw that one care worker had completed the majority of their training in 2013, including safeguarding adults training in January 2013, and had not undertaken any competency testing since. Care workers told us they had medicines training when they began working at the

service and the registered manager said an initial competency test was done after the training but no further competency testing was undertaken. One care worker had last completed medicines training in May 2012, and therefore we could not be sure their current practice was up to date and competency maintained. We raised this with the registered manager who said they would increase the frequency of mandatory training to ensure care workers were competent and following up to date best practice. After the inspection, the registered manager provided evidence that the care worker had updated their training in March 2017.

Relatives of people who used the service said they considered care workers to have the knowledge and skills required to carry out their role. Care workers we spoke with had a good understanding of the needs of the people using the service and had the opportunity to develop their skills through inductions, supervisions and appraisals.

Care workers told us they completed an induction when they began employment with the service and we saw evidence of this in their files. Care workers said they felt supported and that they had regular supervision meetings with their manager. Records we saw confirmed this. Comments included, "I get one to one supervision. You can talk, you can say how you feel, you can say what you want to change, you can get our point across." The registered manager told us they were always available to the care workers and said, "Every day I speak to care workers and any day they raise an issue, we resolve it." We also saw the registered manager completed annual appraisals with care workers. The professional support provided contributed to care workers developing the skills required to support the people they provided care for.

Care workers' meetings were held twice a year and we saw standing agenda items included policies such as safeguarding, health and safety and medicines administration.

We saw menus included two choices and food was prepared freshly each day. The kitchen was stocked with a variety of fresh fruit and vegetables. Care workers we spoke with knew about individual people's dietary needs. They told us one person using the service helped themselves to food in the kitchen when they wanted it. Another person communicated through non-verbal cues when they were hungry and we observed care workers supported them to get a drink. People's likes, dislikes and dietary needs were recorded in their care plans. Relatives told us, "His cultural needs are met. They provide traditional food when I give them the recipe", "I believe she is getting a healthy and varied diet" and "Her needs have been catered for when we are there. I look out for nutrition and I believe it is healthy."

People using the service engaged with a number of other professionals including the community learning disabilities team, social care professionals, the GP and hospital consultants. We saw evidence of appropriate referrals being made to address any health needs people had. This contributed to people maintaining good health and wellbeing. Each person had a health action plan and was supported to have an annual health check. This meant healthcare professionals had the information they needed to meet people's individual health care needs. People using the service had separate health files which included medical correspondence, a health appointments record, an up to date health action plan, information on various medical needs and we saw records maintained for seizures, blood pressure and weight monitoring. A record of external professionals visiting the service was kept and showed the reason for the visit and the outcome. One social care professional said there was good communication with the service and that "the manager usually emails me for any concerns or feedback, and if something requires immediate attention, he gives me a phone call". Relatives said, "Absolutely they help him to go to the GP. The carers tell me how the appointments go. Sometimes I have to ask the manager" and "The service is meeting her medical needs."

The home was clean but sparsely furnished. One relative said, "The home is very clinical and they could make it a bit more vibrant and user friendly, so it's also more warm and inviting for visitors." They did

however also acknowledge their relative's bedroom was decorated colourfully.

Good

Is the service caring?

Our findings

Care workers at the service were kind and caring and had developed positive relationships with people using the service. We observed respectful and caring interaction between care workers and a person using the service. Relatives told us, "The care workers are caring. They offer him if he wants things to eat", "They have a little chat with him. They ask about things he likes", "The care workers are very hands on. She has built up a good rapport" and "They show their professionalism."

Care workers told us they promoted people's independence and choices. They said, "With (person) I can read them with their body language and you will see if they are interested or not", "(Person) will tell you what they want to do. They have an activity planner and we ask them if they want to do it or something else" and "Try to encourage them to do how much they can by themselves." We saw evidence of residents' meetings which provided people using the service an opportunity to give their views and there was evidence of service user opinions in the meetings.

Care workers demonstrated a good knowledge of people's personal preferences as stated in their care plans and increased their understanding through day-to-day interactions with people using the service. Care workers we spoke with were aware of people's cultural and religious needs. We saw evidence of cultural foods being cooked and people being supported to their preferred place of worship. Relatives we spoke with confirmed this.

Care workers told us they respected people's privacy when they supported them with personal care. Comments included, "I will make sure the service user is comfortable and she has choices and has dignity" and "We will communicate with them what we are doing and what we are going to use."

We saw one person had a communication passport and information was contained in the care plan about how the person might communicate in certain situations.

People had individual keyworkers, who had an overview of the person and their needs. This contributed to the consistency of care and provided a point of contact for others in the person's network. A relative observed, "He has a keyworker who is working closely with him."

Family members told us that the service kept them informed about any changes to their relatives' care, health and wellbeing. However, one family member told us, "They only call if there is an issue or concerns or letting us know she is going somewhere. We're invited for Christmas parties and her birthday. It would be nice to get a monthly or quarterly phone call to let me know how (person) is doing."

Good

Is the service responsive?

Our findings

The service undertook pre assessments of people's needs prior to them moving to the service and included the local authority's assessment of needs. We saw evidence that people using the service and their relatives were involved in planning people's care and were present at care plan reviews. The care plans we looked at were person centred and recorded information about people's daily routines and abilities. We saw relevant information such as, "Pin her hair away from her face", "I can stand on my feet but holding onto some support" and "She has a good sense of humour."

Care plans were comprehensive and addressed various areas of the person's life including personal care, eating and drinking and communication. We looked at two people's files to see if individual needs and preferences were met. The care plans provided guidance and details of people's likes and dislikes, such as 'likes bread and jam which he likes to make himself.' Under communication we saw 'use short, slow sentences. Make sure he understands because he can pretend to understand' and another person's care plan explained how they would indicate to care workers if they were hungry between meals. This meant care workers understood how to meet peoples' preferences and these were respected.

Reviews were held yearly and the care plans were updated accordingly. A relative confirmed they did attend reviews but that the minutes and updated risk assessments were not always provided. Another relative said, "They're going to do a review in April/May. The last one I was there and my other sister as well. He attends the reviews. He can say what he wants." Files also contained evidence of placement reviews held with the placing local authority. Regular reviews involving people using the service and their families provided an opportunity to discuss and update the care provided so that the needs of the person were being met in the best possible way.

Each person had a daily record which was completed after every shift. The daily logs reflected people's care plans and we saw evidence of both task based entries and information on how the person was feeling. However, one relative commented, "The diary (daily log) is monotonous and repetitive. If (person) is having a bad day, write it down so I know."

People using the service were supported to access activities both inside and outside the home. Activities included dominoes, aromatherapy, manicures, hydrotherapy and going out into the community. One person's activity planner included photographs of them taking part in each activity. The care workers we spoke with had a good understanding of people's individual likes and dislikes and tried to engage people in activities they were interested in. One relative said, "They do an annual trip to a resort who can cater to her needs." A separate activity folder was kept which provided a descriptive paragraph of activities undertaken. These reflected the information we saw in the care plans. We saw for one person, the issue of activities had been an on-going issue. A social care professional told us at the last review this was no longer a concern and we could see written accounts and photographs of various activities. However, a relative we spoke with had concerns about how meaningful the activities were. Their comments included, "There are other clients but not enough clients so (person) is isolated" and "It's not about just taking her out to town, to the pub for lunch or to the temple. It's for her to be engaged with her peers."

The service had a complaints procedure displayed in a communal hall and which was also in an easy read format and 'how to make a complaint' was included in the service user guide. However, no complaints had been recorded. The registered manager explained this was because it was a very small service and there was regular communication with the relatives when any issues arose. Comments from relatives included, "I would talk to the care manager and the director (if any concerns). The manager does not always listen to what the family says" and "If I raise a concern, (the registered manager) would listen."

Requires Improvement

Is the service well-led?

Our findings

The service had some systems in place to monitor the quality of service delivered and we saw a number of checklists and audits to monitor both the environment and how the needs of the people using the service were being met, including health and safety checks, infection control checks and medicines and finance audits. However, there was a lack of audits to identify when training was due or when DoLS applications had to be renewed to ensure people's safety and minimise risk.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Additionally, the service had not sent in a notification as required by the Care Quality Commission, for an incident where financial abuse had been alleged. The registered manager had taken appropriate action and had raised a safeguarding alert with the local authority's safeguarding team. They had also completed a notification for the Care Quality Commission (CQC) and we saw evidence of this, but this had not been sent. The registered manager told us this had been an oversight and human error on their part.

Relatives and care workers told us if they had a concern they would speak to the registered manager. The registered manager said as the service was very small, they had direct communication with relatives and could act upon information as soon as it was received. However, relatives did not always consider the manager to be proactive. Care workers felt supported and said, "If I have a problem I would talk to my manager. If that doesn't help, I would do whistleblowing" and "They provide every materials. If there is something they need to improve, they consult with us."

The registered manager told us, "We have an open door policy so any service user that wants to speak to us they can come at any time." We also saw a suggestions box in the communal hall.

Service user surveys were completed in August 2016. The care workers last completed satisfaction surveys in June 2016 and we saw evidence that care workers were satisfied working at the service. As the service was so small and no concerns were raised, there was no analysis of the survey feedback to influence future service delivery.

The service kept up to date with current best practice and legislation through contact with other health and social care professionals. We saw from people's files there was on-going working relationships with various community-based professionals that contributed to them being able to meet people's individual needs. A social care professional said, "The care home always contacts me for advice in a timely manner."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider did not ensure care was provided with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not do all that was reasonably practical to mitigate risk. Regulation 12(2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not asses, monitor and improve the quality and safety of the services provided. Regulation 17(2) (a)