Mr Runjith Gopal & Mrs Solony Gopal

Faraday House

Inspection report

16 Faraday Road Acton
Acton
London
W3 6JB

Tel: 02082484599

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 01 December 2015. The last inspection of the service was in November 2013 when we found the provider was meeting all legal requirements.

Faraday House is a care home for three people with mental health needs. The providers and their family live in the property and share some facilities with people using the service. When we carried out this inspection, three people were using the service. All had lived there for at least a year.

The registered providers, Mr and Mrs Gopal, are also the registered managers. 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.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The providers did not identify, assess or mitigate risks to people using the service.

The providers did not inform the local authority of possible safeguarding incidents.

The providers did not always provide enough staff to support people and did not carry out robust recruitment checks on new staff.

The adaptation, design and decoration of the service did not meet people's individual needs.

The providers had not applied to the local authority for authorisation when they placed restrictions on people, as required by the Deprivation of Liberty Safeguards.

The providers did not ensure staff had the training they needed to support people.

The providers did not involve people in planning and reviewing the care and support they received.

The providers did not always record and manage complaints effectively.

The providers did not promote a culture that was positive, open, person centred and empowering.

There was no evidence of the involvement of other professionals in people's care and support.

We recommend that the providers obtain up to date guidance on the management of medicines in care homes.

The provider arranged for and supported people to access the healthcare services they needed.

People told us they enjoyed the food provided in the service.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The providers did not identify, assess or mitigate risks to people using the service.

The providers did not inform the local authority of possible safeguarding incidents.

The providers did not always provide enough staff to support people and did not carry out robust recruitment checks on new staff.

People using the service received the medicines they needed safely.

Is the service effective?

Inadequate

The service was not effective.

The adaptation, design and decoration of the service did not meet people's individual needs.

The providers had not applied to the local authority for authorisation when they placed restrictions on people, as required by the Deprivation of Liberty Safeguards.

The providers did not ensure staff had the training they needed to support people.

People had access to the health care services they needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us staff were not always caring, but we saw they treated people well.

The providers did not always record information about people using the service.

People were able to choose where they spent their time.

Is the service responsive?

Inadequate

The service was not responsive.

The providers did not involve people in planning and reviewing the care and support they received.

Standards of care planning were poor and people's care plans did not reflect the support they told us they wanted.

The providers did not always record and manage complaints effectively.

Is the service well-led?

Inadequate

The service was not well led.

The providers did not promote a culture that was positive, open, person centred and empowering.

There was no evidence of the involvement of other professionals in people's care and support.

The providers carried out checks on the running of the home, but they did not always ensure they completed these fully and accurately.

Faraday House

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 01 December 2015.

The inspection team comprised two inspectors.

Before the inspection, we reviewed the information we held about the service, including the last inspection report and notifications of incidents affecting people using the service. We also contacted the local authority's safeguarding adults and contract monitoring teams for their views on the service.

During the inspection, we spoke with two people using the service, one of the registered providers and another family member working in the service. We saw all parts of the property used by people using the service, including communal areas and bedrooms. We reviewed the care records for all three people using the service, recruitment records for one person working in the service and other records related to the management of the service.

Following the inspection, we spoke with one local authority care manager and a community nurse. We attempted to contact one person's relative but we were not able to speak with them.

Inadequate

Is the service safe?

Our findings

People using the service told us they usually felt safe in the service. One person said, "Sometimes I feel safe, sometimes I feel scared, I have nightmares." A second person told us, "I'm not worried about my safety here."

The provider had a policy and procedures for safeguarding people using the service that they had updated in September 2014. However, the provider had not updated the policy accurately and it included references to a previous regulator and not the Care Quality Commission. The provider did not follow the procedure to make sure people using the service were safe. The complaints record included one entry from November 2014 that the provider should have managed as a safeguarding incident. The record of action taken by the provider was unclear and there was no information about the outcome of any actions they may have taken. We also saw records of two incidents the provider should have referred to the local authority's safeguarding adults team as they placed people using the service at risk. We asked the provider why they had not followed the procedure and they were not able to tell us why they failed to report the incidents.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider failed to assess possible risks to people using the service. People's care records included risk assessments that identified possible risks as 'problems'. There was insufficient guidance for staff on how to mitigate possible risks and most assessments only said that staff would 'monitor' identified risks. There was no evidence the provider had involved people using the service in the assessments of risk and the development of appropriate management plans to keep them safe. We saw a fire safety risk assessment for one person dated October 2014. This lacked detail and there was no evidence the provider had reviewed or updated the assessment. We did not see risk assessments or risk management plans for issues we identified during this inspection. These included risks caused by people smoking, accessing the local community and behaviours that challenged the service.

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

When we arrived at the service, there were two members of staff on duty. One person was one of the registered providers and the other was a family member. We asked to see the staff rota and the provider told us this was not available. They told us they worked from Monday – Friday each week and stayed in the property 24 hours a day to support people if required. They then told us the second registered provider worked on Saturday and Sunday, providing 24-hour support. When we last inspected the service in 2013, a second member of staff worked each day to provide two people on duty. The provider told us this second person had only returned the day before this inspection after a period of 18 months away from working in the service. This meant there had only been one person on duty in the service during the day and night and the providers worked extended hours as they had not arranged to employ additional staff to support people using the service.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider failed to operate effective recruitment procedures to make sure staff they employed were suitable to work with people using the service. The staff record we checked included proof of identity and a Disclosure and Barring Service check. We did not see an application form or record of an interview and the record only included one reference that the provider had not verified.

The provider told us the family member they employed had been away for a period of 18 months and had only returned to work the day before we carried out this inspection. There was no evidence that the providers had carried out checks before the person started work, apart from historic checks completed when they originally worked in the service.

These were breaches of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service received the medicines they needed. When we inspected, only one person was receiving prescribed medicines. The provider stored medicines safely in a lockable cupboard. The record of medicines administered was up to date and this provided a clear audit trail to show people had received their medicines as prescribed. The balance of the medicine we checked against the administration record was correct. The provider had taken action to ensure they obtained emergency medicines from the pharmacist to cover a gap between prescriptions.

The medicines records we saw were disorganised and information was difficult to locate. The medicines file contained out of date information related to people using the service who were not currently receiving prescribed medicines. We did see an up to date record of clinic appointments for one person using the service.

We recommend that the providers obtain up to date guidance on the management of medicines in care homes.

Inadequate

Is the service effective?

Our findings

People using the service gave differing opinions about the service. One person said, "It's nice. I like the television set and the furniture." A second person told us, "I don't like it. I'd love to live by the sea, but I wouldn't know anybody."

The adaptation, design and decoration of the service did not meet people's individual needs. During the inspection, we saw all communal parts of the service and people's bedrooms. Walls in all parts of the service, including bedrooms, lounges, dining rooms and bathrooms needed redecorating. People's bedrooms were bare and there was no evidence staff had supported people to personalise their rooms.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider had not submitted applications to the local authority for authorisation to restrict people's liberty. They told us one person using the service was at risk if they left the service without staff support. Care records showed the provider went to local shops with this person each morning and they usually went for a walk together in the afternoons. When we asked the provider what happened when only one member of staff was available to support three people, they told us, on occasion, the person who needed support to access the local community had to wait to go out. The provider had not recognised this was a restriction and there was no evidence they had applied to the local authority for authorisation, as required by the Safeguards.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was some evidence the provider ensured staff completed the training they needed to work with people using the service. Training records for one person working in the home showed they had completed some relevant training between 2007 and 2012. This included safeguarding adults, the Mental Capacity Act

and Deprivation of Liberty Safeguards, medicines management and food safety. This member of staff returned to the service the day before this inspection, after 18 months away and they told us they would be arranging to update their training. We saw no evidence of training completed by the providers, who both worked in the service regularly.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider arranged for and supported people to access the healthcare services they needed. Care records included some information about people's health care needs and details of how staff met these in the service. For example, staff supported one person to attend a clinic every two weeks.

People told us they enjoyed the food provided in the service. Their comments included, "The food is good. It's nice food. I eat quiche, salad and fish," "[name of staff member] does the cooking, I put the knives and forks on the table, I don't cook." People using the service gave us conflicting information about meal times. One person said they were very inflexible. They told us, "Breakfast is at 8:30, if you come down earlier you're told no breakfast" and "I have to be up at 8:30 to have breakfast." Another person said they usually had breakfast "about 9:00." We spoke with the provider about this and they told us they put bread and tea or coffee out in the kitchen and encouraged people to help themselves but neither of the people we spoke with mentioned this. The record of food provided showed that the provider offered people an alternative if they did not want the planned meal. Staff had recorded the alternatives people chose in the records we saw.

Requires Improvement

Is the service caring?

Our findings

People using the service and their relatives gave us conflicting information about the attitude of staff working in the service. Their comments included, "I don't like it. Would you If someone told you to get up in the morning and do this, do that…it's a boot camp" and "It's no one else's business what I do outside the house. So why does [staff member's name] poke his nose in? He likes to know what you're doing during the day." Another person commented, "I like it here, I like the TV and the furniture. I watch TV in my room."

During the inspection, we saw the provider and staff treated people well. They spent time with people and individuals did not have to wait for staff to support them when they asked. Staff demonstrated a knowledge of each person's care needs. They were able to tell us about significant events and people in each person's life and their individual daily routines and preferences. However, the provider had recorded none of this information in people's care records.

People were able to choose where they spent their time. We saw people spent time in their rooms when they wanted privacy and spent time in the kitchen when they wanted to be with other people. Two people were also able to leave the service without staff support and we saw they did this during the day. When they returned to the home, both people had to ring the front doorbell, as they did not have keys. We discussed this with the provider who told us people had lost keys in the past and left doors open so they opened the door for people to ensure the premises were secure.

Inadequate

Is the service responsive?

Our findings

People using the service, social and health care professionals who worked with them gave us differing opinions about how people were supported. A health care professional told us, "I have never worked with anyone in this home, I don't know why you were given my name." A social worker who supported one person using the service told us, "The situation remains the same. My client still has to stay in their room in the evening till the morning because of 'the rules'. [Client's name] and their family still want them to remain in this home despite my concerns. Their family feel this is where they have been the most stable."

The provider did not involve people and, where appropriate, their relatives, in planning and reviewing the care and support they received. We discussed care reviews with one of the registered providers and they told us none of the people using the service had had a recent review of the care and support they received. They told us they had received very little information about the support needs of one person who moved into the service since our last inspection but they were unable to tell us why they had not followed this up with the placing authority as part of their admission process.

Care plans lacked information about the person's life prior to their move in to the service. We saw no life histories or information about people's previous experiences and contact with other health and social care services. Staff did know some information about individuals but they had not recorded this as part of the person's needs assessment or care plan.

People's care plans were not focussed on the needs of the individual and did not include people's wishes and aspirations to help ensure the care and support provided was tailored to their individual needs. For example, the provider expressed people's care needs as 'problems' that needed an 'intervention' and an 'outcome'. However, the care plans lacked clear guidance for staff on how to support people or promote independence. People we spoke with told us they wanted to move on to more independent accommodation but their care records did not reflect this and did not include any objectives aimed at making this possible.

Staff completed daily records of the support they provided for people but these were very repetitive and staff had not linked their recording to the person's support plan. For one person, every daily entry said they went to the local shop with the provider each morning and for a walk in the afternoon. There was insufficient detail in the recording and the lack of specific objectives in people's support plans meant it was not possible to evidence any progress they had made.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider displayed their complaints procedure on a notice board in the hallway. This set out what people could expect if they made a complaint and who they could contact if they were not satisfied with the response provided by the service. This procedure included up to date information about the Care Quality Commission.

Inadequate

Is the service well-led?

Our findings

The providers, Mr and Mrs Gopal, were registered by the Care Quality Commission as joint registered managers of the service. They employed a family member as the only other member of staff working in the service.

The providers did not promote a culture that was positive, open, person centred and empowering. Care plans did not involve people using the service, they lacked detail and clear objectives and included no guidance for staff on how to support people using the service.

We saw no evidence staff supported or encouraged people to become more independent. Staff carried out most tasks and people had little involvement in the daily running of the service. While people told us they wanted to be more independent, the provider had not identified this and included no support in people's care plans to enable them to achieve this.

The providers were unable to show us evidence of the involvement of other professionals in people's care and support. They told us they had received little information about one person's care needs before they moved into the service, but were unable to tell us what they had done to obtain this information from the local authority responsible for placing the person. They also told us local authorities had failed to carry out reviews of people's care but were unable to show us that they had requested this support from people's social workers or care managers.

The providers did not seek the views of people using the service, their relatives and other health and social care professionals working with them. We saw no evidence the provider had asked people about the care and support they received. The provider was unable to show us examples of quality surveys or records of meetings for people using the service or others.

The providers did not assess, monitor and mitigate risks to the health, safety and welfare of people using the service. Risk assessments were incomplete and were not reviewed or updated regularly by the providers.

The providers carried out checks on the running of the home, but they did not always ensure they completed these fully and accurately. We saw the provider had not recorded hot water temperatures since March 2015 and they had held only two fire drills in the last 12 months.

Records were disorganised, incomplete, out of date or missing. For example, there was no staff rota and the providers had not reviewed or updated care plans and risk assessments. Incidents involving people using the service were poorly recorded and possible safeguarding incidents were not referred to the local authority.

These were breaches of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The providers had carried out other checks. The gas safety certificate was dated October 2015, the legionella checks was dated June 2015 and the employer's liability insurance was valid to February 2016.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care of service users did not meet their needs or reflect their preferences. Regulation 9 (1 b and c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered providers did not assess the risks to the health and safety of service users or do all that is reasonably practicable to mitigate any such risks. Regulation 12 (2 a and b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The providers did not operate effective systems to investigate any allegation or evidence of abuse. Regulation 13 (3). Service users were deprived of their liberty without lawful authority. Regulation 13 (5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The providers did not ensure premises and equipment were clean and properly maintained. Regulation 15 (1).

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 assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2 a, b and c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The providers did not operate effective recruitment procedures. Regulation 19 (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The providers did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. Regulation 18 (2).