

Vijaykoomar Kowlessur

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Inspection report

Shenley lodge
34 Abbey Road
Enfield
Middlesex
EN1 2QN

Tel: 02083631173

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23 May 2017

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This unannounced inspection took place on 22 and 23 May 2017. The inspection was carried out by two inspectors. This was the first inspection of the service since it registered with CQC in July 2016.

Vijaykoomar Kowlessur offers supported living services to people with learning disabilities. On the day of the inspection the service supported five men living in a single supported living location in Enfield, North London.

The service had a registered manager. 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.

Medicines were not being managed safely. We found that there were quantities of 'as needed' medicines that were unaccounted for. We found that some medicines were not being stored and disposed of safely. People's Medicine Administration Records (MAR's) were not always completed in full or accurately.

There were measures in place to monitor quality and safety of care. However, the audit systems in place at the service were ineffective, as they did not identify the significant concerns with medicines management which were found during the inspection.

All staff had received training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and staff understood what to do if they had concerns as regards people's mental capacity.

Detailed current risk assessments were in place for people using the service. Risk assessments in place were reviewed and updated regularly. The risk assessments explained the signs to look for when assessing the situation and the least restrictive ways of mitigating the risk based on the individual needs of the person.

We saw friendly, caring and supportive interactions between staff and people and staff knew the needs and preferences of the people using the service.

Care plans were person centred and reflected what was important to the person. Care needs were regularly reviewed and updated to meet the changing needs of people who use the service.

We saw evidence of a comprehensive staff induction and on-going training programme. Staff were also safely recruited with necessary pre-employment checks carried out. Staff had regular supervisions and annual appraisals.

People were supported to maintain good health and had access to healthcare services.

People were encouraged and supported to access the community and engage in a wide range of activities.

At this inspection we identified a breach of Regulations 12 and 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to medicines management 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?

The service was not always safe. Medicines were not always recorded or monitored safely.

There were sufficient staff to ensure that people's needs were met. There was a recruitment procedure in place.

Risks to people who used the service were identified and managed effectively.

Staff were aware of different types of abuse, how to identify abuse and what steps they would take if they had safeguarding concerns.

Requires Improvement ●

Is the service effective?

The service was effective. Staff had access to regular training, supervisions and appraisals which supported them to carry out their role effectively.

People were given the assistance they required to access healthcare services and maintain good health.

Staff understood the Mental Capacity Act 2005 and the importance of obtaining consent from people.

Good ●

Is the service caring?

The service was caring. There were positive relationships between staff and people using the service. Staff treated people with respect and dignity.

Staff had a good knowledge and understanding of people's background and preferences.

Good ●

Is the service responsive?

Good ●

The service was responsive. Care plans were person centred.

People had access to a variety of activities and they were supported to access the community which supported people to be independent.

Is the service well-led?

The service was not always well-led. The provider had a system in place for monitoring the quality of care with regular audits. However, these audits had not identified the issues we found with medicines management during the inspection.

There was a clear management structure in place and relatives and staff spoke positively of the registered manager and provider.

Requires Improvement ●

Vijaykoomar Kowlessur

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 23 May 2017 and was unannounced. The inspection was carried out by two inspectors on the first day and one inspector on the second day.

Before the inspection, we asked the provider to complete 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 reviewed the completed PIR and previous inspection reports before the inspection.

We also reviewed information we had about the provider, including notifications of any safeguarding or other incidents affecting the safety and well-being of people using the service.

During the inspection we spoke with one person who used the service and one relative and we also observed interactions between staff and people using the service as we wanted to see if the way that staff communicated and supported people had a positive effect on their well-being.

We spoke with the registered provider, the registered manager and four staff members. We looked at six staff files and training records.

We looked at three people's care plans and other documents relating to their care including risk assessments and medicines records. We looked at other records held at the home including staff meeting minutes as well as health and safety documents and quality audits.

Is the service safe?

Our findings

We looked comprehensively at how medicines were managed and administered to ensure people received their medicines safely and on time. Medicines were not being managed safely and people were being put at risk of harm. Four of the five people who used the service were administered medicines by care staff. Three people had been prescribed PRN (also known as 'when required') medicines. When required medicines are medicines that are prescribed to people for pain relief or to relieve anxiety and are only given when necessary. Every person had a PRN medicines protocol in their medicines profile and Medicine Administration Records (MAR) provided staff with clear instructions for the administration of PRN medicines. However, we found that PRN medicines were not always stored securely in the medicines cabinet, quantities of PRN medicines were unaccounted for and staff did not clearly record when PRN medicines were administered or maintain accurate stock records.

For one person, we found 15 strong painkillers (Co-Codamol) unaccounted for. Records indicated that there should have been 85 tablets in stock, but there were only 70 tablets in stock. We also found that for the same person who had been prescribed Diazepam (used to treat anxiety disorders, insomnia, alcohol withdrawal symptoms, or muscle spasms), records indicated that there should have been 27 tablets in stock. This medicine was not stored in the medicines cabinet. The registered manager located 25 Diazepam tablets prescribed to the person in a medicines returns bag.

Another person had been prescribed Lorazepam (used to treat anxiety, insomnia, seizures and alcohol withdrawal). Approximately 15 tablets or 30 administrations of this medicine was unaccounted for. Staff administering this medicine did not record its stock levels on an ongoing basis.

A third person had been prescribed Diazepam. The person's MAR indicated that the medicine had been administered on four occasions in May 2017. However, the person's PRN notes indicated that the person had been administered the medicine on five occasions, of which three occasions did not correspond with what was recorded on the person's MAR. Fifteen tablets had been recorded as having been carried forward on 1 May 2017. The medicine could not be found during the inspection. Following the inspection, the registered manager sent an email confirmation that the person's medicine had been located in the medicines returns bag, which was subsequently checked by the inspection team on the second day of the inspection. However the quantity located, did not correspond with what the person's MAR and PRN notes indicated.

In addition, in the medicines returns bag, we located a quantity of five Diazepam tablets. There was no information as to who these tablets were for.

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

The person we spoke with told us they felt safe living at the service. Relatives told us that they believed their relatives to be safe. They told us, "It's okay, [Relative] seems happy and the place seems reasonable."

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Records confirmed that staff had received training in safeguarding people. They were able to describe the types of abuse to look out for and the steps they would take if they had concerns. Staff identified that they could report abuse concerns outside of the organisation to the local safeguarding authority and the Care Quality Commission. A staff member told us, "[Safeguarding] means that all clients are to be kept safe and secure and not abused. I would write down concerns and inform the manager."

The provider had a whistleblowing policy in place and staff were knowledgeable about what whistleblowing meant. One member of staff told us, "We would go straight ahead and phone CQC."

Risk was managed effectively. Comprehensive personalised risk assessments were in place for people. Risks associated with people's care included personal well-being, nutrition, mobility and finance. Risk assessments detailed implications of risks and an action plan on how to mitigate risks. One person's risk assessment for behaviour that challenged listed how the person behaved when anxious and listed de-escalation techniques to calm the person such as giving space or offering snacks and drinks.

Another person's risk assessment noted that to reduce the likelihood of the person becoming anxious when accessing the community, staff were to ensure that they were completely ready to go and ensure they had money, the person's coat and disabled badge before asking the person if they would like to go out.

People were supported with sufficient staff with the right skills and knowledge to meet their individual needs. On the day of the inspection, there were four people in the supported living location with one care staff on duty. One person who used the service required one to one support whilst in the supported living location. Staff and records confirmed that this was in place and when this person was at the service, there were two care staff on duty. At night, there was one staff member on duty.

Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure that only suitable staff were employed to work at the home. Records seen confirmed that staff members were entitled to work in the UK.

Accidents and incidents were recorded and actions and learning identified as a result of the incident were implemented.

Weekly fire tests were being carried out and regular evacuation drills were being carried out. There was a fire safety checklist and audit carried out, which included checking escape routes, emergency lightings and evacuation equipment. Personal Evacuation Emergency Plans (PEEPS) had been completed for people that provided information on how to evacuate people. People living at the home were able to use the stairs.

Appropriate gas, portable appliance and electrical installation safety checks were undertaken by qualified professionals.

The supported living location was clean and well maintained on the days we visited.

Is the service effective?

Our findings

Staff had the knowledge and skills which enabled them to support people effectively. A relative told us, "The staff are quite helpful."

Staff told us and records confirmed that they underwent an induction and a period of shadowing experienced colleagues when they first commenced employment. A staff member told us, "They showed me clients, what kind of behaviours when they were angry or upset, their routines and how to support them with hygiene. I shadowed three staff. Staff were required to complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers."

Training records showed that people had completed training in areas that helped them to meet people's needs. Mandatory training included challenging behaviour and learning disabilities, MCA/DoLS, epilepsy, medicines, risk assessments and person centred care and fire safety. Staff told us that they received training on a regular basis. Comments from staff included, "I have done NVQ level 2" and "I have done medication training. We are doing medication again next week."

Staff told us they received regular supervisions and an annual appraisal, where necessary and which was evidenced from reviewing staff files. A staff member told us, "We have regular one to ones. They ask how the job is going, my training. It's very important for us to know what is going on."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do 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. We checked whether the service was working within the principles of the MCA. 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 observed that there was a keypad in place at the supported living location. The registered manager advised us that all people had been provided with the access code. At the time of the inspection, there were no DoLS in place for people who lived at the supported living location as the location was not a registered care home. The registered manager advised us that they were in liaison with the local placing authority regarding the use of keypads.

The registered manager and staff had a clear understanding of MCA and had attended training. Staff understood that they were required to obtain consent before providing care. Care plans had been signed by people who used the service to indicate they had consented to their care plan. A staff member told us, "Before we start doing anything we talk to them. At lunchtime, we show them food. We explain everything. We show them clothes before showering."

Care plans identified people's nutritional needs, likes and dislikes and cultural food requirements. Where a

person had a specific dietary requirement or Speech and Language Therapist (SALT) Guidelines, guidelines and information for staff were available in care records. A relative told us that their relative assisted staff with preparing food and minor cooking tasks such as stirring and peeling. The relative told us, "[Person] has lost a lot of weight since being there. [Person] was very obese at one point. It's part of what they have been trying to do with him." A staff member told us, "[People] are involved in food choices. I like cooking and [three named people] help all the time. They tell me what I cook them is very nice. They have two options and we can swap days."

People had access to health and social care professionals. People had a health action plan which listed upcoming health appointments and the health services that people had visited. Records showed people had attended recent urology, optician and hospital appointments.

People had healthcare passports which described the person's medical history, allergies and their treatment preferences in case they were admitted to hospital.

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. We observed positive and caring interactions between staff and people who use the service. A relative told us, "[Relative] has made friends and gets on with the people there."

Staff knew the people they were caring for, including their goals and life histories. One staff member told us, "I read people's care plans, risk assessments, backgrounds, likes and dislikes."

Care plans included background information and a medical history about the person. Care plans contained information about people's families and relationships and preferred hobbies. Staff confirmed that they had read people's care plans and they could access them. One person's care plan detailed that staff should give the person a choice of colours of what to wear. Another person's care plan detailed the person was shy when out in the community and for staff to build confidence through encouragement.

People's abilities to communicate were recorded on care plans. The plans listed how people communicated, for example to ensure a person can see staff hands and face clearly when communicating with the person.

Each person had a designated keyworker. A key worker is a named member of staff who takes primary responsibility for ensuring the person's care needs were met. This included supporting them with activities and spending time with them. We saw that there were regular weekly key working sessions between the keyworker and the person using the service. A staff member told us, "I read [person's] care plan. I know them better. I spend more time with [person]. He is a person who likes to scream. Very quickly I know how to calm him down." The staff member continued, "[Person] is happy with me. I am proud to look after him." A second staff member told us, "I give them assurances that I am here for them. I give them comfort. Sometimes their morale is low, I need to talk to them and make them happy."

Staff understood what dignity and privacy meant when assisting people. One member of staff told us, "All the time, I knock on their door. I keep communication confidential. I don't give anyone's information to others."

Staff we spoke to understood what equality and diversity meant and how that affected the care they provided for people who use the service. When asked how to work with people from a variety of backgrounds, a staff member told us, "I have worked a number of years in care. It's so cosmopolitan now. We work with lots of people. We try to be diverse, it's so nice."

Is the service responsive?

Our findings

People were supported to engage in a range of activities which reflected their goals and interests. People's care plans listed the activities people liked such as music, table top games and football. This included regular shopping visits, eating out, trips to the park and cinema and attending the local day centre. During the inspection, we observed a person attend the local day centre and three people engage with staff in playing musical instruments. A relative told us that their relative engaged in regular activities. They told us, "I ask [person] and see photos. Sometimes he says he has been to the park and does a variety of things. He has been to the cinema and on a holiday."

We looked at care plans of three people who use the service and saw that staff responded to people's needs. People's support plans were separated into areas which included personal well-being, social, nutrition, mobility and behaviours. We saw detailed daily records which detailed people's activities and mood on that day. Care plans showed how to provide emotional support to people when they were anxious or required assurances.

People's needs were reviewed regularly and as required. Where necessary the health and social care professionals were involved promptly and mental health assessments were requested which was discussed with staff and risk assessments updated appropriately. A staff member told us, "I like to read care plans and risk assessments. I point out updates and we agree to change the care plan."

We checked how the service handled complaints. The service had a complaints policy in place. Since registration, the service had not received any formal complaints. A relative we spoke with told us that they could raise concerns if necessary and were confident any concerns would be addressed.

We saw that people who used the service had given staff thank you cards on occasion. People thanked staff for taking them on day-trips.

Is the service well-led?

Our findings

There were systems in place to monitor the safety and quality of the service provided. The registered manager completed a monthly spot check and a quarterly unannounced night spot check. The registered manager completed a monthly report which was submitted to the registered provider which included health, safety and maintenance checks. The registered manager told us that based on the monthly report, provisions such as electrical appliances and soft furnishings would be purchased for the supported living location.

The registered manager's monthly spot check included checks of staffing levels, health and fire safety, record-keeping, food, infection control and medicines. The check documented that Medicine Administration Records (MAR) were cross-referenced with stock levels and PRN medicines were stock checked. The registered manager confirmed MAR's were checked only and medicines stocks were not counted during the audit. This meant that the audit systems in place at the service were ineffective, as they did not identify the significant concerns with medicines management which were found during the inspection. The registered provider and registered manager told us that they would introduce a daily medicines stock check as an immediate measure following the inspection.

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

We received positive feedback from the relative regarding how the service was managed. They told us, "They have been fine, very helpful." Staff told us the registered manager was available to provide support if needed. Comments from staff included, "So far I am very happy with [registered manager]. I get help and support and kept updated", "We get support. The boss will never say no if we need anything" and "Yes, if anything, any issue. We can call [registered manager]."

Staff and residents meetings took place on a regular basis. Residents meetings took place on a quarterly basis. Topics discussed at staff meetings included health and safety, safeguarding and staffing levels. A staff member told us, "At meetings I make suggestions and they listen to us."

We asked the registered manager if people, relatives or health professionals had been asked to provide feedback via a questionnaire or survey. The registered manager advised that they had not yet completed one and would do so before they were registered with CQC for one year.

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
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) The service did not have effective systems in place to record and monitor the quality and safety of service provision.