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Roland Residential Care Homes

Inspection report

4 Compton Road
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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 

Overall summary

This inspection took place over one day on 14 December 2015 and was unannounced. At our last inspection on 04 June 2014 we found that the provider met all standards that we inspected.

Roland Residential Care Homes, 4 Compton Road is registered to provide accommodation and personal care for a maximum of seven adults with mental health needs. On the day of inspection there were seven people using the service.

Summary of findings

The registered manager had recently left. However, a manager had been appointed and is in the process of applying for registered manager status with the Care Quality Commission (CQC).

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.

People told us that they felt safe within the home and well supported by staff. We saw positive and friendly interactions between staff and people.

Staff understood people's individual needs in relation to their care. People were treated with dignity and respect.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report it to if people were at risk of harm.

Staff had an understanding of the systems in place to protect people who could not make decisions and were aware of the legal requirements outlined in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). When people were not able to have input in to decisions affecting their care, there were records of MCA assessments and best interests meetings.

Care plans were person centred and reflected individual's preferences. There were regular recorded keyworking sessions. There were focused keyworking session that looked at specific aspects of an individual's care. People were involved in writing their care plans and risk assessments and were able to express their care needs.

People were supported to maintain a healthy lifestyle and had healthcare appointments that met their needs. Medicines were administered safely and on time.

People's views on how the service was run were listened to. There were regular residents meetings that allowed people to have their views and opinions heard.

Staff training was updated regularly and monitored by the manager. Staff had regular supervision and annual appraisals that helped identify training needs and improve the quality of care.

People were supported to have enough to eat and drink. People were encouraged and supported to cook and plan their meals.

There was a complaints procedure as well as an accident and incident reporting. Where the need for improvements was identified, the manager used this as an opportunity for learning and to improve care practices where necessary.

There were regular health and safety audits and monthly medicines audits. These allowed the provider to ensure that issues were identified and addressed.

There were systems in place to identify maintenance issues. Staff were aware of how to report and follow up maintenance.

There was an open atmosphere within the home. The management encouraged a culture of learning and staff development.

Summary of findings

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 safe; staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

There were sufficient staff to ensure people's needs were met.

People were supported to have their medicines safely.

The risks to people who use the service were identified and managed appropriately.

Good



Is the service effective?

The service was effective. Staff had on-going training to effectively carry out their role.

Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS).

Staff received regular supervision and appraisals.

People's healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

People were supported to have enough to eat and drink.

Good



Is the service caring?

The service was caring. People were supported and staff understood individual's needs.

People were treated with respect and staff maintained privacy and dignity.

People were encouraged to be as independent as possible and supported to make decisions about the care they received.

Good



Is the service responsive?

The service was responsive. People's care was person centred and planned in collaboration with them.

Staff were knowledgeable about individual support needs, their interests and preferences.

People were encouraged to be independent, be part of the community and maintain relationships.

People knew how to make a complaint. There was an appropriate complaints procedure in place.

Good



Is the service well-led?

The service was well led. There was good staff morale and guidance from the provider.

The home had a positive open culture that encouraged learning. Best practice was identified and encouraged.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

Good



Roland Residential Care Homes

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 inspection took place on 14 December 2015 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection we looked at information that we had received about the service and formal notifications that the home sent to the CQC. We looked at four care records and risk assessments, four staff files, seven people's medicines charts and other paperwork that the home held.

We spoke with four people who use the service and two relatives. We observed interactions between staff and people who use the service.

Is the service safe?

Our findings

People told us that they felt safe. One person said, “I don’t feel safe anywhere but here I feel the most safest. Ten out of ten.” A relative told us, “I think [my relative] is fine there, safe.” We spoke with four staff who explained how they would keep people safe and understood how to report it if they thought people were at risk of harm. One staff member said, “It [safeguarding] is to protect adults from abuse, I would report anything if I needed to.” Staff understood what whistleblowing was and how to report concerns if necessary.

Risk assessments were person centred and written in collaboration the individual. Staff told us that people had input into how risks were managed and mitigated against. Risk assessments were detailed and gave guidance for staff on how to support people in the least restrictive way. Risk assessments had a specific section around non-compliance with medicines. What actions staff should take and what health care professionals should be informed in case of people refusing their medicines. Where people had capacity, they had signed their risk assessments. Where people lacked capacity we saw records of best interests meetings and decisions.

We saw records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. We saw that the manager had updated one person’s risk assessment following a specific incident to mitigate further risk.

There were sufficient staff to allow person centred care. We saw that there were two staff throughout the day with two sleeping-in at night. A sleep-in shift is where the staff member is on the premises and available in case of emergency but not awake. The manager told us that if a higher level of support was needed for people, they increased staffing levels to meet people’s needs.

The service followed safe recruitment practices. Staff files which showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role.

The home had a clear medicine administration policy which staff had access to. People’s medicines were

recorded on medicines administration record (MAR) sheets and used the blister pack system provided by the local pharmacy. A blister pack provides people’s medication in a pre-packed plastic pod for each time medicine is required. It is usually provided as a one month supply. We saw that people’s medicines were given on time and there were no omissions in recording of administration. One person had a specific medicine at a different time each day. This had been agreed with the local GP and was recorded appropriately. We looked at MAR records for October and November 2015 and found that there were no omissions in recording.

There were records for ‘as needed’ (PRN) medicines. As needed medicines are medicines that are prescribed to people and given when necessary. This can include medicines that help people when they become anxious. We looked at two people’s PRN medicine records. There were no omissions in recording and stock held by the home for each person matched the audit. There was detailed guidance for staff for when to offer as needed medicines to people and staff were able to tell us in what circumstances they would offer PRN medicines. We observed that one person was distressed during the inspection. We asked staff what guidance around PRN there was for this specific person. Staff told us that there was no specific guidance but that they ‘kept an eye on her’ and offered PRN medicines if they were needed.

Some people had medicines that required the person to have regular blood tests. Records showed when people had their blood tests and when the next one was due. Staff told us that they accompany people to their appointments if needed. One person had injections as part of their medicine regime, provided by a local clinic. We saw records that ensured that the person had received their medicine and when their next one was due. Monthly audits of medicines were in place.

The home had up to date maintenance checks for gas, electricity, electrical installation and fire equipment. Fire alarms were tested and recorded weekly. A recent fire risk assessment was in place. The home had a dedicated ‘handy man’. All staff were aware of how to report any maintenance issues. We looked at maintenance records and saw that issues were dealt with in a timely manner and signed to say that they had been completed. Staff told us that maintenance and its importance were covered in their induction.

Is the service safe?

The home was clean and tidy on the day of our inspection. Staff and people told us that they cleaned daily. People were responsible for cleaning their bedrooms. This was included in people's individual care plans.

Is the service effective?

Our findings

People were supported by staff that were able to meet their needs. Staff told us and records confirmed they were supported through regular supervisions. Staff told us that they received supervision every month. One staff member said, "I have supervision monthly. If staff make mistakes it can be more regular. It helps me understand my progress." All staff received yearly appraisals. One staff member said, "They evaluate my performance. I can comment and make my opinion known. They give me feedback which helps me improve."

Staff had a comprehensive induction when they started to work at the home. This included, getting to know the people who lived at the home, understanding policies and procedures, medication training and specific mental health awareness. Training records showed that staff received regular training that supported them in their role.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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.

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

Staff had received training in the Deprivation of Liberty Safeguards (DoLS) and The Mental Capacity Act 2005 (MCA). One staff member told us, "It's about whether the person can make a decision by themselves. A person needs to be assessed to decide if the person has capacity." Staff were also able to tell us what DoLS was and how it could impact on people's care. One staff said that DoLS was, "Deprivation of liberty. For example, if a client has a risk of tripping and falling when they go out, a DoLS could be necessary to ensure their safety." Another staff member said, "It [DoLS] is for their [people's] safety."

We saw that where people required a DoLS, these were in place. There were dates noted for when the DoLS needed to be reviewed. The home had detailed MCA assessment forms that had been created following appropriate legal guidelines. Where people were unable to make decisions regarding their care there were records of best interest meetings. A best interests meeting is when people have been deemed unable to be involved in aspects of their care and staff, healthcare professionals and relatives, make decisions on their behalf and in their best interests.

Staff were trained in restraint techniques. All staff had received specific training called 'Management of Actual or Potential Aggression (MAPA)'. One care plan noted that, 'MAPA should only be used with [person] as a last resource, where they try to hit staff, service users, to prevent them damaging property or posing a risk of harm to themselves'. Staff told us that restraints are used within the home, "Not often, less than once a month." We saw that if an incident had occurred this was investigated and where appropriate, risk assessments were updated. Staff were able to talk us through how they would restrain someone and the techniques that were used. Staff said that before using any form of physical restraints, they would use other techniques first. This meant that although staff were trained in physical restraint they used other techniques, such as talking and as needed medicines, to support people when they became distressed. One staff member told us, "First we try to talk to the person, give them some space. Try and calm them down through talking, offer PRN if appropriate." Another staff member said, "It's used once or twice a year, it's not really used that much."

People were supported to have enough to eat and drink. We saw a four week menu plan that showed a diverse range of foods. Vegetarian options were always available. Menu plans were clearly displayed in the kitchen area. Staff told us, and we saw, that people were consulted in resident's meetings and people chose what they want to eat.

Care plans showed that people were encouraged to cook on specific days each week. One person told us, "Yeah, I like cooking. It's alright. They [the staff] help me." Another person said, "I like to help [cook]. I often cook curries and pasta." At lunch time, staff engaged with people, asking what they wanted to eat and supporting people to prepare their lunch where needed. One person said that they were not hungry and would eat later. We later observed staff

Is the service effective?

checking with the person if they were hungry. We saw staff supporting one person to prepare the evening meal. People told us that they could make snacks and drinks throughout the day and that staff would help them if they asked.

People's personal files had details of healthcare visits, appointments and reviews. Guidance given by healthcare

professionals was included in people's care plans. Records showed that people had access to healthcare such as podiatry, opticians, and dentists. However, Staff had not signed to say if these visits had been attended by people.

We looked at four people's bedrooms. Bedrooms were personalised according to individual wishes. People told us that they could have what they wanted in their rooms. Care plans contained a section on 'accommodation', one person's noted, '[Resident] has arranged his room according to his wishes; blinds, amplifier, TV and lighting'.

Is the service caring?

Our findings

People were treated with respect and their views about their care were understood and acted on by staff. One person said, “Staff are alright really, nice most of the time.” Another person told us, “They care.” A relative said, “Staff try their best and are very supportive to [my relative].” We saw that staff took time to sit with people and chat about their day and what people had planned. There was a relaxed atmosphere within the home and staff and people interacted well.

Care plans noted what people’s interests were and people were encouraged in keyworking and daily by staff to go out and engage with the local community. The home arranged occasional group activities for people. People living at the home were independent. One person said, “I do my own thing.” Staff supported people as individuals.

Each person had a key worker. A key worker is someone who is responsible for an individual and makes sure that their care needs are met and reviewed. People were able to tell us who their keyworker was. There were regular recorded keyworking sessions in people’s care files. We saw that people also had keyworking around specific areas of their care such as medication. Staff told us that this was to, “Make sure that people understand what their medication is for, why it important.” Staff also explained to people, the possible side effects of medicines they were taking and how to report it if they thought that that were experiencing side effects. Keyworking records were signed by staff and people.

Staff treated people calmly and with respect when they became anxious or showed behaviour that challenged.

Staff told us that they knew people well and understood each person’s individual needs when they became distressed. We saw staff supporting a person who was displaying behaviour that challenged. This had been recorded in the person’s risk assessment and there was guidance for staff on how to work with the person. Staff observed the person and spoke in a calm encouraging voice. Another person became distressed during the afternoon. Staff knew the person well and were aware of what symptoms became evident when the person began hearing voices. A staff member sat in the room with the person but did not engage. They told us that the person found it difficult to communicate when they were feeling like that but would talk when they wanted to; staff were available if people wanted to talk.

Staff at the home do not carry out personal care. People’s care plan noted if they needed prompting with their personal care and how the person liked to be prompted.

We asked staff how they would work with gay, lesbian or bisexual people. Staff told us that this would not make any difference to how the person was treated. One staff member said, “Everyone needs care, regardless of anything else.”

There were up to date records of monthly residents meetings. People had discussed what type of food they wanted. One person said, ‘I’d like stir fry’ and this had been incorporated into the weekly menu. Outings and the general décor of the home were also discussed. Copies of the minutes from each meeting were kept in a file in the lounge area for everyone to read.

We saw that two people had completed forms on what their wishes were in case of their passing away.

Is the service responsive?

Our findings

Care plans were detailed and tailored to the individual. The manager told us that care plans were updated yearly but reviewed monthly. If there were any changes these were completed as and when necessary. We saw that one care plan had not been reviewed since June 2104. The manager told us that the home was waiting for the mental health team to complete their review before updating the care plan. We discussed the home not waiting for external reviews to update in-house care plans.

People living at the home had a high level of independence and were able to come and go as they wished. If people needed support when they went out it was noted in their care plan. We saw a member of staff asking a person if they wanted support to go out to the local shops. The person was supported in accessing their money and the staff member went with them. The staff member and the person were laughing and joking together and there appeared to be a good rapport.

People were encouraged to maintain relationships that were important to them. Staff told us that when a person had a partner they were welcome to visit them in the home and stay for meals. One person's care file noted that, "Resident requested to get in touch with a relative. Staff are supporting the person to locate her." Staff told us that maintaining relationships was an important part of people's lives.

People's religion was noted in their care files. Staff told us that none of the people currently attended a place of worship but would be supported to do so if they wanted to.

Care files noted what people's likes and dislikes were in all aspects of their life including, food, activities and household chores. Staff knew people well and were able to tell us what individuals liked and enjoyed. The inspection took place just before the Christmas holidays. Staff told us that people from the sister home would come over and a special breakfast and lunch would be prepared. Staff showed us presents that the service had purchased for people for Christmas. Staff said they knew people well and knew what type of things they would like.

The home had a complaints procedure that was available for staff and people to read. One person said, "we've got a book to complain, but I tell staff if I need to." A relative told us, "I know how to

[complain] but I don't need to." The manager told us that, "Feedback from complaints is a very important part of the complaint process, giving us vital information which we can act on." We saw that there had been no complaints recorded since late 2013. The manager and staff told us that there had been no complaints since this time. Resident meeting minutes showed that people are encouraged to complain.

Is the service well-led?

Our findings

The service currently does not have registered manager in post. A manager is in post who will be applying for registered status with the Care Quality Commission.

The registered manager had recently left. We talked to staff around how the provider had supported them since leaving. One staff member said, “The managers asked about my well-being, she [the registered manager] was always good with the residents.” Other staff told us that the provider has been, “Really supportive and was there for us.” Staff told us that they liked working at the home and felt supported by the management.

There was an open culture in the home and staff said that they felt comfortable raising issues during supervision sessions; but would not necessarily wait for supervision if they needed to raise something sooner.

Records showed that staff had regular team meetings. Staff told us, “Team meetings are really helpful to connect old and new staff.” The provider has several homes in close proximity. Staff told us, and we saw, that they sometimes had joint team meetings. This meant that staff across the organisation were able to share ideas and discuss issues.

There were systems in place to ensure that staff training was up to date. Training records showed when staff needed to refresh training. Supervision records showed that staff were able to identify and request training. We saw that where a staff member identified training that would improve their care practices, this was provided.

The manager told us that the provider had carried out a ‘provider audit’ at three monthly intervals in the past. This was a detailed audit and covered all aspects of the service, including care plans and staffing. The audit allowed the provider to pick up and address any issues identified and improve the quality of care provided. However, the most recent one was dated November 2014.

There were monthly and quarterly health and safety audits that were up to date. This included a ‘visual inspection’. This means that staff walk around the premises and look at areas and record to say that they are safe. If there is something that is noted as needing action, a time frame is put in place and the outcome noted. We saw monthly medicines audits for October and November 2015 which were up to date.

We saw that the provider used accidents and incidents as an opportunity to learn and improve care. Following a safeguarding issue, the provider put detailed safeguards in place. Information was also shared with other agencies and, where appropriate, at staff meetings.

Some paperwork held by the home was not up to date. This included some care plans and audits of the service. This was in part, due to the recent manager leaving and a new manager being appointed. The current manager was in the process of updating the paperwork.

Records showed joint working with the local authority and other professionals involved in people's care. The manager told us that they work closely together to make sure that people receive a good standard of care.