National Society For Epilepsy(The)

Russell House

Inspection report

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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?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Russell house is a care home which provides accommodation and personal care for up to twenty people with learning/physical disabilities and epilepsy. The home has been purpose built and is made up of four individual units which accommodates five people on each unit. There are two units on the ground floor and two units on the first floor.

At the time of our inspection there were 19 people living in the home. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The inspection took place on the 24 and 25 June 2015 and was carried out as part of our schedule of comprehensive inspections. The inspection was unannounced which meant the provider did not know we would be visiting.

Summary of findings

Relatives were generally happy with the care provided and felt confident their relatives received safe care. However we found people's safety and care was being compromised in a number of ways.

The home had a high number of staff vacancies and as a result there was not enough staff to support people and meet their needs. We saw staff were trying to do multiple jobs at the same time and one to one care for people who required it was not consistently maintained.

Staff were not aware of potential risks to people and these risks were not addressed or managed in a way which promoted people's safety and well- being. Medical advice in relation to an accident was not followed which put the person at risk. Items such as knives and hazardous cleaning substances were not kept locked and secure. Some people were not assessed appropriately prior to admission. People's nutritional needs were not met and care plans did not address people's identified needs to ensure staff provided consistent care to people.

The environment was generally clean although the design of the kitchen/diner was not suitable to meet people's needs. Systems were in place to ensure the premises were safe. However, the hot water temperature was not consistently maintained which put people at risk of injury. Although systems were in place to manage infection control, some staff spoken with did not know who the infection control lead was and the risks associated with cross infection were not well managed and known to staff.

Medication was generally well managed although staff did not follow the policy for administration to ensure medication was signed for when administered to people.

Team leaders were not suitably trained to fulfil their roles and supervision was not provided in line with the organisations policy. Not all staff had an appraisal and appraisals were not scheduled to take place.

Quality monitoring systems were in place. These were not effective in ensuring the service was properly monitored and managed. Staff and relatives told us the registered manager and deputy manager were accessible and approachable. However, the registered manager and deputy manager were not seen to be accessible to staff during the inspection. In view of the issues found and the number of breaches of regulations we found the service was not well led and suitably managed to promote people's health and safety.

Staff were recruited safely and they felt the induction and training provided was suitable to their role. Staff were observed to be kind, caring and had a good understanding of people's needs.

People had access to a range of activities and complaints were managed appropriately.

People who were able to communicate with us told us they were happy living at Russell house. We saw some people appeared happy and looked relaxed and settled. Others appeared restless, anxious and required staff intervention to keep them safe and occupied which was not always available.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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

Summary of findings

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.

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 not safe.

Sufficient staff were not available to ensure people's needs were safely met.

Risks to people were not always identified and managed to promote their safety and well-being.

Medication was not always signed for when administered.

Inadequate

Is the service effective?
The service was not effective

Team leaders were not suitably trained for their roles and they were expected to manage and monitor the units as well as provide care to people.

Staff were not supervised in line with the organisations policy.

People's nutritional needs were not monitored and met.

Inadequate

Is the service caring?
The service was not always caring.

Some staff were kind, caring and supportive of people.

Opportunities were provided for people to be consulted on the service and make choices and decisions in relation to their care and treatment.

Some staff did not always engage positively with people and did not promote their choices and dignity.

Requires improvement

Is the service responsive?
The service was not always responsive.

New admissions to the home were not assessed to ensure the home could meet their needs and to ensure they had identified their care needs and risks to their wellbeing.

People's care plans lacked detail as to how their identified needs were to be met.

Person centred activities were provided.

Requires improvement

Is the service well-led?
The service was not well-led.

The service was not effectively audited and managed to ensure people received the care they needed.

Inadequate

Summary of findings

The registered manager and deputy manager were not accessible to staff and did not have a visible presence in the home.

Records were not kept up to date and accurate.

Russell 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 inspection took place on 24 and 25 June 2015 and was unannounced. This meant staff and the provider did not know we would be visiting. The inspection was carried out by one inspector.

We previously inspected the service on the 7 January 2014. At that time the service was meeting the regulations inspected.

Before the inspection the provider completed a Provider Information Return (PIR) The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed the previous inspection reports of the home and other information we held about the home.

Some people who used the service were unable to communicate verbally with us. Therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we walked around the home to review the environment people lived in. We spoke with two people who used the service, the registered manager, deputy manager, two team leaders and six support staff. We also spoke with ten relatives by telephone after the inspection and obtained feedback from professionals involved with the home. We looked at a number of records relating to individual's care and the running of the home. These included six care plans, medicine records for four people, staff duty rosters, shift planners, three staff recruitment files, seven staff training and supervision records.

Inadequate

Is the service safe?

Our findings

One person told us staff were always available to support them. Relatives told us they thought their relatives were safe at the service. Some relatives felt the staffing levels could be better at times to enable people to do more. A relative commented "Staff always appeared rushed and pulled in all directions". Another relative told us the home did not have enough staff. They commented "Good staff leave as they feel underpaid and under-valued".

We found there were not sufficient numbers of staff available to keep people safe. The home had eighteen full time vacancies and was actively recruiting into the vacancies. Regular bank staff were used to cover shortfalls in the rota and staff on each unit told us they helped each other out as and when it was required. Staff told us they thought the staffing levels could be better and that their workloads had increased which made it difficult to provide the care people needed. They told us they were also responsible for the cooking and cleaning which took them away from supporting people.

We saw staff were rushed and were doing more than one task at a time such as supporting people with their meals whilst getting drinks and providing one to one care.

The home had a number of people who were assessed as requiring one to one staff observations and support during the day. We saw on one unit two people required one to one care for 10 hours per day and another person required one to one care for four hours per day. However only three staff were provided to meet those needs as well as provide care and support to the other two people who lived in the unit. The registered manager told us this was because a bank staff member had cancelled their shift at short notice. The registered manager and deputy manager told us they were made aware the unit was short staffed at 9.30 am that morning and they had arranged for a staff member from another unit to assist. The assistance provided was for a staff member to take a person who received one to one care out for a walk, due to their anxiety. A staff member told us "One of the people on one to one care likes to go out but they could not go out earlier today as there was no staff to do that". The person had to wait for the staff member from another unit to be available to escort them for a walk. This meant although funding had been provided for extra staff this was not consistently available to people for the allocated time. The registered manager and deputy manager took no other action to ensure sufficient staff were available to provide the required care to people and they did not increase their support to the unit to ensure safe care.

During our inspection two people left one of the units and two staff followed them to supervise, support and encourage them to return. During this time the other staff member was providing personal care to one person and the other two people were left unsupervised. One of the people left unsupervised should have been receiving one to one care. At this time the lunch which was in the process of being cooked was turned off and left unattended and accessible to people, whilst the staff members supported the two people to return to the unit. During this time only the inspector was left on the unit. The lack of staff supervision placed those people at risk of injury.

A relative told us their relative required 24 hour observations but they worried this was not always maintained particularly at night. This was fedback to the provider to provide confirmation and reassurance to the relative that the required care was given.

The deputy manager told us they managed the rota as this enabled them to have an overview of the four units and ensure staff were deployed appropriately. They told us there was always a team leader or shift leader on each shift on each unit. We saw on the unit that was short staffed that there was no team leader or shift leader on duty during that shift. Therefore a support worker had taken responsibility for managing the shift. The support worker told us they had completed the shift leader training but had not passed the assessment to confirm they were competent to take on the role. However they were left in charge of that shift. We saw from the rotas that there was not always a designated shift leader on each shift, therefore people were not always supported by suitably qualified and competent staff.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. This was because the provider failed to ensure that at all times there were sufficient numbers of suitably qualified, competent, skilled and experienced staff employed to make sure they could meet people's care and treatment needs.

We saw risks to people were not identified and managed. We saw a person was at risk of severe constipation which had previously resulted in admissions to hospital. A risk

assessment and bowel chart was in place. According to the bowel chart records they had not opened their bowels for the eight days leading up to our inspection. Staff on the unit thought the person had opened their bowels but they were unable to find any records to confirm if this was the case. Therefore the identified risk was not been effectively managed.

We saw people had risk assessments in place in relation to the use of bed rails, challenging behaviours, personal care, trips out. However the risk assessments were not always dated and signed. Some staff spoken with were aware of those risks to people, whilst other staff were not sure what risks were present and how they were to be managed.

We saw in one person's care plan that they had a health related medical device in place and that immediate medical treatment was required if the device became blocked. There was no risk assessment to identify and manage the risks associated with the medical device. We saw another person had a Percutaneous Endoscopic gastronomy (PEG) feed in situ. A PEG is where a tube is passed into the abdomen to provide a means of feeding a person when oral intake is not adequate or possible. There was no risk assessment in place to manage the risks associated with the PEG feed. Staff were aware the medical device and PEG feed were in place but were not aware of the potential risks to the person as a result of this.

We saw two people leave the home and staff followed and supported them to return. Their care plans made no reference to this and there was no protocol or risk assessment in place to manage the risk. Staff told us this was a regular occurrence.One staff member said "They just try and talk them back".

In another person's file we saw they were initially diagnosed with a medical condition in January 2015 which required them to have their fluids restricted. This was confirmed by a further blood test by the GP in March 2015. The GP requested that the person should have fluids restricted to 1500 millilitres daily. There was a note at the front of the person's care plan to say the person's fluids were restricted to 1500 millilitres a day. This was the only reference to it within the person's care plan. A risk assessment was not in place to manage the risks associated with this and the care plan provided contradictory advice in that it indicated the person was to be supported to drink plenty of fluids. Two staff who were providing care to this person during the inspection were not aware of the need for the person's fluids to be restricted or why. Fluid charts were in place but were not accurately completed to confirm if the required fluid levels of 1500 millilitres were being maintained. Staff had recorded on the fluid charts "regular fluids offered and taken" but not how much. Where the amount of fluids taken was recorded a daily total was not always maintained. During our inspection we saw the person drinking a mug of tea which was not recorded on their fluid chart at that time. These practices had the potential to put the person at serious risk. A clinical review meeting took place weekly involving the registered manager or deputy manager and the team leader from each unit. We saw in the minutes of the clinical review meeting dated the 7 April 2015 that they had recorded the person was on a restricted fluid intake and fluid charts were in place. However they had not established if a care plan and or risk assessment was in place to address and manage the risks associated with this and whether staff supporting the person were aware of it. As a result of our findings we asked the registered manager to make a safeguarding alert to the local authority in respect of neglect of that person and their well-being.

We saw in one person's care plans that they were at risk of falls from seizures and they were to wear a helmet in high risk areas. It did not outline what was considered a high risk area and the person was noted not to wear the helmet during the course of the two days of the inspection even when walking up the stairs. In another person's care plan we saw a risk assessment was in place that they were to wear their helmet and ankle splints at all times. The risk assessment indicated the splints were required due to previous fractures. During the two days of the inspection we did not see their helmet or splints being worn.

We saw some people required assistance with mobility but there was no moving and handling risk assessment to provide guidance for staff on how the person was to be supported. We saw in two of the six care plans viewed that they were at risk of choking. One person had a risk assessment in place to manage the risk which indicated a thickener was used in fluids. However the information about the consistency of the food was not documented within the risk assessment to ensure staff always followed the correct guidance. The other person's care plan told us they were at risk of choking due to rushing their food. There was no risk assessment in place to manage the risk and staff seemed unaware of it.

Inadequate

Is the service safe?

Care plans contained Waterlow risk assessments which is a tool used to assess if a person is at risk of developing pressure sores. We saw one person had a Waterlow risk assessment dated October 2014. They were assessed as being high risk. However this had not been reviewed since that date which had the potential to put the person at risk.

Policies and procedures were in place to provide guidance to staff on how to deal with accidents. We saw in one person's care plan they had an accident resulting in a head injury. A body chart and accident report was completed. The person was provided with immediate medical intervention and staff were advised and it was recorded on the accident report that staff were made aware to monitor the person for the next 12 hours. The daily records viewed did not indicate the person was monitored and the handover record for the date of the accident made no reference to the accident and made no mention of the medical advice given.

During our walk around the home we saw the laundry room which was meant to be locked was left insecure. Cupboards containing hazardous cleaning materials and drawers containing sharp knives were meant to be locked at all times. In all four units we found they were unlocked or the key was left in the cupboard/drawer. We saw in one person's care plan that they were at risk of injuring themselves with a knife due to impulsive behaviours. Therefore the practice of not keeping the drawers and cupboards locked meant the risks to people was not being managed.

Staff carried out health and safety checks which should include weekly water temperature checks. The records indicated the water temperature checks were not being recorded weekly. We saw occasions where the water temperature exceeded 44 degrees centigrade which is considered by the Health and Safety Executive to be maximum safe temperature for water outlets in care homes. On some occasions the water temperature was taken again but on most occasions there was no indication that action had been taken. A health and safety audit was completed on the 23 June 2015. Whilst the audit had picked up the water temperatures were not been carried out weekly it failed to see that water temperatures in some outlets exceeded 44 degrees and no action was taken.

The registered manager told us two staff were nominated as infection control leads. Staff spoken with were not all aware of who the infection control leads were. We saw from the records viewed the infection control leads were trained in the role. We noted the laundry room had a strong smell of urine. This was dealt with immediately. On day two of the inspection the smell was still present but less offensive. We saw in one person's care plan that there was a risk assessment to say they had a bacterial infection. The risk assessment was not clear whether the bacterial infection was still present or a historical risk. Staff told us they were not aware if the person still had the infection and were not aware of the measures to take to prevent cross infection. This meant there was a risk of cross infection and infection control measures were not being appropriately managed.

We looked at medication records for four people. We saw medication was given as prescribed. Staff carried out a daily stock check of medication. This enabled them to pick up on any discrepancies with medication quickly. We saw on one unit notes were regularly left for staff who had not completed the medication administration records properly to remind them to sign for medication they had given. The practice of not signing for medication when administered puts people at risk.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.This was because risks to people were not properly managed which meant safe care and treatment was not provided.

The home had a contingency plan in place which provided guidance for staff on what to do in the event of a major disaster at the home. We saw the environment people lived in was not always suitable to their needs. Each unit had a large kitchen and dining area. The dining area was small and crammed and did not allow for people to eat comfortably together taking into account large pieces of equipment such as chairs. The provider confirmed they were looking at getting quotes to improve that space to make it more useable and appropriate to people's needs. We were previously notified that the lift between floors was out of order. Relatives we spoke with expressed their dissatisfaction about this as it is the only means for people in wheelchairs to get from the first to the ground floor and on a recent occasion people in wheelchairs on the first floor were confined to their units for over two and half weeks. The provider confirmed they were looking at ways of trying to prevent a reoccurrence. Each unit was generally

Inadequate

Is the service safe?

clean. Areas of the home were in need of decorating. We saw in the maintenance log some bedrooms were scheduled to be decorated but a full refurbishment plan was not in place.

Staff were trained in safeguarding. They understood types of abuse and their responsibility to report any allegation or observation of abuse. However they failed to see that their own practice of not providing safe care to people put people at risk of neglect.

We saw fire equipment and moving and handling equipment was serviced and safe to use. We saw records were maintained to demonstrate equipment was cleaned. A gas safety check was carried out in October 2014 and electrical testing was carried out in May 2015. We saw fire safety checks were not being carried out in line with the providers own guidance. This had been picked up on the health and safety audit completed on the 23 June 2015.

The fire authority had visited in October 2014. A number of deficits in fire safety were found. The registered manager told us all of the issues raised by the fire authority had been addressed. There was no action plan in place to confirm this. The registered manager told us all actions from audits were added to the homes development plan and signed off when completed. The provider confirmed after the inspection all actions from the fire report were completed.

Staff files showed the required checks were carried out on staff before they commenced work at the home. We spoke to the newest staff member who confirmed they had completed an application form, attended for interview and had to provide names of previous employers to act as references and had a disclosure and barring check carried out before they started work. This meant safe recruitment processes were in place.

Inadequate

Is the service effective?

Our findings

Relatives told us they thought staff had the skills and training to do their job. One relative commented "Staff handled difficult and complex situations well". Another relative said staff do a terrific and difficult job under pressure and felt confident that staff were suitably supported.

Staff told us they felt suitably inducted and trained to do their job. New staff confirmed they had completed an induction into the home and were working through the common induction standards. A staff member told us the induction was well structured and planned. We were provided with a training matrix which indicated the percentage of staff with training the provider considered as mandatory. These included training in fire, first aid, epilepsy awareness, infection prevention, safeguarding, food hygiene, support planning, eating and swallowing, Mental Capacity Act training and deprivation of liberty safeguards, medication and safer passenger training. The training matrix provided indicated that a low percentage of staff on one unit had the required training. On the other three units the majority of staff had the required training. We saw staff were assessed and deemed competent to administer medication and peg feeds. Staff told us they had access to specialist training such as autism and management of behaviours that challenged. They said they were also given the opportunity to enrol on a diploma course.

Staff told us they were clear about their roles and responsibilities. Team leaders told us their roles and responsibilities had increased and they found they did not have the time to do all that was required of them and to a high standard. We saw team leaders were responsible for managing the unit which included managing the shift, implementing care plans, supervising and appraising staff, carrying out audits of practice as well as providing personal care and support to people.

A professional involved with the service told us they were concerned support staff may not have a thorough understanding of their various roles and the responsibilities within those roles such as key worker, shift leader and team lead. They felt line management and provision of support to identify areas where development was needed and facilitation to do so may benefit from attention.

Staff told us they felt supported and received supervision. However we saw the team leaders were not adequately supported and were struggling to keep on top of their job. We saw two of the team leaders responsible for supervising staff and carrying out appraisals did not have supervision and appraisal training to enable them to carry out that task. Staff told us supervision should take place every other month. The supervision policy indicated supervisions should take place every six weeks. We saw from the supervision records viewed staff were not having supervision when planned. One of the team leaders had supervision on the 22 March 2015 and 1 June 2015. Another team leader had supervision 27 February 2015, 21 April 2015 and none since. A support worker had supervision on the 4 February 2015 and 16 May 2015. Another support worker had supervision on the 6 April 2015 and the next one was planned for the 1 July 2015. This indicated supervision was not taking place in line with the organisations policy.

We asked to see confirmation of appraisals of staff. The registered manager told us not all staff had an appraisal. We saw this had been picked up on a monitoring visit carried out by the provider in May 2015. At the inspection the registered manager was unable to provide evidence to confirm the number of appraisals that had taken place and if any were scheduled. The provider confirmed after the inspection 21 out of 32 staff had an appraisal.

This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.This was because staff were not suitably skilled and trained for their roles and they were not receiving appropriate on going supervision.

We saw people's nutritional needs were not met. People's care plans contained nutritional assessments which outlined whether people were at risk of low weight. We saw in one person's care plan they were at risk of low weight. The last weight recorded was on the 31 October 2014. There was no indication they had been referred to a dietician or that their food and fluid intake was being monitored. We saw in another person's care plan that their food and fluid was to be closely monitored and that they were to have fortified diet due to their low weight and refusal to eat. The food and fluid charts were incomplete and on many occasions only one meal a day was recorded and no fluids were recorded. Another person was on a reducing diet and the care plan indicated they were to

Is the service effective?

follow a low fat diet and to be weighed monthly. There was no guidance on what was considered a low fat diet and the last recorded weight for this person was on the 31 October 2014.

We observed lunch. We saw people were provided with aids and equipment to enable them to eat independently. We saw staff supported people who required assistance. Each unit had a four week rolling menu and people were provided with a choice of meals. We saw people had an alternative to what was on the menu and people who were able to were assisted to make a sandwich as they did not want the lunch on offer. People told us they thought the food was nice. We saw the meal was nicely presented and smelt appetising. Relatives told us they thought the meals provided were nutritious and varied. The provider was looking at changing the way meals were managed and had consulted with people and their relatives on the proposed changes. Some relatives raised concerns about the proposed change to have the meals supplied by a private company. This was fed back to the provider to consider.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.This was because people's nutritional needs were not met.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. People's care plans included a consent to care form. We found in all of the care plans viewed that this was not signed or dated and care plans did not indicate whether people had capacity to consent to their care or not. Staff had been trained in MCA and they told us people had capacity to make decisions on some aspects of their daily care but may not be able to make decisions on treatments. In view of the lack of guidance in care plans it was not clear how staff would know who did and did not have capacity.

A professional involved with the home told us people were afforded opportunities for choice at a level from which they can function. If a decision must be made where the person has not got capacity to make an informed decision, a best interest meeting is scheduled with input from all parties involved. People's care plans viewed did not evidence best interest meetings had taken place.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.This was because it was not established and recorded if people had the ability to consent to their care and treatment.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. It ensures the service only deprives someone of their liberty in a safe and correct way and this is only done when it is in the best interest of the person and there is no other way to look after them. We were told DoLS application had been made for all of the people living at Russell house. Copies of the referrals were maintained.

People had access to health professionals to meet their specific needs. We saw records were maintained of appointments with professionals and the outcome of those visits. A relative told us their relative was in need of urgent dental care. The home made an appointment but they did not inform the relative of the date. The person refused to go and the relative thought if they had been there they may have been able to reduce the anxiety to ensure the person attended. Relatives told us staff kept them informed of changes in people's health and sought medical input if required. There were annual reviews of people's care and progress. Relatives told us they were invited to and included in people's annual review. Two relatives told us that they found actions agreed at reviews were not acted on and followed up. One relative commented "They come out of annual reviews feeling positive and enthusiastic and then actions that were agreed do not happen". This was fed back to the provider to address.

A professional involved with the home told us they thought the service was effective to people's needs. However they said there was variability in the way advice and interventions from professionals was responded to. Some members of the team were excellent, capable and motivated whilst others were not. This meant there were two occasions when key information had not been relayed that impacted on the effectiveness of the therapy being provided.

Another professional told us staff follow the advice provided to improve people's nutritional status. They said if staff had any queries they did not hesitate to contact them.

Requires improvement

Is the service caring?

Our findings

People told us staff were kind and caring. One person commented "Staff do care, they are very helpful". Relatives told us they felt staff were kind, caring, empathetic and that they take time to listen to the people they supported. A relative said what impressed them was the way staff always treated their relative in a dignified way and with respect.

Professionals told us they thought staff were caring. A professional told us staff supporting people for therapy sessions were knowledgeable, interested and caring towards the people they supported. Another professional commented "Staff treat people with care, compassion and friendliness".

We observed staff engaging with people. We saw staff were kind, caring, gentle, supportive and enabled people to be independent. One person was being supported to have their meal and the staff member supporting them provided the right support to enable them to do as much as possible for themselves. We saw staff distract and reassure people when they became distressed and allowed them to get up and walk away from the table when they needed to.

We also saw some aspects of poor practice. On one unit we saw a staff member was sat at the table with two people. The staff member was peeling the potatoes but did not engage with the people sat at the table. We saw a staff member from another unit was asked to take a person out for a walk. The staff member came onto the unit and stated to another staff member "What do you want me to do with him". These practices did not promote people's dignity or demonstrate respect.

We saw people were offered choices in relation to what they wanted to eat. We saw on one unit people were given drinks but were not given a choice of drink. A staff member made drinks and gave them to people. We asked staff how they knew what people liked to drink. Staff told us because they knew what people liked. This practice did not promote people's choices.

We saw resident meetings took place and people were informed and supported to be involved in making choices and decisions in relation to issues which affected them, such as the environment they lived in, holidays and activities. The outcome of those were recorded in a user friendly way. Information was displayed on notice boards throughout the home to inform people on issues that were important to them such as what to do in the event of a fire, how to make a complaint and details of forthcoming activities.

People's care plans outlined their communication needs. Staff were aware of how people communicated and were able to understand and engage appropriately with people. Staff had an awareness of what triggered behaviours that challenged and we saw them manage those in a safe, caring and empathetic way. A professional involved with the home told us their advice had been sought on several occasions for people who had substantial deficit in both understanding language and self-expression. All communication was unique to individuals and they presented with behaviours which were difficult to manage. They said staff remained respectful, gentle and caring when working with people who challenged. They placed themselves at risk of injury, due to violent outbursts. However staff had been pro-active in seeking possible solutions through improved communication and implementing strategies to help them understand what is happening, what to expect and what is expected of them.

Another professional involved with the home told us staff supported people with complex needs and related social issues. They felt they managed those challenges well.

People's care plans outlined what people liked to be known as. We heard people were called by their preferred names. Staff were proactive in supporting people to promote their privacy by encouraging them to close bedroom and bathroom doors when they were in there and ensuring they were dressed appropriately.

An advocate involved with the organisation told us staff at Russell house were aware of the advocacy service and role. The advocate told us they had been involved in supporting people to communicate their views in relation to surveys and had acted as an Independent Mental Capacity Advocate (IMCA) for people where this was required.

It is recommended the provider address staff's poor practice to promote people's dignity, respect and choices.

Requires improvement

Is the service responsive?

Our findings

Relatives told us they thought staff were responsive to people's needs. One relative told us "Staff seem to know when something is wrong". Another relative commented "Things have improved for "X" and since being at the home it has enhanced their life". A relative told us their relative's spiritual needs were met which was important to that person.

The National Society for Epilepsy has a number of registered locations on site. A relative told us their relative moved from one of their other locations to Russell House. They said the registered manager initiated the move as they felt Russell House was more suitable to the person's needs. The relative told us this was the right intervention for their relative and the person had made good progress.

Another relative told us their relative was impulsive and required staff supervision. They said some staff seemed too laid back and they worried staff would not always respond quickly to maintain the person's safety.

A professional involved with the home told us the home was not always responsive. They gave an example where a person went for a hospital appointment with a bank support worker who had no knowledge of the person they were supporting. The professional was able to intervene to provide the hospital with the key information on the person. However that incident reflected to them a lack of consistency of care when other services were sought.

At the time of the inspection the home had a person receiving respite care which meant they were staying for a short period of time to give the family a break. They also had a new admission of a person who previously received respite care but had recently been admitted for permanent residency. We saw the person admitted for respite care had a care plan in place dated 4 December 2013. There was no indication this had been reviewed and up dated. The registered manager told us a senior house officer from the medical unit on site had admitted them and this was the only assessment that had taken place. We saw in the medical records that a medical assessment had taken place but staff had not assessed and established if they could meet the person's needs. We looked in records for the other new admission. They had no admission assessment in place either and this was not completed when they were previously admitted for respite care or when they became permanent. We asked to see the provider's policy on respite admissions. We were told there was no specific policy in place to support practice. This meant people were not assessed to ensure the home had established they could meet their needs.

People had care plans in place. Care plans around personal care were generally detailed and informative but we found a care plan on the support required with personal care was not in place in all six care plans viewed. Care plans in relation to support with behaviours, general health, nutrition, promoting people's choices and decisions lacked detail or were not in place where required. Care plans were not updated to reflect changes in people's needs and care required. This meant people were not getting the required care which put them at risk. Care plans showed no evidence of people being involved in them and some were not signed and dated.

Relatives told us they were aware their relative had a care plan. One relative told us they were given the opportunity to have input into their relative's care plans. This was not evidenced in the care plan files viewed. Another relative told us they had worked with the staff in ensuring person centred care plans were in place before their relative was admitted to the home and as far as they knew the required care was provided.

Peoples' care plans included protocols on the management of seizures. These were detailed and informative. We saw a seizure protocol was not in place for one of the new admissions. This was printed off and put on file unsigned. It was dated the 24 February 2014 and there was no evidence it had been reviewed. A seizure protocol was in place for the other new admission. However this was not dated or signed and there was no indication it was current.

Relatives told us they attended people's annual reviews and felt able to contribute to these. Most felt actions agreed were implemented. One relative told us that in their experience actions from reviews did not get completed and they were not kept informed or updated of that. Relatives told us each person had a key worker who was a named member of staff that liaised between them, their relative and the home. Relatives were generally happy with this and felt the key worker played a key role in their relative's life at the home. Two relatives told us that the keyworker for their relative changed frequently and they were not informed or consulted on the decision. Another relative told us their

Requires improvement

Is the service responsive?

relative's key worker had recently changed and they were only made aware of that when the key worker rang them to ask if the person could speak to them. The relative felt the key worker would know this if they knew the person that they were key worker to. Another relative told us the home did not have a pen picture handy reference sheet to send with a person when they went to hospital and this meant key information on the person was not accessible to professionals treating the person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.This was because the provider failed to ensure people admitted to the home were assessed and care and treatment was provided in line with their needs.

One person told us they liked the activities available. Relatives told us they thought there was a good range of activities provided and they were happy with what was provided. A relative commented "Staff do a good job and "X" is out and about a lot". During the inspection we saw people attended one to one activities and an in house arts and crafts session. The activities were co-ordinated centrally. Each home had a named activities co-ordinator who was responsible for developing person centred and group activities programmes. We saw a trip to the coast was planned. Resident meeting minutes showed people were consulted on the activities on offer and given the opportunity to suggest activities they would like. A recent survey had been carried out to find out what activities people were interested in across the site. The feedback from the survey was being collated to provide more person centred and varied activities.

A person using the service told us they would talk to staff if they had any worries or concerns. Relatives told us concerns and complaints raised were acted on. Another relative told us they had not made a complaint but felt confident if they did it would be dealt with. A relative told us they were discouraged from emailing their concerns as the registered manager told them they would have to treat their email concerns as a complaint. The registered manager suggested instead the relative could talk to them when visiting. The relative told us this was not an option as they usually visited at weekends and the registered manager was not on duty. As a result they felt disempowered to raise concerns. This was fedback to the provider to address.

We saw concerns and complaints were logged, investigated and responded to. Information on how to make a complaint was displayed on notice boards throughout the home and staff knew what to do if a complaint or concern was raised with them.

A professional told us they felt the registered manager took concerns raised seriously. They gave an example where the registered manager responded quickly and positively to concerns raised and met with them to discuss and agree appropriate actions. They said the registered manager took an assertive role in ensuring things improved.

Inadequate

Is the service well-led?

Our findings

Relatives told us the home was well managed and well-led. They felt the registered manager and deputy manager were approachable and accessible. One relative told us how the registered manager was effective, a problem solver and thinks outside the box. They gave an example where they had sorted out transport and staffing problems to get their relative to a regular activity that was important for that person. Another relative described the registered manager as professional, open, transparent, hard-working and felt they had contributed to the progress their relative had made whilst at the home.

One relative told us they did not find the registered manager approachable. They found the registered manager did not take kindly to criticism and was quite confrontational. This was fedback to the provider to follow up on.

Professionals involved with the home felt the home was well- led. One professional said they felt the registered manager took their responsibility and accountability seriously. Another professional said the staff tell them one thing and the management team tell them another but they are able to resolve those issues to everyone's satisfaction.

A professional told us many members of the support teams were highly motivated and capable. Some teams were quite cohesive and work well together. When problems arise, the registered manager was efficient in responding to them. They said the registered manager works collaboratively with the multidisciplinary team. He/she encouraged the team to seek the advice of other health care professionals and was quick to authorise the team leads to act on suggested solutions. They told us the registered manager was assertive, yet fair, in dealing with people, families and the staff team. They felt the management style may be somewhat strict and by-the-book. They commented "More flexibility and consideration of extenuating circumstances would make the registered manager more approachable to the staff team".

Staff said they thought the home was well managed. Some staff felt the registered manager and deputy manager were approachable but they told us they would never ask them to assist on shift and they sort out staffing issues between the units. A staff member commented "The registered manager and deputy manager never come on the floors and as a result the units help each other out rather than ask management". One staff member told us they did not have a problem with the registered manager but knew other staff did as they found the registered manager strict and not always open to feedback. We saw one unit was short staffed. The registered manager and deputy manager were aware but they did not provide support to the unit. This meant risks to people were not mitigated. During the two days of the inspection the registered manager and deputy manager were in their offices and did not have a visible presence on the units.

We found the home was not being effectively monitored and managed. The registered manager and deputy manager told us their workload had increased which meant they were required to attend meetings which kept them away from the home more. During the course of the two days of the inspection the registered manager was off site on the first morning of the inspection and was at the home for the remainder of the time. The deputy manager was at the home throughout the two days of the inspection.

We saw regular team meetings and weekly clinical review meetings took place but these failed to alert the management team to the issues of concern we found. We saw quality monitoring audits of medications, health and safety, finances, care plans, catering and infection control took place. These were delegated to team leaders to undertake. There was no evidence it had been established if those staff had the skills and competencies to carry out these audits and the management team were not overseeing the audits to ensure they were effective in picking up issues. We saw the care plan and health and safety audits failed to pick up the issues we identified at the inspection. Food and fluid charts were not monitored and there was no schedule in place for auditing care plans. We saw one person's care plan had not been audited since they were admitted in 2009. Staff supervision and the rotas were not being audited and therefore it had not been identified that staff were not getting the required support and supervision in line with the policy and that safe staffing levels were not maintained.

The provider carried out quality monitoring visits of the service. We saw a visit was carried out on the 1 May 2015 by a registered manager from another service and a two day

Inadequate

Is the service well-led?

visit took place on the 19 and 21 May 2015 by a senior manager. That report was comprehensive and picked up some of the issues we had identified in relation to cupboards being left unlocked, care plans and risk assessments not signed and staff appraisals not happening. There was no indication that those issues had been actioned or addressed by the registered manager.

Night staff and day staff checklists were in place. These were incomplete and were not being monitored or addressed. Staff told us they were clear about their roles and responsibilities. Team leaders were expected to cover shifts and provide personal care as well as doing all other aspects of management on the units they worked in. They were not provided with the required support and monitoring to enable them to do to their job effectively. The registered manager and deputy manager told us they do a regular walk-about of the units. The provider confirmed that their expectation was that this was happening. This was not evidenced during the inspection.

The registered manager told us the key challenges for the service was staffing vacancies and trying to keep within the set budget. The key challenges we found was that the service was not been managed, monitored and staff were not adequately supported and guided to do the tasks delegated to them.

Relatives told us relatives meetings took place and they felt consulted with and kept updated on the service. They told us they had recently being sent a survey to complete to give their feedback on the service. A relative told us communication could be better and that they were not always informed of key issues affecting their relative. Another relative told us they were not informed in a timely manner of a decision to admit their relative. They had been made aware the decision to offer the placement had been agreed a month earlier but they were not informed.

The location had changed its registration from a nursing home to a care home without nursing in May 2012. At this inspection we saw the location was still registered for the regulated activity diagnostic and screening and treatment of disease, disorder or injury. The registered manager was unaware of this and agreed to complete an application to remove those regulated activities.

We saw records required to meet the regulations were not kept up to date and suitably maintained. Care plans were not reflective of people's needs. Risk assessments were not in place to ensure risks to people were properly managed. Care plans were not dated and signed and food and fluid monitoring charts were not properly completed. People's daily records did not outline the care given and did not indicate the required monitoring was provided where this was required.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. This was because systems and processes were not established and operated effectively to ensure the service was effectively managed and monitored.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 18 HSCA (RA) Regulations 2014 Staffing **Staff were not suitably skilled and trained for their roles and they were not receiving appropriate on going supervision.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People's nutritional needs were not met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had not established and recorded if people had the capacity to consent to their care and treatment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider failed to ensure people admitted to the home were assessed and care and treatment was provided in line with their needs,**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Systems and processes were not established and operated effectively to ensure the service was effectively managed and monitored.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to people were not properly managed which meant safe care and treatment was not provided.

The enforcement action we took:
We served the provider a warning notice due to a breach of regulation 12. We asked the provider to take appropriate action by 20 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider failed to ensure that at all times there were sufficient numbers of suitably qualified, competent, skilled and experienced staff employed to make sure they could meet people's care and treatment needs.

The enforcement action we took:
We served the provider a warning notice due to a breach of regulation 18. We asked the provider to take appropriate action by 20 August 2015.