Care Quality Commission

Roland Residential Care Homes Limited

Roland Residential Care Homes - 6 Old Park Ridings

Inspection report

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Date of inspection visit:
29 January 2016

Date of publication:
22 March 2016

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

Summary of findings

Overall summary

This inspection took place over one day on 29 January 2016 and was unannounced. At our last inspection on 29, 30 December 2014 we made a recommendation around a fire risk assessment specific to people who were using sedatives. The decoration of the home was poor in places. At this inspection we found that the provider had addressed the issues identified.

Roland Residential Care Homes, 6 Old Park Ridings, is registered to provide accommodation and personal care for a maximum of ten adults with mental health needs. On the day of inspection there were nine people using the service.

There was a registered manager in place who was present during our inspection. 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. 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.

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.

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 2005 (MCA) 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 mental capacity assessments and best interests meetings. □

Care plans were person centred and reflected individual's preferences. There were regular recorded key working sessions. 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 and transparent culture in which good practice was identified and encouraged.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

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.

Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were mitigated against.

People were supported to have their medicines safely. Staff were knowledgeable about the medicines they were giving.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role. Staff received regular supervision and appraisals.

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

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

People were supported to have enough to eat and drink.

Is the service caring?

Good

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

People were encouraged to have input into their care.

Staff treated people with dignity and were patient and kind in their interactions.

Is the service responsive?

Good

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.

There were individual and group activities. People's preferences were listened to and acted upon.

People were encouraged to have full and active lives, be part of the community and maintain relationships.

A system for complaints was in place and people were encouraged to complain.

Is the service well-led?

Good

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

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.

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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 29 January 2016 and was unannounced. The inspection was carried out by one inspector.

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

We spoke with six people who use the service, three relatives and five staff. During the inspection we also spoke with a visiting district nurse. We observed interactions between staff and people who used the service.

Good

Is the service safe?

Our findings

People told us that they felt safe. One person told us. "I think it's safe. I'm ok here." Another person said, "Safe? I'm safe here." staff were able to explain how they would keep people safe and understood how to report it if they thought people were at risk of harm. Staff were able to explain different types of abuse and how they would recognise it. One staff member said, "It's [safeguarding] to protect vulnerable people from any form of abuse." Another staff member said, "Safeguarding is to make sure people are not abused. Such as sexual, financial, physical and emotional [abuse]." Staff understood what whistleblowing was and how to report concerns if they needed to. Staff were aware that they could report concerns to the local authority, The Care Quality Commission and the police.

Risk assessments were person centred and written with the individual. Staff told us that people had input into how risks were managed and mitigated against. People had signed their risk assessments. 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 telling staff what action to take and what heath care professionals should be informed when people refused their medicines.
At our last inspection we found that the home did not have a specific fire risk assessment in place for people who used sedatives, such as sleeping tablets. People that are using sedatives may have a reduced response time to the fire alarm. We saw that the home had included this specific risk in their fire risk assessment. The registered manager told us that there was no one in the home that was currently prescribed sedatives. However, if someone were to be prescribed sedatives, the home would risk assess the person and put a personal evacuation plan in place.

We saw records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. Records were detailed and noted the issue, if there had been any investigation, the outcome and any learning from the accident or incident. The registered manager told us that any accidents or incidents were discussed at team meetings to provide an opportunity to learn.

There were sufficient staff to allow person centred care. We saw that there were three 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 registered manager told us that if a higher level of support was needed for people, they increased staffing levels to meet people's needs.

Where staff were on a sleep-in shift, we saw that one staff member slept in the office. However, the second staff member slept in the kitchen. The kitchen was locked at night. We saw that there was a risk assessment for people who were allowed to use the kitchen at night and were provided with a key. There was no risk assessment in place to address safety of the staff member sleeping in the kitchen. The registered manager told us that other people were provided with refreshments for the night, such as a flask of tea or coffee, before the kitchen was locked. However, people were unable to access snacks if they required them during the night.

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 medicines in a pre-packed plastic pod for each time medicine is required. It is usually provided as a one month supply. There were specific medicines that were not appropriate to be in the blister pack and these were clearly labelled with the person's name and kept in the medicines cabinet. There were records for 'as required' (PRN) medicines. As required 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 MAR records for November and December 2015. People's medicines were given on time and there were no omissions in recording of administration.

Staff were able to explain different types of medicines given to people living with mental health conditions and what side effects could occur. Staff were aware of how to recognise side effects and knew how to refer people if they needed to.

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 accompanied 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 carried out.

The home had appropriate storage for controlled drugs. There was a separate controlled drugs cabinet. Controlled drugs are medicines that are included under The Misuse of Drugs Regulations (2001) because they have a higher potential for abuse. Medicines classed as controlled drugs have specific storage and administration procedures under the regulations. We saw that there were detailed administration records for people that received controlled drugs. One person had their medicines administered and recorded by two district nurses. Where staff within the home were administering a controlled drug, we saw that two staff administered the medicine and both signed the controlled drugs book.

There was a policy for returning medicines to the pharmacy that had not been used for safe disposal. Staff were able to explain the returns process to us.

People had given informed consent to their medicines administration. The registered manager told us that staff sit with people and go through their medications and explain why it is necessary for the home to administer them. The consent form allows people to be more involved in their care and helps them understand the importance of their medicines.

No one in the home was currently self-medicating. If a person was working towards independent living, the home had a procedure in place for people to become self-medicating. Currently, people are on direct observation therapy. This is when staff give people their oral medicine and they take it in front of them. One person told us "They [the staff] give me my medication, I do know what I'm taking but sometimes I forget. They'll always tell me if I ask though." We observed staff administering medicines and saw that people were not rushed and chatted with staff throughout the process.

The home had up to date maintenance checks for gas, electricity, electrical installation and fire equipment. Fire alarms were tested and recorded weekly and there were three monthly fire drills. A recent fire risk assessment was in place. 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.

A our last inspection we found that flooring in the first floor bathroom and paint work in other areas of the home was in poor condition. This has now been resolved. The provider had laid new flooring in the bathroom and the home had been repainted. The registered manager told us that there is a rolling programme of redecoration in place.

Fridges and freezers were clean and well stocked. Fridges had food labelled with when it was opened or cooked and when it should be discarded. Fridge and freezer temperatures were recorded daily. There were health and safety notices in the kitchen explaining how to store certain foods and what could happen if they were stored inappropriately. For example, incorrect storage of vegetables could lead to growth of bacteria and contamination. Staff told us that this was to help people remember and understand the importance of food safety.

The home was bright and clean on the day that we inspected. Staff told us that they were responsible for daily cleaning of the home. People who lived at the home were supported by staff, where needed, to clean their bedrooms. People also had certain responsibilities for helping clean communal areas. We observed people being supported to clean their personal space during our inspection. One person told us, "They [staff] help if I need it but I do it on my own."

Good

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 two to three months. One staff member said. "It [supervision] is useful and helpful. Helps me refresh information and I can talk about what I want to." Another staff member said, "It [supervision] allows me to talk and ask questions. It's a conversation." All staff received detailed yearly appraisals.

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, medicine 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 MCA. One staff member told us, "it [the MCA] is there for people who may not have the capacity to make their own decisions. If they were not able you would need to do a best interests meeting and possibly involve an Independent Mental Capacity Advisor (IMCA)" 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, "To make sure that individuals' freedom is not restricted. For example, if someone wants to go out they should be able to do so. If they have been assessed and do not have capacity and do not understand dangers of going out they would need to go with staff."

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 professional 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.

The home had a policy around using physical restraints. Staff were trained in restraint techniques. All staff had received specific training called 'Management of Actual or Potential Aggression (MAPA). Staff told us

that MAPA should only be used as a last resort. 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 required medicines, to support people when they became distressed. The registered manger told us that although staff had received the training, physical restraint had never been used within the home.

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 records showed 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. People who were cooking each day were given money and completed the shopping for what they were cooking on the day. People told us that staff supported them to cook in the evenings if they needed help. Snacks and drinks were available throughout the day.

We observed the evening meal. Food looked appetising and people ate together. There was a relaxed atmosphere during meal time. Staff told us that if a person wished to eat in a different room this was their choice.

People's personal files had details of healthcare visits, appointments and reviews. Guidance given by healthcare professionals was included in peoples care plans. Records showed that people had access to healthcare such as podiatry, opticians, and dentists. However, people had attended appointments and outcomes were noted but had not been signed by staff. We saw that people had regular, recorded meeting with community mental health teams.

Bedrooms were personalised according to individual wishes and people told us that they felt "comfy and homely." Staff said that people were encouraged to make their bedroom their own space and decorate it however they wanted to.

Good

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, "The staff are really nice here." Another person said, "Yeah, they're nice. They're good to me." The atmosphere within the home on the day of inspection was calm and relaxed. We saw friendly, pleasant interactions between staff and people.

We observed and people told us that they were involved in planning their care. Care plans noted what people's interests were and people were encouraged in key working and daily by staff to go out and engage with the local community. Each person had a key worker. A key worker is a member of staff who is responsible for an individual and makes sure that their care needs are met and reviewed. We saw that staff knew people's likes and dislikes and how they liked to be treated as individuals. People were able to tell us who their keyworker was. One person said, "I like my keyworker. She does her best to help me and we have meetings." Staff and people had signed their key working meetings.

People's care plans 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, "I would treat everyone the same, they are part of our society and should be equal." Another staff member said, "I would work with anyone regardless. I don't see the problem. I respect others."

We saw that people's care files noted if they had a faith. People were independent and able to attend a place of worship if they wanted. Staff said that if someone needed support to practice their faith, this would be included in the person's care plan and staff would ensure that their wishes were met.

Staff understood how to provide care and support in a way that maintained a culture of dignity and respect. One staff member said, "It [dignity and respect] is things like, how will I address this person? Being empathetic, how will they feel if I talk in a certain way? Will they feel respected when I talk to them about private things? It's a person centred approach." We observed staff asking people if they would be happy for the inspector to look at their bedroom and have a chat with them.

Daily reports were detailed and showed how staff had supported people who had become distressed or showed behaviour that challenged. Staff were able to explain how they worked with people when they became anxious or distressed.

There were up to date records of monthly residents meetings. The complaints procedure was regularly discussed and people reminded how to complain if they needed to. People were also informed about advocacy services and how to access them. Food and activities were also discussed. People told us that they were able to talk about anything that they wanted to during the meetings.

We saw records of what people's wishes were if they were to pass away. This included their faith and who they wanted to be contacted in the event of their passing. One person had refused to complete the form and their wishes not to do so had been respected and recorded.

We saw that one person who had recently been terminally ill had chosen to die at the home. We spoke with the palliative care nurse and a relative, who were visiting the home on the day of our inspection, and told us that the home and staff had been "wonderful" and that "nothing was too much trouble [the person] received such care and compassion". The person's relative said, "They [the staff] gave him 110%, fantastic care. He could phone me anytime he wanted to. They always paid us respect and made us comfortable. The staff have all been outstanding." Staff had been sensitive and supportive to other people living at the home during this time.

People were encouraged to maintain relationships that were important to them. Care plans noted the importance of family and friendships to individuals and how these relationships were maintained and encouraged. One person saw his relative every week and was supported to call by staff when he wanted to. Staff told us that people's friends and family were welcome at the home.

Relatives said that they could visit whenever they wanted. One relative said, "It's never been a problem. I come regularly and I'm always welcome." People said that staff made their relatives and friends welcome when they visited.

Good

Is the service responsive?

Our findings

Care plans were detailed and tailored to the individual. Care plans were written yearly following multi-disciplinary Care programme Approach (CPA) meetings. CPA meetings provide a way in which services are assessed, planned, co-ordinated and reviewed for people living with mental health needs. Care plans were reviewed yearly. If there were any changes these were updated as and when necessary.

Care records showed that people and their relatives had been involved in the initial assessments and on-going reviews of people's needs. As part of the initial assessment, people were able to spend time at the service on a trial basis so that staff could become familiar with their needs. This included day visits and overnight visits. This also allowed people to become familiar with the staff and the service. There was a detailed, step by step, referral procedure for both healthcare professionals and people. This was given to people when they were referred and explained what they could expect from the process and what their rights were.

People living at the home were independent and had individual activities noted in their care plans. People had specific tasks that they completed on certain days such as; laundry, cleaning bedroom, cooking and going out for coffee. Staff and people said that this gave structure to their week and encouraged independence in preparation for moving on to independent living. One person volunteered part time at a local charity shop. Another person was supported to go horse riding on a regular basis. All activities were reviewed on a regular basis by people and their keyworkers. The home had a large garden. One person told us that they enjoyed gardening and often helped out planting and maintaining the garden. People had purchased a bird feeder to encourage wildlife into the garden.

The home also provided group activities. Some of the group activities were done in partnership with nearby homes that the provider ran. Groups included a film group where people would decide on what film they wanted to watch and have snacks and refreshments. A yoga group, art and crafts, and a meditation group that was run by staff. People told us that they liked the activities that the home provided but also felt comfortable not attending if they didn't want to.

The home had a complaints procedure that was available for staff and people to read. There had been no complaints since June 2015. Complaints were investigated and recorded in detail, including the outcome. We saw that people were regularly reminded of the complaints procedure during residents meetings and key work sessions. A relative told us, "I'd just go to [the manager]. I've never had an issue he's not taken up. It's [how to complain] in the booklet they gave us when [relative] moved in."

Good

Is the service well-led?

Our findings

The home had a registered manager. However, the current manager was moving to manager another service run by the same provider. On the day of the inspection we met the newly appointed manager who will be applying for registered manager status.

During our inspection we saw that people knew that manager well and there was a friendly rapport. The manager spent time with people discussed their day and asked how they were.

Staff and relatives told us, and we saw, that the home had an open culture that encouraged good practice. One staff member said, "The manager is good. He's helpful. If you want to learn something he encourages you and you can talk to him if you have concerns." Another staff member said, "we have the same values here. The people we work with are the most important thing." A relative told us, "Nothing is ever too much trouble for the manager and staff here. The manager always responds and he is compassionate."

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.

During induction, staff were trained in the values of the home. Training records showed that staff were encouraged to maintain and update care skills and knowledge. Staff told us that the feedback they received during supervision and appraisals from the manager was constructive and supported them in their role. Staff also received feedback outside supervision where necessary. This allowed staff to be clear on actions that they needed to take in their day to day work. Staff that we spoke with were able to tell us how they had put their training into practice. Staff told us that the manager was supportive and addressed any issues that were identified fairly and professionally.

There were records of regular team meetings. Team meetings were often held with staff from other homes that the provider has. This allowed an opportunity to share experiences and good practice.

We reviewed the accident and incident log. It showed that the manager used accidents and incidents as an opportunity for learning and to change practice or update people's care needs. Procedures relating to accidents and incidents were clear and available for all staff to read.

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 November and December 2015. Where any issues were identified these were noted and the actions taken recorded.

Records showed joint working with the local authority and other professionals involved in people's care. The

registered manager told us that they work closely together to make sure that people receive a good standard of care.