Admiral Healthcare Limited

Admiral House - London

Inspection report

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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?	Requires improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 21 May 2015 and was unannounced. The service met the requirements of the regulations during the previous inspection which took place on 7 January 2014.

There was a registered manager at the service. 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.

Admiral House is a residential and rehabilitation care home for up to 12 men with mental health needs. It is located in Streatham, South-West London and is close to amenities such as a high street, parks and has good transport links.

There were nine people living at the service at the time of our inspection. People living at the service stay for up to two years before moving onto more independent accommodation. However, there was one person who had been living at the service for five years.

Summary of findings

The home was arranged over four floors. Bedrooms were located on the ground, first and second floor. The kitchen, lounge and a smoking room were in the basement. There was smaller lounge on the first floor.

People using the service told us they felt safe living at the home. They told us they led independent lives and were encouraged to manage aspects of their care such as administering medicines if it was safe to do so. Some people had restrictions placed on them under the Mental Health Act, however those who did not were able to leave the home without restriction. People were supported to maintain family and community links and said they would not hesitate to raise concerns if they were unhappy about any aspect of their care.

Staff told us they felt supported and were provided with training and opportunities to further their career. There were enough staff employed by the service. A long standing staff team worked at the service which meant that staff were familiar with the needs of people using the service. People told us they felt comfortable speaking with staff about issues that concerned them. We observed this to be the case during the inspection.

People had their nutritional and healthcare needs met by the service. People were encouraged to prepare their evening meal. The service was well stocked with food and people were supported by staff to improve their cooking skills. People were supported to take medicines on time and were registered with clinicians such as a GP and dentist. They attended regular community psychiatric nurse (CPN) review meetings for their mental health needs.

We found that some people did not have their religious needs met by the service. However, the provider was quick to rectify this once we had highlighted it during the inspection.

Rehabilitation and improving people's daily living skills was a core part of the service. People met their key workers regularly and information was shared with relevant health and social care professionals to help ensure people were supported in all aspects of their lives. We found that although care plans were reviewed regularly, goal monitoring for people was not always effective. We have made a recommendation to the provider about this.

The registered manager demonstrated a good understanding of the service and its people. Regular audits of records and health and safety were completed.

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?

Good

The service was safe. People told us they felt safe and liked living at the home. They said they got on well with other people there.

Medicines were managed well at the service. Staff had attended training in medicines management. Some people who used the service were assessed as being safe to self-administer their medicines.

There were enough staff to meet people's needs and there were robust recruitment checks in place.

Is the service effective?

Good

The service was effective. Staff completed a comprehensive induction and were supported to gain further qualifications in health and social care.

People said the food at the service was nice and they were given a variety of meals and choice by staff.

Staff understood the requirements of the Mental Capacity Act 2005.

Regular health checks were carried out and reviews undertaken by the community mental health team.

Is the service caring?

Good

The service was caring.

We saw that people were supported to live independent lives.

We observed staff speaking to people in a respectful manner.

Is the service responsive?

Requires improvement

The service was not responsive in some aspects. Progress that people had made with their goals was not always captured effectively in goal monitoring or care plan reviews.

A comprehensive pre-admission process was in place which helped to ensure that the service could meet people's needs.

People told us that the service was quick to respond to any concerns they had.

Is the service well-led?

Good

The service was well led. Staff told us they felt well supported and were able to raise concerns in both team meetings and one to one supervisions.

The registered manager was hands on and demonstrated a good understanding of all aspects of the service.

People had the opportunity to give feedback about the service through residents meetings and questionnaires.

Admiral House - London

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 21 May 2015 and was unannounced. The inspection was carried out by an inspector. The service met the requirements of the regulations during the previous inspection which took place on 7 January 2014.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

We spoke with three people using the service, and four staff including the registered manager. We looked at three care records, three staff files and other records related to the management of the service including, training records, audits and complaints. We also observed interaction between staff and people using the service. We contacted health and social care professionals to ask their views about the service following the inspection.

Good

Is the service safe?

Our findings

People using the service told us that they felt safe living there. Some of their comments included, "I feel safe, the other residents don't give me any trouble" and "Staff are nice."

Staff were aware of their responsibilities in terms of reporting any safeguarding concerns. A safeguarding poster from the local authority which had contact details for reporting concerns was on display in the staff office.

Safeguarding training had been delivered to staff and those that we spoke with were able to identify possible signs of abuse and the reporting procedures for the service. They told us, "Some people are vulnerable, and can be at risk of abuse. Safeguarding is about protecting them", "I would tell the manager immediately", "If people are in immediate danger, I can call the police if I can't get hold of the manager" and "We haven't had any issues here. If we did, I would report it to the manager and record it. I can also contact the local authority."

We did not find any evidence of safeguarding concerns. Neither the local authority nor the service had reported any to us.

Robust checks were completed prior to offering staff jobs. Copies of criminal record checks, written references, identity checks and proof of address were retained. This showed the provider took steps to ensure that people were kept safe with respect to the staff who were employed.

There were enough staff working at the service to meet the needs of people. One person said, "There's always someone around to help if needed." Care staff also said that there were no staffing issues. One member of care staff said, "There are enough staff. Nobody needs help with personal care. They sometimes need help with their own rooms."

There were two care staff on duty during the day and at night. People living at the home were independent and did not require support with their personal care. The registered manager told us that they did not use any agency or bank staff as there were enough staff to provide cover from within the existing staff team. They said they were also able to rely on staff from a sister service, who were familiar with the people living at Admiral House. Therefore continuity of care was assured as staff knew people's needs.

Each person had a medicines profile which included their photo for easy identification and any allergies they had. They also had a medicines information sheet detailing any potential side effects.

Staff arranged for some people to receive medicines in blister packs whereas others who were more independent in this area told us they went to the pharmacist to pick up their own medicines and self-administered them. These people kept their medicines in their own room and completed their own medicines administration records (MAR) charts. They had been encouraged to start self-administering after a review with the community psychiatric nurse (CPN). We spoke with one person who was self-administering their medicines and he told us that he was happy and confident with this arrangement. He said, "I'm self-medicating and I collect my medicines." There medicines were kept safely in a cabinet in their room.

Some people were given depot injections for treatment for their mental health. A depot injection is a way of administering medicines where the medicine is slowly released into the body over a number of weeks. Depot injections were administered by a CPN and records kept by the service.

MAR charts were completed correctly and records were kept to show when medicines were delivered to the home. We counted out the stocks of medicines and saw that they corroborated with the recorded amounts. Medicines were stored appropriately and were checked to be within their expiry date. No homely remedies were kept at the home.

Care plans contained risk assessments that documented potential triggers and the interventions staff needed to take in order to manage the risk. Risk assessments were reviewed every three months. Some people using the service were restricted in some ways, under the Mental Health Act. These restrictions had been put in place by a responsible clinician under a hospital order given by crown court. These decisions were taken in their best interests in agreement with health and social care professionals. People understood why these restrictions were in place. One person told us, "They told me all the rules before I came here." Care staff told us, "People are aware of why they are here and the restrictions."

There were other general house rules in place, for example no smoking allowed in bedrooms and an expectation that people did not stay out later than 23:00. However, there

Good

Is the service safe?

was some flexibility with regard to some of these rules, although people had agreed to them prior to moving in. Staff told us, “Everything is explained to them when they first arrive, they agree to them before moving in”, “We can’t force people” and “They can leave home anytime, there is an expectation they are back by 11 and we ask them to let us know if they will be later.” During our conversation with people and observing interaction, it was clear that people understood these boundaries and why they were in place. We also heard one person telling the registered manager that they would be staying out late to go to a family party and the registered manager said that that was fine.

Good

Is the service effective?

Our findings

Staff told us, "I've done all the mandatory training, safeguarding, fire safety." Some staff, who had expressed willingness, had been supported by the service to gain nationally recognised qualifications in health and social care, one staff member said "I've done NVQ level 2 and 3 here and I am currently studying for level 5." Staff were happy with the support they received from the registered manager and from other staff members, they said "I find this job really interesting", "It's been good", "[the registered manager] has been very helpful", "I get targets to work towards" and "Other staff have been supportive."

Staff were given an overview of the service during their induction, which also covered policies and procedures. They were given information about mental health such as diagnosis, signs, symptoms and developing relationships with people.

All the short courses delivered at the home were done online through an external training provider. Staff were able to complete the training within the service or at home. Evidence of training that was delivered in this way included safeguarding, food and hygiene, Mental Capacity Act 2005 (MCA), medicines, communication and behaviour that challenges, and person centred planning. We were given a copy of an up to date training record on the day of our inspection, this showed little evidence that staff had received specific training in respect of mental health. However staff demonstrated a good understanding of people's mental health needs and how they could support them. Social care professionals told us staff members had the necessary skills to support people.

People using the service told us, "The food is nice, [the staff] are good cooks", "I've had rice, prawns, noodles, different things", "For lunch I have cheese on toast, or sausages and eggs" and "I sometimes eat out." No one using the service was at risk of malnutrition. One person was identified as being overweight; this was being managed through offering advice about what to eat, regular weight monitoring and encouraging them to attend the gym. Staff told us that people were expected to prepare their own breakfast and lunch. Evening meals were cooked by staff, and people were able to assist if they wanted.

The kitchen was kept clean and was stocked with food such as eggs, milk, meats, salad and cereal. Snacks and biscuits were available for people to help themselves.

People using the service told us they were able to see a dentist or optician if needed. One person said, "I make my own appointments." All people using the service were registered with a GP and attended regular community psychiatric nurse (CPN) review meetings for their mental health needs. GP, CPN, dentist, optician, chiropodist contact details, as well as those of other healthcare professionals, were recorded in people's care plans.

Some people were diabetic and they had their blood glucose monitored regularly, some up to 3 times a day. Staff were familiar with the procedure for this and the response required if people's blood sugar was too low or too high.

Care plans contained evidence of appointments with healthcare professionals and medicines reviews. People's weight and blood pressure were monitored every month. There was evidence that care programme approach (CPA) meetings took place which involved the registered manager, people using the service, consultant psychiatrist, care coordinator and family members. These were comprehensive and covered issues related to mental health, physical health, eating habits, relationships, daily living. The views of people using the service were sought and considered. The care programme approach or CPA is a way in which mental healthcare is planned and delivered. It means that a person should be allocated a care coordinator, have multi-disciplinary care planning and review meetings and a written care plan.

Staff had received training in the Mental Capacity Act 2005 (MCA) and demonstrated a good understanding of the Act and its implications. One staff member said, "People have capacity to make decisions for themselves, if people can't make decisions we need to make sure we give them enough information so they can." There had been no application for a Deprivation of Liberty Safeguards (DoLS) authorisation because none were required. Restrictions that were in place for some people were authorised under the Mental Health Act and appropriate procedures had been followed in these instances.

Good

Is the service caring?

Our findings

Two people ate halal food and staff were aware of their requirements. People told us, “I’ve not had any halal meat here for a few months." They told us they had mentioned it to their key worker but they had recently left the service. We checked receipts, the last time halal meat was brought was on 10 April 2015.

We raised this with the registered manager during the inspection. They told us when they had previously bought halal meat, it had been left as people did not want to prepare meals independently.

Following the inspection, the registered manager contacted us and provided evidence that halal meat had been bought for the home and a freezer drawer had been designated to store it in. This was done to avoid meat getting mixed up or potentially being used by other people.

People using the service led independent lives and were encouraged to take responsibility for aspects of their daily living, for example to maintain their bedrooms, self-administer their medicines and make appointments. They were encouraged to assist staff in meal preparation. People were expected to make their own breakfast and lunch, however staff cooked dinner for them and people were able to assist staff with this if they wanted. People told us, “I’m happy”, “Staff are OK”, “The other people here are fine, no problem”, and “It’s really nice here.”

Care records contained information about people’s daily routines, interests, social needs, relationships, community links and meal preferences. This meant that staff had access to information about people to enable them to support them in a way that was individual to them and of their liking.

Staff demonstrated they knew about the backgrounds of people they key worked, as well as their daily routines. When we asked staff to tell us about some of the people they supported they said, “[This person] has schizophrenia. He is very social, his family are abroad”, “[This person] goes to the library”, “We do meals together”, “I have encouraged him to go the gym to try and lose a bit of weight.”

We saw examples of the caring attitude of staff towards people. We heard one person asking staff if they could buy a certain food item next time they went shopping as they liked it and staff told them they would do so. People were able to maintain relationships with family and friends. People told us, “I’m free on weekends, I go visit my parents”, “I go to the mosque”, “I go out to meet my friends.” The registered manager told us that visiting hours to the service were restricted to 10:00 and 20:00 in order to avoid disruption to other people using the service.

Requires improvement

Is the service responsive?

Our findings

People using the service told us, “Staff cook for me”, “I go mosaic (day centre), on Mondays I do English, Thursdays cooking and cleaning and washing”, “I’m just going to the shops.” Staff told us, “I found a free tennis and gardening club for him, but he has not taken it up”, “he likes his music”, and “I make sure I speak to [my key resident] regularly, make notes from our meetings.”

We spoke with the registered manager about the process for accepting people wanting to move into the service. She told us that the majority of referrals came from the community mental health team (CMHT). She said “We get information from the team following which I carry out a visit to meet the person.” The average length of stay for people was for approximately one year before they moved onto semi-supported living. She also said, “I attend [hospital] discharge planning meetings and carry out an assessment of clients. I talk to them about their aims and what they hope to achieve.” People were given the opportunity to visit the home to see if they liked it. This was a gradual process, designed to ensure that the service was able to meet people’s needs and also to see if people were happy. People initially come for a day, then for an overnight stay, and then for a weekend. Discussions were held with the referring team following these stays. Once people had moved in, they received regular visits from the CMHT and their care co-ordinator.

Pre-admission information and questionnaires were also seen which evidenced the type of assessment that people underwent before coming to use the service. Any relevant hospital documents were also included and a mental state assessment was completed with input from the CMHT.. This gave a snapshot of people’s mental health when they first came to live at the service. This demonstrated that the provider took steps to get a thorough understanding of people’s needs.

Social care professionals we contacted after the inspection told us that the pre-admission assessments were thorough and helped to ensure that people’s individual’s needs and well-being could be met.

We were provided with a copy of the service user guide and the house rules that were issued to all people using the service. Staff told us, “They sign the service user guide and agree to it.” The guide made reference to how people could raise concerns, what they could expect from the service and house rules.

Care records were developed when people started to live at the service and a copy was given to the CMHT and the care co-coordinator for their input. Care plans contained information about people, such as a brief history, personal details and any professionals involved in their care.

Care plans consisted of an area of need, a goal, staff approach/interventions and service user approach. The registered manager told us areas of need were identified for each individual person by looking through the risk assessments and life history.

Care plan reviews took place every three months. We found that it was difficult monitor how much progress people had made towards their identified goals. For example, a person’s goal was to develop their rehabilitation skills to live in less supported accommodation. Care records had stated that staff needed to devise and implement a rehabilitation plan in agreement with the person and for this plan to incorporate all aspects of rehabilitation including domestic tasks, cleaning and tidying. The person was required to carry out a cooking session at least once a week as part of this plan. When it came to care plan reviews, staff did not clearly record any progress that had or had not been made towards this goal. Many of the entries for the reviews said, ‘no change’ but did not explain why or lead to the goal being revised or different support being offered. This was not an accurate or appropriate recording of goal monitoring.

Other goals for people included ‘to be relocated to step down accommodation’, ‘to have a structured day’ and ‘manage weight’. In numerous instances, staff had recorded no changes during every subsequent three month review. This meant that progress was difficult to track.

Some of the feedback we received from healthcare professionals was that the service could improve by engaging more proactively with people who used the service and motivating them to participate more with aspects of their daily living skills and community involvement. Better use of the care plan review system could assist with this.

Staff were assigned as key workers to people and weekly keyworker meetings took place. Staff told us, “[People who

Requires improvement

Is the service responsive?

use the service] give me details about what they have planned for the coming week, any appointments, activities. If they need help with anything, they ask me." Key workers updated the registered manager and health and social care professionals with any significant information following these meetings.

Keyworkers also carried out more in-depth, monthly key work sessions. During these sessions, things like people's weight and blood pressure were checked in addition to having a more detailed discussion about how people were feeling. Records of weekly key work sessions showed that mental health, activities, nutrition, leave to go home, appointments and other issues were discussed. One staff member said, "It allows us to build a rapport with them." The monthly key worker sessions looked at the same issues as the CPA meetings; this enabled the service to have a valid and valuable input into CPA meetings as information from the key work sessions could be provided to healthcare professionals for consideration during CPA reviews.

People using the service told us they knew how to make a complaint or raise a concern. One person said, "If I'm not happy with something I would tell staff" and another said, "I can tell my key worker." People told us that when they had complained previously, the service had responded quickly. One person said, "They fixed my lights straightaway, they do things quickly."

People were also able to raise concerns through residents meetings. They were given information on how to raise concerns in their service user guide. We looked at the record of complaints and saw that there had been no formal written complaints since the last inspection. However, the provider kept a 'concerns and grumbles' book in which informal concerns were recorded. We saw that these were resolved quickly without the need for formal procedures.

We recommend that the provider seeks advice and guidance from a reputable source to enhance regular care plan reviews so they become a useful tool for supporting people to maintain or improve their daily living skills.

Good

Is the service well-led?

Our findings

People using the service told us that both the registered manager and the support staff were approachable. Staff also said they worked well together as a team and received good support from the registered manager. They told us, "She's nice, friendly", "She tells you if things need to improve" and "We can call her any time." The philosophy of care of the service as stated in the provider's statement of purpose was to 'create a happy and homely atmosphere at all times which makes you feel like being 'home from home'.

The registered manager, as well as being one of the directors of the company, was hands on and was visible at the service daily. She therefore had a good oversight of all aspects of the service. Health and social care professionals confirmed that they had a good working relationship with her.

Staff told us that they were given opportunities to develop and take on more responsibilities. One staff member we spoke with told us that they had been given responsibility for some administrative duties recently which they felt would be beneficial in their development and learning.

Residents' meetings were held monthly, people who were not able to or chose not to attend were briefed about the discussions afterwards during key worker meetings. Staff meetings were also held monthly, we saw minutes of these and various items were discussed such as staffing issues, medicines, CQC inspections and menus. Meetings provided an opportunity for both people and staff to raise issues in a group environment rather than individual settings such as keyworker meetings and supervision sessions.

Quality monitoring was carried out by the provider. Satisfaction questionnaires were sent to people using the service and also to health and social care professionals. Feedback from two out of five professionals said the service needed to be 'more proactive in terms of residents' involvement" and rated the service 'fair' in developing rehabilitation and social skills. There was evidence that the service had taken on board these comments and implemented changes such as emailing professionals details of weekly and monthly key worker meetings evidencing some of the support they were offering people.

Environmental audits and checks were also completed. Current certificates for gas safety, electrical appliance checks, legionella and a fire risk assessment were seen. Each person had a personal emergency evacuation plan (PEEP). Regular fire drills, fire point testing and fire extinguishers were checked weekly. Water temperature and maintenance checks around the home were also completed.

Audits of staff files were carried out and the service was registered with the Information Commissioner's Office (ICO). This demonstrated that the service was registered as required under the Data Protection Act 1998 and compliant in processing personal information.