Social Responsibility Investments Limited

851 Brighton Road

Inspection report

851 Brighton Road
Purley
Surrey
CR8 2BL

Tel: 02087630002

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28 February 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We visited 851 Brighton Road on 23, 24 and 28 February 2017. The inspection was unannounced.

This was the first time the service had been inspected under the current provider.

851 Brighton Road provides rehabilitation and recovery care for up to six adults who have mental health problems. There were three people using the service at the time of the inspection.

The service had a registered manager until September 2016. A replacement manager had not been recruited at the time of the 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.

We found some areas of concern in relation to the environment where people received care and support. These related to health and safety issues and infection prevention and control. We noted the provider was in the process of making improvements. Medicines were not always managed safely. Staff had a good understanding of their safeguarding responsibilities. Risk assessments were created reflecting people's individual needs. They identified risks and provided guidance for staff. There were sufficient numbers of staff to meet people's needs. Appropriate checks were in place to ensure suitable people were employed.

There was insufficient training and refresher training. People were supported for by staff who had the general knowledge and skills to deliver safe care and support. The service worked within the principles of the Mental Capacity Act. People were supported with their nutritional and healthcare needs.

Staff were caring and worked well with people using the service. People were involved in the planning and delivery of their care and support. They were encouraged to express their views and had access to external bodies for further support. Staff respected people's dignity and privacy and encouraged independence.

People received person centred care that was focussed on their needs. The creation of care and support plans involved people to ensure the delivery of personalised care and support. Clinical support was provided by a consultant psychiatrist with the assistance of registered mental nurses, a psychologist and occupational therapist. People were encouraged to take part in communal and individual activities within the service and in the community. Regular 'community' meetings and monthly surveys provided people with opportunities for people to feedback their experiences of the service. The service had systems in place to deal with complaints.

The service did not have a registered manager. We found systems to assess and monitor the quality of the service were not always effective. Staff meetings were held monthly providing staff with a forum to feedback

their experiences and ideas for improvement. Records relating to the provision of the regulated activities were fit for purpose.

You can see what action we have asked the provider to take in the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People felt safe and staff understood their personal responsibilities to recognise and report any suspicions of abuse. There were concerns about the environment in relation to some health and safety issues and infection prevention and control. Medicines were not always managed safely. There were sufficient numbers of staff to meet people's needs. Risk assessments for people using the service identified risks and provided guidance for staff.

Is the service effective?

Requires Improvement

The service was not always effective. There were training deficiences. Staff had the general knowledge and skills to deliver effective care. The service was working within the principles of the Mental Capacity Act. People were supported with their nutrition and healthcare.

Is the service caring?

Good

The service was caring. Staff were supportive. People were supported to express their views and were involved in their care and treatment. People were treated with dignity and respect and encouraged to be independent.

Is the service responsive?

Good

The service was responsive. People received person centred care. They were encouraged to join in communal and individual activites and maintain contact with family and friends. The service actively sought feedback about people's experiences.

Is the service well-led?

Requires Improvement

The service was not always well-led. The service did not have a registered manager. The systems for monitoring and assessing the service were not always effective. The service sought feedback from staff in order to improve. Records relating to the provision of care by the service were fit for purpose.

851 Brighton Road

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 23, 24 and 28 February 2017 and was unannounced.'

The inspection was carried out by an adult social care inspector.

We reviewed information we held about the service. We spoke with three people using the service, three members of staff, the nurse clinical lead and the deputy manager. We carried out general observations throughout the inspection. We looked at records about people's care and support for the three people using the service. We reviewed three staff files, policies and procedures, general risk assessments, complaints and service audits.

Requires Improvement

Is the service safe?

Our findings

The provider was in the process of making improvements to make the service safe for people, however, we identified some areas of concern. In the upstairs bathroom there was a towel rail on the wall parallel with the bath and adjacent to the washbasin. There was just enough room to stand between the towel rail and bath. The towel rail did not have thermostatic controls to control the temperature. Although the towel rail was switched off and cold there was a risk of burns if it was switched on.

When the inspector was leaving bedroom two they slipped on a step outside the door. The step was tiled in the same materials as the floor and did not stand out. Although it had some old hazard tape the step did not stand out clearly and there was no secondary signage or warnings about the step. Outside, in the paved area some of the paving stones were not level and two actually moved when they were stood on. They were a possible trip hazard. The provider told us they had a programme of improvement and they had employed a maintenance person.

We checked the ligature risk assessment (LRA) for the service. Although the LRA covered all rooms and the exterior of the property, the identified risks did not correlate with fixtures and fittings at the service. We pointed out various discrepancies to the deputy manager. For example, a radiator in a bathroom was identified as a risk yet there was no radiator in the bathroom. We identified a number of ligature points not identified in the LRA such as domestic tap fittings, clothes hooks and window fittings. People using the service had a history of self-harm including the use of ligatures. Door handles were ligature proof. We informed the deputy manager of the importance of an accurate and up to date LRA to raise staff awareness and minimise the associated risks.

These concerns we have identified were a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service shared a kitchen and catering staff with a sister service, Rosina Gardens, situated next door. We inspected Rosina Gardens following the inspection of 851 Brighton Road. The following was included in the report for Rosina Gardens and as a shared facility applies to this service.

We found areas of concern in relation to infection prevention and control. These centred mainly on the kitchen area. The serving hatch from the kitchen to the dining room had a painted base that was severely chipped making it impossible to clean effectively. We found two areas of a Formica type work surface near to the cooker and the sink were worn. The shiny surface had been worn away and meant these areas of the worktop could not be cleaned effectively. Some of the wall tiling was broken or cracked. Tiles were missing around the air outtake between the cooker and cupboard. Although some tiles had been deliberately removed with a view to creating a window these areas could not be cleaned effectively. We also noticed the floor tiles were cracked in places. The bottom of the splashback was covered in grease to the left and right. These were areas that were difficult to reach when cleaning the splashback. One of the refrigerators was in serious need of defrosting. In places the ice was over an inch thick. It was difficult to move the trays

containing frozen food and it was surprising the door shut. The presence of ice indicated the door seal was damaged or the drain was blocked. It also meant food might not be properly frozen or had defrosted and frozen again presenting a risk to people's health. Despite these findings, the service was otherwise clean and tidy.

These concerns were a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about safeguarding vulnerable adults from abuse. In our conversations it was apparent they knew how to recognise the various types of abuse and the procedures for reporting abuse. They were aware of how to escalate concerns and whistle blowing procedures. Staff told us they were confident they could report any concerns and they would be dealt with appropriately. Although staff had completed safeguarding training they had not received refresher training in 2016 or 2017. There were systems in place to ensure people's money and financial information was available to them. All receipts of people's spending were retained by the service so that people's money could be audited or checked at any time in order to protect people's finances.

Medicines were stored securely and appropriately. We checked records in relation to the receipt, administration and disposal of medicines. We found some errors between what was recorded and the actual quantity of medicines. For example, when we checked one person's medicines we saw 84 tablets of one medicine had been booked in with no date. This made it impossible to accurately check the number of tablets remaining. The records for these tablets did not tally with those actually remaining. We found other examples where this was the case. We discussed this with two members of staff and found the system in practice did not reflect service policy. Although there was nothing to suggest medicines were not being given correctly the records of stored medicines were not accurate. Accurate records of medicines are essential to ensure there are sufficient medicines to meet people's needs and people receive the right medicines at the right time.

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

We saw risk assessments had been completed as part of people's care records which identified a range of social and healthcare needs and risks. It was evident in the records that people had been involved in the development of their risk assessments and were made aware of their personal responsibilities. There was a narrative providing background information, incidents and specific issues relating to the risks identified and enhancing factors. These ensured staff were aware of risks associated with people using the service and provided them with appropriate guidance.

We examined service rotas and found they corresponded with the members of staff who were actually on duty. One member of staff told us there were enough staff on duty. One person using the service required one to one supervision and additional staff carried out this role. A psychiatrist carried out regular visits and further support was provided by a psychologist, occupational therapist and an activities coordinator. Staff were also supported by domestic and catering staff which enabled them to spend more time providing support to people using the service.

There were policies and procedures in place to ensure suitable people were employed by the service. This included checks through the Disclosure and Barring Service which identify people who are barred from working with children and vulnerable adults and informs the service provider of any previous criminal convictions.

Requires Improvement

Is the service effective?

Our findings

We found the service was not always effective. When we examined records we found staff were not completing training or refresher training in 2016 and 2017. For example, only the deputy manager was up to date in medicines training and no staff had completed training or refresher training in the: prevention and control of infection; Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS); safeguarding; health and safety; and, basic life support.

We were concerned with the lack of specific training in relation to mental health bearing in mind the complex needs of people using this service. For example, one person was on one to one supervision to meet their complex mental health needs and in response to identified risks. One member of staff carrying out this role for a full shift had been brought in from the sister home next door and had limited experience of dealing with people detained under the Mental Health Act (MHA). 'The Mental Health Act: Code of Practice' (CoP) provides guidance and outlines expectations where enhanced observations take place. These expectations include provider policies; staff performing the role; people's individual characteristics; respecting privacy and dignity; therapeutic engagement; and, regular reviews. We spoke with the person involved and the staff member and the arrangement was working well in the circumstances. However, the level of therapeutic engagement was limited and we did not find regular reviews in care records. The person concerned was satisfied staff were respecting their privacy and dignity.

There was a risk staff did not have the experience or up to date or sufficient training and guidance to support them to provide people with safe and effective care and support.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager completed regular supervision sessions with staff to support their development and assess performance. A record was made of these sessions under headings that clearly identified the issues discussed. Staff confirmed these supervision sessions took place at regular intervals.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Records confirmed this was the case. For example, we saw mental capacity assessments in people's care records.

However, we found the three people using the service were detained under Section 3 MHA. The service was not appropriately registered to take people detained under Section 3 so these people were not lawfully detained and there was a deprivation of their liberties. The provider was directed to make an immediate application to vary the registration or relocate the people using the service. These people have been transferred to other services since the inspection.

We checked with people that they had their rights explained under the MHA and nearest relative informed and provided with copies of information. They agreed this had taken place and care records indicated this was the case. We were informed by the nurse there was a MHA administrator at a nearby sister home who dealt with all MHA requirements.

We found the service supported people to meet their nutrition and healthcare needs. Catering staff ensured there were choices of cooked meals and were aware of people's dietary needs. Staff were able to provide food outside of normal mealtimes. People were registered with a local GP in addition to their regular contact with a psychiatrist. Staff supported and encouraged people to make and attend appointments. Where appropriate, clinical observations were completed when people were taking certain medicines.

Good

Is the service caring?

Our findings

One person using the service told us, "I'm comfortable here. They (staff) knock on my door and support me to see my relatives." Another person told us, "They are okay but sometimes they wake me up too early. Generally, they are quite friendly and try to help but one or two I am finding them difficult." When asked to elaborate the person said, "It might just be my paranoia," and declined to say any more. Another person said, "They (staff) encourage us here."

We observed and listened to interactions between people and staff throughout the inspection. On occasions staff were unaware we were observing or listening to them. In our conversations with staff they spoke about enjoying their work at the service and liking people using the service. Staff thought they worked well as a team. People and staff were on first name terms. We found staff were respectful, attentive and communicated positively. We saw people and staff regularly chatting with each other and on occasions laughing and joking. When one person became agitated and upset, staff communicated calmly and gave them time and space to calm down. Staff seemed to have time to sit with people. People enjoyed activities with other people using the service although one preferred not to join in with singing.

We spoke with people about making choices and staff respecting their preferences. Two people using the service told us this was the case. When asked what choices they made they referred to choices such as getting up and going to bed, food, clothes, where they spent time in the service and activities. This was further confirmed in conversations with people and staff including involvement in their care and support and their privacy, dignity and independence.

We examined care records for the three people using the service. People were supported to understand the care and support they received and were involved as far as possible in being part of the process. This enabled them to understand why certain things were necessary and what was expected of them. We spoke with one person subject to enhanced observation and they confirmed they understood the reasons for it. People were encouraged to express their views and we saw numerous examples of people acknowledging this in care records such as care planning, risk assessments and medicines.

People had access to Independent Mental health Advocates (IMHA) who could provide them with support and guidance around understanding their care and treatment and to be involved with it. An IMHA could also help them with their rights and reviews under the MHA. In addition to contact details displayed on the communal noticeboard the service held a monthly IMHA drop in session where people could speak to an IMHA without a specific appointment.

We observed staff respected people's privacy and dignity. We saw staff knocking on people's doors and asking to come in. Staff knocked on bathroom doors to ensure they were not being used before entering. We spoke with people about using first names and they confirmed they preferred to do so as it was more informal. Any discussions or visits in relation to matters of a personal nature such as care and support, clinical matters and ward rounds were conducted in private. One person told us everybody was given their

medicines at the same time on occasions and they did not like this but they had already raised this with staff.

The service encouraged people to maintain and develop their independence as far as they were able and wanted and to the extent that was appropriate within their care and support plans. One person told us about a course they had completed and how they were encouraged to do things for themselves. This included daily living tasks such as washing clothes. One person was supported to cook a meal for herself once or twice a week. People told us they were supported to maintain contact with their family. One person regularly visited family in West London.

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their needs. Staff were knowledgeable about the needs of people they supported. They were aware of people's preferences and understood person centred care. We looked at a random selection of care records. They were written using person centred language and identified people's needs, goals and preferences. This information supported staff to deliver appropriate care and support.

We examined care records for the three people using the service. People were usually assessed before they came to the service. This was important to ensure the service could meet that person's needs and of equal importance to ensure they would fit in with other people using the service.

Regular rounds were completed by a retained consultant psychiatrist who then provided directions about people's care and treatment to the nurse in charge and the deputy manager. This meant people's care and support needs, such as treatments and medicines, were regularly reviewed by a senior clinician. It was not immediately clear how this information was cascaded to staff including the nurses. We found this information was recorded in a separate file. One nurse had recently been appointed as the clinical lead for the service. They told us that they saw this transfer of information from the psychiatrist to other clinicians and staff as one of their roles. This would ensure staff had the most up to date information about the care and support for each person using the service. The provider supported the consultant psychiatrist and nursing staff by employing a psychologist and occupational therapist.

We found the service shared a full time activities coordinator with the sister service next door. They were guided and supervised by the occupational therapist. There were regular activities and people were encouraged to join in or develop their own interests. These activities took place within the service and in the community and were communal or individual. However, we observed one occasion when a person decided not to join in and played games on their tablet. We spoke to this person who said they did not enjoy the activity taking place. They were content to sit away from the group and do what they wanted. Although people were encouraged to take part it was their choice. There was a range of activities available such as board games, cards, group singing. One person told us they particularly enjoyed cards and a particular board game. People were supported to identify and take part in activities they preferred outside of the service such as swimming. Group and individual activities were recorded in each person's care records. The activities coordinator maintained these records and met the occupational therapist weekly to discuss and plan activities to meet group and individual people's needs.

People told us the service held regular community meetings where they could talk about the day to day running of the service and raise any issues they had. The deputy manager explained there were monthly surveys that enabled people to provide anonymous feedback if they wanted to do so. The deputy manager told us most feedback from meetings could be addressed quickly. Anything more complicated or serious would be referred to the provider for action.

We spoke to people about making complaints. They told us they would initially approach staff and expected them to deal with it or pass it on to somebody who could. Policies and procedures were in place outlining the process for dealing with formal complaints. These reflected recognised good practice for complaints procedures.

Requires Improvement

Is the service well-led?

Our findings

We found that the service was not always well-led. The service used a number of internal systems to monitor and assess the quality of service provided that included regular checks, reviews and audits. However, these systems were not always working effectively as they were not identifying or addressing the problems we found. This was apparent with the lack of training, medicines management and issues with the environment people were living in.

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

The registered manager left the service in September 2016. The service has made attempts to recruit a new manager but nobody had been appointed at the time of the inspection. A deputy manager provided management support for this service and the sister service next door.

Although the service was registered with CQC it was not appropriately registered for the regulated activities provided. The provider clamed the registration was recommended by CQC. We were aware the service was registered to provide these regulated activities under the preceding provider. The matter will be addressed outside of this report.

We spoke with staff to identify how they provided feedback about their experiences of the service and made suggestions to make improvements. We were told there were regular staff meetings held once a month. A note of the discussions was made for records and staff not attending. The deputy manager used the meeting to provide information and directions about the running of the service. Staff contributions were welcomed. One member of staff told us they were confident they could speak freely. The deputy manager was also readily accessible to staff who wanted to speak in private.

All accidents and incidents, that were not notifiable to the Commission, were recorded outlining what occurred, actions taken at the time and subsequent actions. The deputy manager told us they supervised these records and where appropriate identified learning for the service and provider. During their time as deputy manager they had not identified any learning opportunities from these accidents and incidents. We examined the 2016 records of accidents and incidents.

We checked records that related to the provision of the regulated activities. We found they were legible, accurate, up to date and readily accessible. Where required records were stored securely and access was controlled to ensure they were only seen by people entitled to do so. In relation to people using the service, records were complete and recorded contemporaneously.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Parts of the building and exterior areas were not appropriately maintained to ensure the safety of people, staff and visitors. Medicines were not always safely managed. Regulation 12(2)(b)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Poor maintenance of the building did not allow the service to maintain standards of hygiene appropriate for the purposes for which they were being used. Regulation 15(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not effectively assess and monitor the quality of the service. Regulation 17(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have appropriate training to enable them to carry out the duties they were employed to perform. Regulation 18(2)(a)