

Admiral Healthcare Limited

# Admiral House - London

## Inspection report

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London  
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### Ratings

Overall rating for this service

Requires Improvement 

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?

Requires Improvement 

# Summary of findings

## Overall summary

About the service:

Admiral House – London is a residential and rehabilitation home for up to 12 men with mental health needs. At the time of the inspection, there were 10 people living at Admiral House – London.

People's experience of using this service:

Individual care plans were in place for each person and these were reviewed on a regular basis by key workers. They focussed on ways in which people's independence could be improved. Although keyworkers completed regular care plan reviews and one to one sessions with people, we found that these could be used more effectively to review people's goals and amend them according to people's level of engagement. We have made recommendations regarding this.

Although regular resident meetings were held, we found that some suggestions that people had made were not always followed up in subsequent meetings. We have made recommendations regarding this.

Some areas of the home were in need of refurbishment. This had been identified by the registered manager as an area of improvement.

People using the service told us they were happy living at Admiral House and they felt safe. They lived independent lives and were free to come and go as they pleased. They were able to have family and friends come and visit them.

Staff supported people to eat by preparing their meals for them. They also supported them to make and attend regular health appointments.

People said staff gave them their medicines on time, this was confirmed through the medicine records and audits that we saw during the inspection.

Staff recruitment procedures were robust and there were enough staff employed to meet people's needs. Staff received regular training and supervision which enabled them to support people with mental health needs.

Risks to people were identified and steps taken to manage the risk. Where an incident had taken place, the relevant risk assessment was reviewed.

When people had made a complaint, the provider had resolved these to their satisfaction. Feedback was sought from people, relatives and professionals through surveys and the feedback received was positive.

The service met the characteristics for a rating of "Requires Improvement" in two of the key questions we inspected. Therefore, our overall rating for the service after this inspection was "Requires Improvement".

More information is in our full report.

Rating at last inspection:

At our last inspection, the service was rated "Good". Our last report was published on 16 March 2017.

Why we inspected:

This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Follow up:

We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates a per our re-inspection plan.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

Details are in our Safe findings below.

Good ●

### Is the service effective?

The service was effective.

Details are in our Effective findings below.

Good ●

### Is the service caring?

The service was caring.

Details are in our Caring findings below.

Good ●

### Is the service responsive?

The service was not responsive in all aspects.

Details are in our Responsive findings below.

Requires Improvement ●

### Is the service well-led?

The service was not well-led in all aspects.

Details are in our Well-Led findings below.

Requires Improvement ●

# Admiral House - London

## Detailed findings

### Background to this inspection

#### The inspection:

We carried out our inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. Our inspection checked whether the provider was 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.

#### Inspection team:

Our inspection was completed by one inspector.

#### Service and service type:

Admiral House – London is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection:

Our inspection was unannounced.

#### What we did:

Before the inspection, we reviewed the information we held about the service. This included notifications sent to us by the provider and other information we held on our database about the service. Statutory notifications include information about important events which the provider is required to send us by law. We used this information to plan the inspection.

We spoke with two people using the service.

We spoke with the registered manager and two care workers.

We reviewed care records for three people, two staff personnel files, audits and other records about the management of the service.

We received feedback from one healthcare professional.

We requested additional evidence to be sent to us after our inspection. This was received and the information was used as part of our inspection.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were safe and protected from avoidable harm. Legal requirements were met.

Staffing and recruitment:

- The provider followed appropriate procedures when recruiting staff.
- Staff files included completed application forms, interview notes, proof of ID, address, right to work and a signed contract.
- All staff had completed a Disclosure and Barring service (DBS) disclosure check. A DBS is a criminal record check that employers undertake to make safer recruitment decisions.
- There were enough staff employed to meet people's needs. There were either two or three staff on duty during the day and two waking staff at night.

Using medicines safely:

- People told us they received their medicines on time. They were supported to take their medicines in a safe manner by care workers who were competent and trained in administering medicines. A care worker told us, "He has regular medicines review, he had one last week."
- Care records included information charts and medicines profiles with details of medicines that were prescribed, a photo of the medicines so they could be identified by staff, dosage instructions and possible side effects.
- Medicine administration record (MAR) charts were completed correctly and in a timely manner.
- Medicines were stored safely and were checked on a regular basis.

Systems and processes to safeguard people from the risk of abuse:

- People using the service told us they felt safe.
- Care workers had received training in safeguarding and were able to explain what steps they would take to protect people from harm. One care worker said, "We have to protect people from harm, I would speak to the manager after speaking with people and reassuring them."
- Safeguarding factsheets and policies were available for staff to refer to. These included contact details of the local safeguarding team.
- There had been no safeguarding concerns raised against the service.

Assessing risk, safety monitoring and management:

- The provider took steps to manage any identified risks to people using the service.
- Risk assessments included ways in which the level of risk could be reduced to minimise any potential harm from occurring.
- We saw examples where incidents had occurred, any associated risk assessments were reviewed to make sure they were still relevant and whether any more steps were needed to manage the risk.
- Care plans included a contingency plan for staff to follow if there was a relapse in people's mental health.

The contingency plan included what to do in an emergency situation and what to do if there are any warning signs of relapsing.

- Risks to the environment were managed appropriately. Current test certificates for fire safety equipment, fire alarm system, electrical installation and appliances and gas safety was seen.
- Fire alarms were tested weekly and emergency lights were tested monthly. Fire extinguishers were available throughout the home and had been tested.
- Fire evacuation drills took place monthly. Each person had a Personal Emergency Evacuation Plan (PEEP) for staff to follow in an event of an emergency. Fire action notices were on display throughout the home.
- The registered or deputy manager completed an environmental audit every month assessing the fire alarms, extinguishers, exit routes, fire doors and smoking risk.

Preventing and controlling infection:

- Care workers had received training in infection control.
- Food hygiene and cross contamination guidelines were on display in the kitchen.
- Colour coded mops and food preparation boards were available and there was a separate hand washing sink in the kitchen.
- A current Legionella test certificate was seen.
- Hazardous cleaning materials were kept in a locked cupboard.
- Domestic staff cleaned the communal areas and any bedrooms twice a week.

Learning lessons when things go wrong:

- Incidents and accidents that had occurred at the service were recorded on incident reports which included details of the action taken.
- Records showed the provider took action following any incidents to try and prevent them from reoccurring in future, this included updated risk assessments and care plans and notifying any relevant people such as care co-ordinators and the community mental health team.

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Adapting service, design, decoration to meet people's needs:

- The environment was dated and some areas were in need of refurbishment. There was a broken cupboard in the kitchen and damaged ceiling tiles in the lounge and kitchen.
- There was a communal lounge for people to socialise in if they wished. However, this only had two two-seater sofas with the remaining seating being dining chairs. This did not give the impression of being a conducive environment for socialising. There was a second lounge on the first floor as another area for people to socialise with friends and family if they wished.
- We spoke with the registered manager about the issues we found with the environment. He assured us that this was something that was being looked into including a refurbishment of the kitchen area and the tea room and how they could be made more conducive to socialising and a means to engage and promote people with their independent cooking skills.
- After the inspection, the provider wrote to us and showed us that the broken cupboard had been reported and fixed the day after the inspection. They also showed us a quote that had been sought for a refurbishment of the kitchen.
- We will check on their progress at the next comprehensive inspection.
- People lived in individual bedrooms, the majority of which were en-suite.
- There was a large, garden that was pleasant and well maintained.
- There were fire resistant doors and appropriate fire exit signs on display.

Staff induction, training, skills and experience:

- Staff supervision was completed every two months where they were given an opportunity to discuss issues such as work performance, the people using the service and employment issues.
- Care workers told us they felt they had the necessary skills to support people and they completed regular training. One care worker said, "The manager encourages training and his advice is very useful."
- Newly employed care workers completed induction training which included an introduction to the organisation, an overview of policies & procedures and topics relevant to supporting people living at the service such as mental health, rehabilitation, care plans and medicines.
- Care workers completed mandatory training in a number of areas. The registered manager monitored these regularly to ensure all staff were up to date with their training.
- The registered manager had started to enrol staff onto a 'Level 2 Certificate in Awareness of Mental Health Problems', a three month course to further raise their awareness of mental health.
- Some staff had completed training in the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. This was not the case for all staff, we recommend the provider implement this for all staff to help ensure consistency in the training



delivered.

Supporting people to eat and drink enough to maintain a balanced diet:

- Comments from people included, "The food is nice, I had patties last night. They also do spaghetti bolognese and roast dinners" and "I can cook myself but staff make breakfast and dinner."
- Care workers prepared cooked meals for people and supported them to make breakfast. People were able to give their choices and opinions about meals during resident meetings. The weekly menu was on display in the kitchen and the lounge.
- The kitchen was adequately stocked with food, both fresh and ready-made frozen food. A healthy eating guide was on display
- The kitchen was locked outside meal times to prevent people from accessing it independently, however people and staff told us it was always available for them to use under staff supervision and there were no restrictions when staff were present.
- There was a 24 hour tea room available for people to help themselves to a snack. However, we saw this only had provision for tea/coffee. There was one loaf of bread in the fridge but no other ingredients to make a sandwich such as butter, cheese or other condiments. We raised this with the registered manager during the inspection who said they would ensure this was done. They also said that people had access to food in the kitchen.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

- Care records included people's date of admission and a 'service user profile' that had details of their placement officer and a 'care summary'. The care summary included details about potential causes of relapse and the typical features of relapse. This meant that staff were able to anticipate any changes in behaviour and what steps to take in response.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:

- One person said, "I have a social worker or CPN (Community Psychiatric Nurse) who comes to see me."
- We saw correspondence with health and social care professionals such as GPs and community teams and records of medical appointments were kept. A care worker told us, "He had a (CPN) but has now been discharged to his GP. We look after all his appointments."
- Care records included details of GP's and other health professionals, and also included details of any relevant medical history including mental health diagnosis.
- A healthcare professional told us, "[The registered manager] was very co-operative, supported the patient and his team put their best support. They worked with the CCG collaboratively reporting and updating us with the ongoing issues and management."

Ensuring consent to care and treatment in line with law and guidance:

The Mental Capacity Act 2005 (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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

- People using the service were not under any restrictions, either through a DoLS or a Community Treatment Order (CTO) and were free to leave the service as they pleased. A CTO is a legal order made by the

Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community.

- Care records included evidence that Mental Capacity Assessments had been completed by the Community Mental Health Team and people had the capacity to make decisions in relation to their care and a DoLS was not required.
- People using the service had signed their care records indicating their consent. They had also given consent for relevant information to be shared with other agencies and for their photographs to be taken. They had also given their agreement to abide by certain house rules.
- Staff respected people's wishes and where people had declined to give their consent, had respected their wishes. For example, staff sometimes asked people if they could carry out random room searches or urine drug screen (UDS), these were voluntary and if people refused to participate they were not forced to do so.

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:

- People said they liked living at Admiral House and that staff were nice to them. Comments included, "I like it here", "Staff are helpful" and "I enjoy it, everything's OK."
- We observed care workers speaking to people in a friendly manner. A care worker told us, "We have a good understanding with the service users. If they have any issues, we are here to guide them and help them."
- Staff received training in equality and diversity and inclusion. They told us that people were able to live their life as they wished without any prejudice. Although some of the people had expressed some religious support needs in their care plans, when we spoke to them they said that they were happy living as they were and did not wish to take part or want to be supported in this aspect.

Supporting people to express their views and be involved in making decisions about their care:

- Regular meetings took place where people were able to express their views.
- Feedback surveys were also completed by people, these showed that people were happy with the care and support they received.

Respecting and promoting people's privacy, dignity and independence:

- People's privacy and dignity was respected. Care workers were aware of asking for people's consent before supporting them. They respected people's right to privacy and got their permission before supporting them with medicines or other areas of support. A care worker said, "I would not stop people from making an unwise decision but would tell them pros and cons."
- People lived independent lives and were free to come and go as they pleased. The majority of people's time was spent doing their own thing rather than group activities. One person said, "I go out when I want but I like to stay in." People told us they told staff whenever they were going out and when they would be back as a courtesy so staff would not worry about them. People agreed to abide by house rules and understood they were there to keep them safe. One person said, "They ask when you are going out and when you will be back."
- People said family and friends could come and visit them at Admiral House if they wanted and staff did not stop them from doing so.
- Care plans included ways in which people's independence could be managed and promoted so they could eventually move onto more independent settings. These included supporting them to take ownership of maintaining their bedrooms and doing their own laundry, helping them to improve their cooking skills or accessing community services such as healthcare appointments. A care worker said, "At the beginning I used to support [person] to the GP but now he goes by himself."

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

- People had individual care plans in place which had been reviewed recently. They were focussed on achieving positive outcomes for people and helping people to become more independent. They included an identified need, goals/outcomes, steps to achieve the goal, timescales and support needed.
- We found there were instances where people's identified goals were not always followed up. For example, in one person's 'living skills' care plan, it stated that he would benefit from having cooking sessions to enable him to prepare a simple healthy meal. We did not see any evidence in their care plan reviews or key worker sessions whether these sessions took place. In another person's 'activity' care plan, the actions for staff were to help him find a leisure centre, to look for activities that best suit him, to help him to socialise in the community by getting him interested in community activities. In his care plan review it stated 'he does not participate in room cleaning, refuses to take part in any form of activity. Declined to register for swimming/gym and also refused to attend day centre.'
- The registered manager said people sometimes refused to engage with their care plans, however more thought could have gone into agreeing on more realistic targets for people to achieve.

We recommend the provider looks into ways in which care plan reviews or one to one sessions could be used more effectively to review people's goals and amend them according to people's engagement.

- Care plans lacked some person centred information about people's preferences and information in relation to their life history or story. We spoke with the registered manager about this who said it was sometimes difficult to obtain relevant information from previous placements or referring bodies but they would endeavour to gather more of this information in future if possible.
- Care plans were reviewed by people's keyworkers which included how people had progressed since their last review and an overall evaluation. Key workers completed monthly one to one sessions with people, providing a narrative of people's current mental and physical health, their interaction with staff and other service users, and any incidents or concerns.
- Care workers completed daily notes with details of how people spent their days. We spoke with the registered manager about ways in which the quality of these notes could be improved to evidence staff and community engagement more clearly.
- None of the people using the service had any specific communication needs. Care plans were written in plain English which people could understand and agree to their content.

Improving care quality in response to complaints or concerns:

- People told us they would speak to staff if they had any complaints.
- The provider kept a complaints register with details of any complaints and action taken. There had been two formal complaints received, both of which were resolved quickly to the satisfaction of the complainant.

- People were given information on how to raise concerns or complaints through a notice that was on display. There was suggestions, comments and complaints box in the hallway.

#### End of life care and support

- Although the service was not supporting people who were on palliative or end of life care, there were records in relation to any wishes and arrangement/agreement in case of death. We saw that these were explored with people but people did not always want to discuss this topic.

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Engaging and involving people using the service, the public and staff:

- Monthly residents meetings took place during which people were able to express their views. We reviewed the minutes from the last three meetings. We saw that where people had raised points for follow up, these were not always explored or discussed at subsequent meetings. For example, in the January meeting some residents mentioned going for a day out during the spring holidays which the registered manager acknowledged and said he would look into arranging. One person mentioned he would like to arrange cooking lessons and others said they would like to have another BBQ. However, none of these points were followed up in the February meeting.

We recommend the provider implements a system to feedback any points raised by people using the service.

- Staff had the opportunities to express their views through regular staff meetings which took place every two months.
- Feedback surveys were completed every three months, for people, friends/relatives, staff and visiting professionals. The questions were based around CQC Key Lines Of Enquiries (KLOES) and the feedback received was positive.

Continuous learning and improving care:

- Quality assurance checks took place on a regular basis, focussing on four main areas. These were care records, staffing, home audit and medicines.
- The home audit included both a bedroom and communal areas safety and quality checks.
- Care record audits looked at whether they were up to date and we saw that any identified actions were allocated to staff and ticked off when they were resolved.
- Staff audits looked at recruitment, training, supervision, appraisal records.
- Internal medicines audits took place weekly and a quarterly one was completed by a pharmacist. No issues were found during these.
- Mock CQC inspections took place using a toolkit to replicate the KLOES, these were used to identify any areas of improvement.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

- People were happy with how the service was run.

- Care workers said the registered manager was approachable. One care worker said, "I have learnt a lot of thing since I have been here, the manager is so helpful."
- Although the registered manager demonstrated a good understanding of CQC regulatory requirements and his responsibilities under the Duty of Candour, we did find that there was one incident that we had not been notified about. We spoke with the registered manager who said it was an oversight and would be submitting this after the inspection. All other notifiable incidents were received. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

Working in partnership with others:

- There was evidence that the provider worked with external professionals such as care coordinators, mental health community teams.