Care Quality Commission

Mrs Alice Manteaw-Dankyi

851 Brighton Road

Inspection report

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Date of inspection visit: 1 and 2 December 2014
Date of publication: 27/04/2015

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

Overall summary

We visited 851 Brighton Road on 1 and 2 December 2014. The inspection was unannounced. The service provides rehabilitation care for up to six female adults recovering from mental disorder.

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

People at the service felt safe and happy. Staff knew how to recognise and respond to abuse and had completed safeguarding of vulnerable adults training. They knew how to report safeguarding incidents and escalate any concerns if necessary. People were confident they could speak to staff and the manager if they had any concerns. Accidents and incidents were reported appropriately. The buildings and external areas were well-maintained and provided a safe environment for people, staff and visitors.

Summary of findings

People's needs were assessed and corresponding risk assessments were developed. There were sufficient numbers of staff to meet people's needs. People's medicines were administered safely.

Staff had the skills, knowledge and experience to deliver effective care and treatment. Mental capacity assessments had been completed to establish each person's capacity to make decisions and consent to care and treatment. Where people were detained under the Mental Health Act 1983 (MHA) they had been informed about their legal status and rights. The manager and staff were aware of the Deprivation of Liberties Safeguards (DoLS) and people not subject to the MHA were assessed and where appropriate an application had been made for DoLS authority. People were supported to have a healthy diet and to maintain good health.

People commented positively about their relationships with staff. They were supported to express their views and were involved in making decisions about their care and treatment. Keyworkers provided additional support for people. There were community meetings every other week where people could express their views and opinions about the day to day running of the home. Staff respected people's privacy and dignity and helped them to be more independent.

People received personalised care. Care plans were person centred and addressed a wide range of needs. People were involved in the development of their care and treatment. Care plans and associated risk assessments reflected their needs and preferences. Ward rounds took place every other week to review care and treatment. People were encouraged to take part in activities to build their confidence and independence. People were confident that they could raise concerns with staff and the manager and those concerns would be addressed.

Staff spoke positively about the service and the manager. Staff meetings were held once a month and included discussions about and learning from incidents. There was a system of regular audits that monitored and assessed the quality of service provision.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe. People felt safe and happy. Staff understood their responsibilities to protect people from the risk of abuse or harm. There were enough staff to support people's needs. The service provided a safe and comfortable environment. Medicines were administered appropriately.

Good

Is the service effective?
The service was effective. Staff received regular training and management support. People's rights were protected because staff understood their responsibilities in relation to mental health legislation, mental capacity and consent. People were supported with their health and well-being.

Good

Is the service caring?
The service was caring. People spoke positively about staff who were aware of people's needs, preferences and planned care and support. People were supported by a keyworker and involved in their care and support. Staff respected people's privacy and dignity.

Good

Is the service responsive?
The service was responsive. Staff were knowledgeable about the people they supported and provided personalised care and support. People were confident they could raise any concerns with staff. There were regular meetings to discuss the running of the service.

Good

Is the service well-led?
The service was well-led. Staff spoke positively about the manager. Issues and learning were raised at regular staff meetings. A wide range of regular audits were completed to monitor and assess the quality of the service provided.

Good

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.

The inspection took place on 1 and 2 December 2014 and was unannounced. The inspection was undertaken by an inspector. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service which included statutory notifications and safeguarding alerts sent to us by the provider. We spoke with four people using the service, one visitor and eight members of staff including the manager. We carried out general observations throughout the inspection. We looked at records about people's care and support which included three care files. We reviewed records about staff, policies and procedures, general risk assessments, and safety certificates, accidents and incidents, minutes of meetings, complaints and service audits. We inspected the interior and exterior of the building and equipment used by the service.

Is the service safe?

Our findings

People told us that they were happy and felt safe at the service. One person said, "I like it here, I am happy, I have no worries. I do feel safe here." Another person said, "I trust the staff here." One person told us, "Yes, I feel safe here." A visiting relative told us, "This is a good place, my daughter is very lucky to be here."

The service had policies and procedures for safeguarding vulnerable adults, whistle blowing, accidents and incidents. Staff answered our questions about safeguarding which showed they understood the different types of abuse, how to report, escalation of concerns and whistle blowing procedures. They were confident that any safeguarding concerns raised would be dealt with appropriately by colleagues and management. Staff drew our attention to a noticeboard in the office. It displayed safeguarding contact numbers and a safeguarding flow chart for staff to follow. We saw that there was a noticeboard in the hallway. It also displayed safeguarding contact numbers and flow chart. In addition, there were safeguarding leaflets produced by the local authority and a 'How safe are you poster.' Accidents and incidents involving people and staff were appropriately recorded providing information about what happened and any actions taken at the time and subsequently. Staff told us that handovers took place between each shift. One member of staff said, "Everyone comes in for handover." The handover gave staff the opportunity to be made aware of any incidents on the previous shift and how people were feeling or behaving.

The building and gardens provided a safe environment for people, staff and visitors. The building, outside smoking shelter and garden area were well maintained as were fixtures and fittings. Basic steps had been taken to minimise risks of self-harm in an environment that encouraged people to be as independent as possible. For example, anti-ligature handles were fitted to internal doors and there were window restrictors on the upper floor. An alarm had been fitted to the rear door so that staff knew when people were leaving the building and could respond appropriately if that person was at risk. As we observed staff over the inspection period it was evident, due to the size of the service, that they had a good idea who was opening the rear door each time the alarm went off. The service carried out regular fire drills to ensure people and staff knew how to respond to the fire alarm and each person had a personal emergency evacuation plan. The fire alarm system was appropriately maintained.

We saw risk assessments had been completed as part of people's care and support plans 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 knew their personal responsibilities. For example, people had recorded in the risk assessments what they would do when they recognised they were at risk. Specific examples have not been given as this would reveal personal information. A general example could have been an agreement to tell staff when certain things were happening to enable staff to provide support. Risk assessments covered general areas such as medicines compliance and self-harm and specific areas that were relevant to each individual. The risk assessments included positive risks that were deemed appropriate and acceptable for the promotion of recovery and independence. Permanent staff were knowledgeable about each individual including risks and where relevant recognised triggers and signs of deteriorating well-being.

There were sufficient numbers of suitable staff to care for people and meet their needs. One member of staff told us, "I am happy with staffing levels in relation to patients." At the time of the inspection there were six people living at the service. During the daytime there was a registered mental nurse (RMN) and two support workers and overnight a RMN and one support worker. Extra support workers were brought in when people needed to be accompanied to external appointments. Staff were supported by a domestic and a chef enabling them to concentrate on providing care and treatment. The registered manager was also an RMN. We were told by the manager that there were two vacancies for nurses and one of those would be recruited as the deputy manager. The service managed planned staff absences, for example training, through the staff roster. Short notice absences could also be covered by staff and bank staff but if that was not possible agency staff were used. The service only used agency staff who were familiar with the service. In emergencies, there was a sister home next door and another one a short distance away that could be called

Is the service safe?

upon to assist. There were clear policies on staff recruitment. Staff records showed Disclosure and Barring Service checks, references, identification and previous employment history.

Medicines were safely managed and securely stored in appropriate conditions. We examined records of medicines received, administered, disposed and looked at a random sample of medicines held against records and did not find any discrepancies. Medicines policies and procedures were available to support staff. Registered nurses administered medicines and they retained the keys throughout their shift. We observed staff safely giving medicines to people and saw records were completed at the time. Staff initials were clearly identified on a signature sheet. Where required (under Section 58 Mental Health Act 1983) we saw the responsible clinician's records of people's capacity and consent to treatment on the appropriate forms. One person was self- medicating. We saw that this had been risk assessed and although the person was self-medicating they was supervised each time.

Is the service effective?

Our findings

People were supported by staff with the knowledge and skills they required to carry out their role. One person said, "I really like the doctor." Another person told us, "I am happy here, I feel that I am being looked after." One member of staff told us, "We have had lots of training, I'm all up to date, things have improved a lot." Another member of staff said, "We are getting a lot more training than we used to. I recently had mental capacity training and DoLS." (DoLS is an abbreviation commonly used for Deprivation of Liberty Safeguarding). A member of staff said, "The supervisions are definitely worthwhile, I have learnt more from the manager in the time I have been here than anywhere else."

Staff had the skills, knowledge and experience to deliver effective care. In addition to speaking to staff we checked records of staff training and supervision. It was evident that staff were receiving regular, relevant training and supervision or appraisal sessions. The service had a multi-disciplinary team that included a visiting psychiatrist, in house nurses, a part-time psychologist and an occupational therapist.

Staff had completed or were scheduled to have Mental Capacity Act 2005 refresher training including training about the Deprivation of Liberty safeguards (DoLS). We saw the service had systems in place to assess and record people's mental capacity to make decisions. Where appropriate, records clearly showed people's legal status. Records of those people detained under the Mental Health Act showed they had been informed of rights of appeal against their detention. One person told us, "I was told my rights when I arrived here." Another person said, "I am very aware of my rights under the Mental Health Act." We saw records where people had appealed against their detention to first tier tribunals and hospital managers' hearings. In one appeal the person had been legally represented.

People were aware of the external support and advice that was available to them. The service displayed a leaflet in the communal hallway providing advice about independent mental capacity advocacy. There was also information available about independent mental health advocates. Records showed people's involvement in and consent to care and treatment. The service had reviewed people who were not subject to orders under the Mental Health Act against the DoLS requirements. There were no DoLS authorisations required for any people using the service at the time of the inspection.

The service supported people to have sufficient food to eat and liquids to drink. People helped themselves to breakfast and two hot meals a day were provided. One person told us, "The food is not fattening, except for the white rice I suppose. It's healthy. The food is not bad but it is not like my cooking." One member of staff told us, "The food is home made. I eat here because I work 'lates.' We usually sit and eat with [people]." People were given a choice of hot meals and there was always a vegetarian option available. One person bought and prepared their own food and one person was in the process of being assessed to do so. Risk assessments had been carried out and people were assessed and supervised for a period of time before being given full responsibility for their food. When necessary a dietician was consulted about individuals to provide advice on diet and portion size.

People were supported to maintain good health. People were registered at a local GP practice and visited the doctor at least once a year for a full check-up. Any new people were registered and taken to see the doctor at the earliest opportunity. One person had arrived at the service a few days before our inspection and we saw that an appointment had been made to see the GP. People were weighed at least once a month. They had their blood pressure taken every week. We saw records of visits to other healthcare services such as the dentist and optician.

Is the service caring?

Our findings

One person said, “Staff are really nice and helpful. They involve me with general things to do with my care. The manager is really nice and supportive.” Another person told us, “I get help when I need it. Staff always offer to help me. They even help me take my laundry basket to the washing machine.” One member of staff said, “I’m happier here than I have been anywhere else.” We observed positive interactions between people and staff throughout our inspection. First name terms were used when speaking. There was a key worker system in place which provided people with additional support from a nominated member of staff. We saw evidence of keyworkers providing input into care records.

People were supported to express their views and were actively involved in making decisions about their care and treatment. We saw evidence in care planning of people’s involvement. Some people wrote comments in their records. One person commented, “They ask my opinion.” One person told us about the community meetings that were held every other week. One person chaired it and they discussed topics such as the menu and day to day running of the home. One person said, “They listen to what we say, I’ve asked for things and they have provided them.” People were encouraged to contribute when ward rounds took place and were asked their thoughts and opinions about their care and treatment.

Staff respected people’s privacy and dignity. One person told us, “I like my room, it’s private, my space. Staff knock on my door before coming in.” We saw that medicines were administered in private to people away from communal areas. People were supported to become more independent. People were encouraged to do things for themselves as residents and out in the local community. One person had been supported to do regular voluntary work. People had organised a ‘pampering session’ for themselves where they painted each other’s nails. There was evidence of positive risk assessments that enabled people to experience various levels of independence away from the service but within parameters discussed and agreed by the person and staff.

Is the service responsive?

Our findings

People received personalised care. One person told us, “The ward rounds are longer now and more people are involved. It’s quite supportive.” One person said, “The staff can tell when I am in pain and they offer to help me.” Another person said, “The staff take me out shopping to Croydon and Purley. I go to college once a week. I do international cooking. I have made cakes at the home. I have been gardening over the summer and planted some winter vegetables.” One person told us, “They took me to IKEA one evening and I got that plant there and some pictures. It was nice on Friday because I went to Croydon and met my mum. We had lunch together.”

We looked at care plans and saw they were person centred and addressed a wide range of people’s needs. The care plans also contained relevant risk assessments for each person and focussed on people as an individual. People were assessed before they came to live at the service unless they were admitted as an emergency. The assessment along with other admission information provided the basis for planning care and treatment for people. People were involved in the process and consequently, care plans and associated risk assessments reflected their needs and preferences. If appropriate there were contributions from relatives.

We found that ward rounds took place every other week. They were taken by a visiting psychiatrist. We were told by people and members of staff that the rounds were very thorough and not rushed. One person told us, “It is better now with this doctor but it can be intimidating because I have to address things.” Staff told us that ward rounds had resulted in clinical improvements, transparency and confidence. Staff were aware of people’s needs and preferences and demonstrated their knowledge in conversations with us. There were arranged activities for people and ad hoc activities. People were encouraged to take part in activities to build their confidence and independence. They were also encouraged to complete daily living tasks such as cooking, laundering their clothes and various levels of managing financial matters.

There were regular meetings for people to raise issues relating to the service or areas that could be improved. They could also talk with staff, their keyworker or the manager. One person told us, “If I had any problems I would be confident to speak to the manager.” Another person said, “If I had any concerns I would report it to staff.” One person informed us the manager had dealt ‘very well’ with a complaint they had. There was a complaints procedure but most matters were addressed at an early stage. We looked at how one complaint had been dealt with and saw that the process followed recognised steps around responses, timescales and appeals.

Is the service well-led?

Our findings

Members of staff spoke positively about the manager of the service and the changes that had taken place since their arrival. One member of staff said, “There has been a big improvement since the manager came along, the manager is very good.” Another said, “Anytime you have an issue you can go and speak to her.” We were told that staff meetings were held once a month. At each meeting, providing confidentiality was not an issue, there were staff discussions about safeguarding reports, incidents and complaints and how they could learn from them. We read about one incident and the learning from it. We also looked at the minutes of the most recent staff meeting. The manager wanted staff to feel involved and valued. To that end the manager was planning to introduce an employee of the month with a small gift as a reward. The manager was a RMN, held appropriate management qualifications and was registered with the Care Quality Commission. We noted from our records that the manager was submitting statutory notifications as required and was aware of their responsibilities.

Audits were regularly undertaken to assess and monitor the quality of the service. We saw evidence of daily and monthly audits carried out by both staff and the manager.

For example, staff carried out a daily medicines audit that had to be completed four times a day. The audit covered areas of responsibility of the person administering medicines and decreased the likelihood of mistakes being made. The manager was also required to complete a series of audits once a month on behalf of the provider. The audits provided comprehensive checks of service provision and the manager had to specify which audits had been completed and what actions were necessary when identified. These audits covered areas such as the kitchen, medicines, staff files, infection control, health and safety and care records. There were unannounced visits where audits were carried out on behalf of the provider by employees outside of the service.

Where reports had been written following visits from professionals such as Mental Health Act Commissioners or local authority commissioners we saw that recommendations were addressed and met. For example, the Mental Health Commissioners required the service to provide a statement of actions in relation to records of authorised leave and a responsible clinician’s review of one person’s medicines. We saw the statement of actions provided to the Commissioners and during the inspection saw that the changes were in place.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

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