

Laurel Residential Homes Limited

Russell Hill Lodge

Inspection report

39 Russell Hill Road
Purley
Surrey
CR8 2LD

Tel: 02086683212

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19 January 2016

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

We visited Russell Hill Lodge on 18 and 19 January 2016. The inspection was unannounced.

At the previous inspection in August 2014 the service was meeting the Regulations we inspected.

The service provides rehabilitation and recovery care for up to 18 younger adults with mental health needs. There were 14 people at the service when we inspected.

The service had a registered manager until November 2015. A replacement manager was in post but has not yet registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe. The service had appropriate policies and procedures for safeguarding and whistle blowing. Staff understood their personal responsibilities to recognise and report any suspicions of abuse. Handovers between shifts ensured staff were aware of recent incidents and the moods, health and welfare of people using the service. The service provided a safe and comfortable environment for people, staff and visitors. Risk assessments were in place for people using the service and provided staff with guidance to provide safe and appropriate care and support. There were sufficient numbers of staff to meet people's needs. Staff recruitment procedures ensured suitable staff were selected and included checks with the Disclosure and Barring Service. Medicines were managed safely.

We found gaps in some areas of training and refresher training. You can see what action we told the provider to take at the back of the full version of the report. Overall, people were supported by staff who had the knowledge and skills they needed to deliver effective care. Staff were supported to obtain further, relevant qualifications. Staff were aware of the provisions of the Mental Capacity Act and Deprivation of Liberty Safeguards. People were supported to have a healthy diet and to maintain good health.

People told us staff were supportive. Keyworkers provided additional encouragement and support. People were supported to express their views and be involved in the planning and delivery of their care and support. Staff respected people's dignity and privacy and treated them with respect. People were also encouraged to be independent.

People received person centred care that was focussed on their needs. Support plans and risk assessments were developed with people using the service and helped staff to deliver safe and appropriate care and support. People were encouraged to take part in activities to reduce the risks of social isolation and to enhance their lives. People were also encouraged to maintain relationships with family and friends. The service regularly obtained feedback about people's experiences of the service with continual improvement in mind. The service had appropriate processes for dealing with complaints.

Staff spoke positively about the management team and said they were approachable. Staff meetings were held every month giving staff the opportunity to feedback their thoughts about the service. There was a system of reviews, checks and audits to assess and monitor the quality of service provided and identify any risks to the health safety and welfare of people using the service, staff and visitors. Records relating to the provision of care were appropriately stored and were fit for purpose.

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 felt safe and staff understood their personal responsibilities to recognise and report any suspicions of abuse. The service provided a safe and comfortable environment. There were sufficient numbers of staff to meet people's needs.

Is the service effective?

Requires Improvement ●

The service was not always effective. There were gaps in training and refresher training. Despite this staff had the knowledge and skills to carry out their role. Staff were aware of the provisions of the Mental Capacity Act and Deprivation of Liberty Safeguards. People were supported with their health and well-being.

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 respect and encouraged to be independent.

Is the service responsive?

Good ●

The service was responsive. People received person centred care that was focussed on their needs. They were encouraged to be involved in activities and maintain relationships with family and friends. The service sought feedback from people in order to improve.

Is the service well-led?

Good ●

The service was well-led. The service sought feedback from staff in order to improve. There was a system of reviews, checks and audits to assess and monitor the quality of service provided and identify any risks to the health safety and welfare of people using the service, staff and visitors. Records relating to the provision of care by the service were fit for purpose.

Russell Hill Lodge

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 18 and 19 January 2016 and was unannounced.'

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

Before the inspection the provider completed a Provider Information Return. 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 reviewed information we held about the service. We spoke with five people using the service, four members of staff, the manager and regional manager. We carried out general observations throughout the inspection. We looked at records about people's care and support which included five support plans. We reviewed records about staff, policies and procedures, general risk assessments, safety certificates, complaints and service audits. We consulted three health and social care professionals for general feedback about the service.

Is the service safe?

Our findings

People told us they felt safe. The service had policies and procedures for safeguarding vulnerable adults, whistle blowing, accidents and incidents. We spoke with staff about safeguarding which showed they understood the different types of abuse, how to report any concerns, escalation of concerns and whistle blowing procedures. They were confident that colleagues, the manager and senior management would deal appropriately with any safeguarding concerns they raised. Where the service retained money on behalf of people using the service they were protected from financial abuse and staff were supported by robust procedures. Two members of staff checked the balance before and after giving the person their money. Both members of staff and the person receiving the money signed a receipt. The manager regularly checked people's finances.

Whenever there was a changeover of shifts there was a comprehensive handover. This meant we were aware of what had happened on the previous shift; how people had been behaving; and, people's health and well-being. Those members of staff on overlapping shifts also attended. We observed a handover where staff exchanged information about each person using the service. This handover included information about moods, behaviours, improvements, appointments, the condition of people's rooms and medicines. Everybody was involved and voiced opinions irrespective of their experience. There were also discussions about how to approach people in relation to tasks and goal setting for one individual. Information was passed on to a key worker who had just returned from leave. Such handovers ensured staff were up to date and supported the delivery of safe and appropriate care and support.

The service provided a safe and comfortable environment for people, staff and visitors. The service had general risk assessments in place for the building, environment and equipment. There was a record of safety certificates with dates of issue and dates due for renewal including gas, electrics, fire safety (alarms and equipment) and legionella. The building was reasonably well maintained and the provider had a rolling maintenance programme. The service shared maintenance staff with two other locations nearby that ensured a quick response to any urgent or immediate needs for repairs.

We found the service identified and recorded risks in relation to the care and support they provided for each person using the service and assessed how they would address these risks. The risk assessments reflected care and support plans including people's needs, goals and preferences. They were created in consultation with people using the service and we saw evidence of this in risk management plans signed by individuals. Risk assessments also supported staff by providing clear guidance about how to practically deal with identified risks in terms of prevention or response in order to provide appropriate care and support. Risk assessments covered diverse areas such as finances, self-harm, behaviour that challenges, isolation, medicines, substance abuse and daily living. They were reviewed at periodic intervals or in response to changes in people's needs or specific incidents.

There were sufficient numbers of suitable staff to meet people's needs. Staff told us they were happy with the numbers of staff on each shift. There were a minimum of three staff on each day shift and two covering the night shifts. The manager was available to support staff during their scheduled working hours. There was

no domestic or catering support but people using the service were relatively independent. This left times when staff could carry out domestic tasks. Staff took turns to cook and some people were able to prepare certain meals for themselves or assist staff to prepare meals and snacks. Planned absences for training and leave were covered by the staff rota. Short notices absences, such as sickness, were covered by staff remaining on duty or being called in. The service benefitted from the provider having two other services nearby giving access to additional staff if needed.

We looked at a random selection of staff records and were satisfied there were robust procedures around staff recruitment. We saw applications for employment which included a full employment history and qualifications. There was a record of interview, identification documents and two references. Staff could not start their employment at the service until they had passed enhanced checks with the Disclosure and Barring Service.

We found medicines were managed safely. We observed medicines being administered with people's permission. Medicines were administered in the office to one person at a time. This allowed the staff member to concentrate on what they were doing in a calm environment whilst maintaining people's privacy and dignity. Each time medicines were administered the member of staff checked the outstanding balance of medicines was correct.

Medicines, including controlled drugs, were stored safely and securely in an appropriate environment and administered by trained staff. The medicines trolley was neat and uncluttered. There was a suitable drugs cupboard for controlled drugs. Staff were supported to administer and manage medicines training, guidance, procedures and policy.

We examined records for the administration of medicines to people using the service. Staff signed their initials to identify who made entries in medicine's records. Those people self-administering medicines were clearly identified. Medicine administration records (MARs) were preceded by a front sheet showing the name of the person with an up-to-date photograph to minimise the risk of medicines being given to the wrong person. It clearly identified any allergies. We examined MARs and other records for the management of medicines. We found records had been completed correctly. We audited a random selection of medicines which corresponded with completed records.

Is the service effective?

Our findings

The service was not always effective. We found some areas of training and refresher training had been overlooked by the previous manager. For example, three members of staff had not had any refresher training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) since 2013; two members of staff had not completed safeguarding refresher training since 2013; and, one team leader had received no medicines awareness training since 2013. We did not look for further examples as the records confirmed what we had already been told by staff about the decline in training. We were concerned that staff might not have up to date knowledge in key areas for them to deliver safe and appropriate care and support. In the area of MCA and DoLS, for example, there was a significant ruling in March 2014 at the Supreme Court. In response to the ruling, the local authority provided a substantial amount of free training for services in the area that this service had not taken up. These anomalies in training provision were a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the problems with training we found the impact on people was limited because staff had the knowledge and skills they needed to carry out their roles. Staff told us training had improved since November with the arrival of the new regional manager and new service manager. Provider audits had identified the gaps in training and every effort was being made to bring staff back up to date. We saw records and were told by staff about recently completed training. The regional manager informed us about planned training. New members of staff were required to complete an induction programme, including training, that reflected the requirements of the Care Certificate. The Care Certificate sets out the learning outcomes, competences and standards of care expected in health and social care.

Staff were supported to obtain further, relevant qualifications. They were required by the provider to complete National Vocational Qualifications (NVQ) or Qualifications and Credits Framework (QCF) in Health and Social Care Level 2. Those who had not completed Level 2 were enrolled on courses to do so. We found there were gaps in staff supervisions and appraisals under the previous manager. Supervisions and appraisals should have taken place regularly as part of the process of assessing staff competence and recognising training needs. Staff had received a one-to-one supervision session since the new regional manager had arrived. We were assured a schedule of supervisions and appraisals would be taking place under the new manager.

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. People at the service were relatively independent and were assumed to have capacity to make decisions about their care and support. We spoke with staff who understood the principles of the MCA and in practical terms were effectively complying but decisions around capacity were not clearly documented and recorded. Although we found forms for mental capacity assessments in care records they were not completed. The service had not applied for any authorisations under DoLS. The service did not use any form of physical restraint and people were able to come and go as they pleased.

People had sufficient food to eat and liquids to drink. One person said, "The meals are really good. There's two different varieties, you have options. There is enough portion size." Another person said, "The meals are fine, there could be more variety." One person said, "I don't like the food here. I [sometimes] do my own cooking." Food menus were discussed with people using the service at house meetings. We saw monthly nutrition records that showed what people had consumed. Food allergies and preferences were clearly recorded. For example one person was allergic to nuts and one person did not eat pork. Where there was a risk to people's health, such as the allergy to nuts, this was highlighted in support plans and risk assessments. Drinks and snacks were available to people outside of normal mealtimes.

We found the service supported people with their healthcare needs. People were reminded about and encouraged to keep appointments. A communication book reminded staff of any upcoming appointments. We saw evidence in support plans of medical appointments and visits including the GP, dentist, chiropodist, psychiatrist, substance misuse team and the community mental health team. There were hospital transfer records for people providing relevant information if they were taken into hospital for any reason. We also saw that people were supported with reducing smoking habits or smoking cessation. There was also support for people to address substance misuse.

We have recommended that the provider considers the guidance contained within the Mental Capacity Act 2005 Code of Practice and refers to current guidance for good practice in relation to policies, procedures and record keeping.

Is the service caring?

Our findings

People felt that staff were supportive. One person told us, "Staff do listen and are very supportive." Another person said, "Staff are very supportive, most of them." Another person told us, "Staff are helpful and supportive." One person said, "Everything here is working for me." In our observations throughout the inspection we found staff were patient, caring and friendly in their dealings with people using the service. There was one incident we observed where a person's behaviour was challenging. Staff took time to listen and were patient and calming when the person became extremely agitated. During this period staff remained patient, calm and reassuring until the person had calmed down.

People were paired with a keyworker to provide additional encouragement and support. Keyworkers also helped people with the more practical aspects of day-to-day living. People were involved in choosing their keyworker. The people we spoke with knew the name of their keyworker. The key worker also completed regular one-to-one sessions with people and worked with them on their recovery star plan.

We found people were supported to express their views and were actively involved in making decisions about their care and treatment. One member of staff told us, "[The manager and regional manager] are promoting people's involvement. I am really positive about it." We saw evidence in care planning, support plans and risk assessments of people's consent and involvement in developing their care and support. The service had introduced a star recovery programme that was dependent on the involvement of people using the service and where appropriate their representatives. People we spoke with were aware of the availability of mental health advocates to support them express their views and feelings.

Staff respected people's dignity and privacy and treated people with respect. Interactions between people and staff were seen to be friendly, informal and positive. People and staff referred to each other by their preferred names. We saw people and staff having friendly conversations and laughing and joking. People were challenged about inappropriate behaviour in a firm manner but also calmly and politely. For example, one person was challenged about carrying a lit cigarette through the building to the smoking area in the rear garden. There were no raised voices and the incident was subsequently discussed in private. Discussions about care and support were carried out away from the hearing of others. Staff only entered people's rooms after knocking and asking permission to enter.

People were also supported and encouraged to be as independent as possible. For example, some people required support, guidance, prompting and reminders about daily living tasks such as personal hygiene, finances, appointments and laundry. One person was being supported and encouraged with verbal guidance when setting up a bank account.

Is the service responsive?

Our findings

People received personalised care. We looked at care records and support plans and found they were person centred and addressed a wide range of people's needs. The support plans also contained relevant risk assessments for each person and focussed on people as individuals. Needs assessments were completed before people came to live at the service taking into account diagnoses and professional support and advice. These assessments were used as the basis for developing support plans and risk assessments. People, or their representatives, were involved in the process and wherever possible were party to and agreed with support plans and associated risk assessments. Consequently, support plans not only reflected people's needs but also their preferences and choices.

The service had introduced a recovery star programme that at the time of the inspection was running alongside existing support plans. Staff had completed training to deliver the programme. The programme looked at 10 areas of people's lives such as managing mental health; living skills, social networks; and, relationships. People spent time with a member of staff, usually their keyworker, assessing where they were in each area, such as 'stuck', 'accepting help', 'learning', and 'self-reliant.' This identified areas for each individual that were working well and not so well and formed the starting point for working out goals and the support needed to achieve them. The recovery star was a continuing reference point for people and staff to see where people were in their recovery. We received positive feedback about the recovery star from staff who had started using the programme. Although the programme was still in the early stages at this service and was not in place for everybody at the time of the inspection it demonstrated that care and support was focussed on the individual and their specific needs.

The service encouraged people to become involved in activities both individually and in groups within the service or externally such as art therapy, cooking, swimming and outings. Activities were important for people because they reduced the likelihood of social isolation or distancing and enhanced their lives. People were also encouraged to maintain relationships with family and friends. Visits were welcomed provided they did not adversely impact other people using the service. People had their own keys and were free to leave and return whenever they wanted.

We found the service had systems to obtain people's feedback about their experiences of the service. In addition to weekly one-to-one meetings with keyworkers, there were house meetings every two weeks where people and staff discussed matters relating to the day to day running of the service. These have included items such as the menu, smoking and cleanliness of rooms. The provider also carried out an annual survey of people using the service and their representatives. This information was used by the service to improve care and support provided to individuals and informs service improvements. The provider had policies and procedures to deal with complaints. People told us if they had any concerns or complaints they would inform either a member of staff or the manager. One person spoke to us about a complaint and we found it was already being dealt with through the complaints process.

Is the service well-led?

Our findings

The registered manager left the service in November 2015. A new manager had been recruited and had been at the service for four weeks when we inspected. The manager was being supported by the regional manager who had managed the service in the intervening period. Members of staff spoke positively about the manager and regional manager. Staff told us they were approachable and had made a number of positive changes.

We found the service had systems to obtain feedback from staff. In addition to an open door policy operated by the manager there were monthly staff meetings. These provided an opportunity for a two way exchange of information. Certain agenda items such as safeguarding were included in every meeting for discussion. Staff were encouraged to feedback their experiences and ideas about the service. The manager had held one staff meeting since his arrival but we were aware regular staff meetings were a requirement of the provider. The manager was positive about the value of staff meetings and assured us they would take place regularly. The manager and regional manager provided a visible presence to people using the service and members of staff. We observed a number of occasions when either one provided support to people or completed daily tasks.

The service met the statutory requirements of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). In addition to RIDDOR incidents the service recorded other accidents and incidents and complied with the statutory requirements in relation to CQC notifications and safeguarding's. We checked our records and found the occurrence of these incidents were within normal parameters for comparable services. Details of any such incidents were considered by senior management with a view to identifying any learning opportunities and making improvements at service or provider levels.

The service and the provider used a system of reviews, checks and audits to assess and monitor the quality of service provided and identify any risks to the health safety and welfare of people using the service, staff and visitors. Care records, support plans and risk assessments were reviewed periodically or in response to specific needs or incidents. Checks were regularly carried out in specific areas such as the management of medicines. There was a formal system of audits completed by senior management on behalf of the provider including safeguarding audits and quality assurance visits. We saw the audits resulted in action plans that clearly identified areas for improvement, the action needed, who was responsible for the action and timescales. We were provided with subsequent action plans that showed completed actions and progress. Any service specific issues were addressed by the manager and more general issues at provider level to benefit other services owned by the provider. These systems identified training, refresher training and staff supervisions had fallen behind. The service identified action to address these areas and were in the process of doing so when we inspected.

We found that records relating to the provision of care by the service were fit for purpose. They were readily accessible, up to date, legible and accurate. Where appropriate records were stored securely and restricted to those people authorised to see them.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Training and refresher training for some members of staff were not up to date. Regulation 18(2)(a).