

National Society For Epilepsy(The) Russell House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 1 and 2 March 2016. It was an unannounced visit to the service.

We previously inspected the service on 24 and 25 June 2015. The service was not meeting the requirements of the regulations at that time. Warning notices were served and the service was placed in special measures. The service was inspected on the 10 September 2015 to follow up on the warning notices. The warning notices were met but the service remained in special measures.

Russell house is a care home which provides accommodation and personal care for up to twenty people with epilepsy, learning and/or physical disabilities. The home has been purpose built and is made up of four individual units. Each unit accommodates five people. There are two units on the ground floor and two units on the first floor. At the time of our inspection there were seventeen people living in the home.

In this report the name of a registered manager appears who was not in post and not managing the regulatory activities at this location at the time of the inspection. Their name appears because they were still a Registered Manager on our register at the time. At the time of this inspection the home did not have a registered manager. However a new manager had been appointed and would complete the process to be registered with the Care Quality Commission.

People and their relatives were generally happy with the care provided. They felt people got safe care. Staffing levels had improved but there was not sufficient staff on one unit to meet people's needs. The provider addressed this and we have made a recommendation for this to be monitored and maintained.

Staff were inducted, trained, supported and supervised. They were clear of their roles and responsibilities and felt suitably skilled to do their job. Robust recruitment processes were not followed. We have made a recommendation to address this.

Appropriate Deprivation Of Liberty Safeguards (DoLS) applications were made to the local supervisory body for people who had restrictions imposed on them. The provider failed to notify the Commission when these had been approved.

People's health needs were met and systems were in place to promote safe medicine administration practices. We have made a recommendation for the provider to update guidance and for medicine records to accurately reflect if people have allergies to medicines or not.

Systems were in place to keep people safe and safeguarded from potential abuse. Risks to people were addressed and managed. People's nutritional needs were met.

The home was clean, suitably maintained and systems were in place to keep it updated and fit for purpose. Equipment was serviced and safe to use.

Staff were kind, caring and had a good understanding and knowledge of the people they supported. They promoted people's privacy, dignity and independence and provided opportunities for people to have access to activities. They recognised that access to community based activities could be better.

People had care plans in place. They were person centred, detailed, up to date and reflective of people's care needs. People were regularly reviewed and changes in people were acted on to promote their well-being. People's records were up to date and suitably maintained.

The provider had increased and improved their monitoring and auditing of the service to promote safe practices. The management team had a more visible presence on the units and made themselves more accessible and available to staff. They supported staff on shifts where required. As a result staff felt better supported which enabled them to provide safer care to people.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The service was in special measures as a result of the comprehensive inspection in June 2015. This inspection showed improvements had been made. Therefore the service is now out of special measures.

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

Staffing levels had increased but were not sufficient on one unit to ensure people received the level of support and observation required.

People were safeguarded from abuse however robust recruitment procedures were not in place which had the potential to put people at risk.

People's likelihood of experiencing injury or harm was reduced because risk assessments had been written to identify areas of potential risk. Some areas of medicine practices needed to improve to further mitigate risks to people.

Is the service effective?

Good 

The service was effective.

People were supported by staff who were suitably inducted, trained and supported in their roles.

People's nutritional needs were met and monitored.

People's health needs were met and they had access to a range of health professionals to promote their health and well-being.

Is the service caring?

Good 

'The service was caring

People were supported by staff who were kind and caring.

People's privacy, dignity and independence were promoted.

Is the service responsive?

Good 

The service was responsive

People had care plans in place which provided guidance for staff on how they liked to be supported.

People had access to person centred activities on site although access to community based activities was impacted by lack of drivers.

People were provided with the information and support they needed to enable them to raise concerns about their care.

Is the service well-led?

The service was not always well led

The service did not have a registered manager.

The provider monitored the service to ensure people received the required care.

People's records were up to date and suitably maintained.

Requires Improvement 

Russell House

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 1 and 2 March 2016. This was an unannounced inspection which meant staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors.

At our previous inspection on the 24 and 25 June 2015 the service was not meeting the regulations inspected. The service was rated inadequate and placed in special measures. This inspection was a comprehensive inspection to review the rating and progress made.

Prior to the inspection we reviewed the Provider Information Record (PIR). The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed the previous inspection reports of the home and other information we held about the home. After the inspection we contacted health care professionals involved with the service to obtain their views about the care provided.

During the inspection we spoke with seven people living at the home. We used the Short Observational Framework for Inspection (SOFI) to observe the care and support provided to other people in the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke to staff which included the deputy manager, three team leaders, seven support staff and the activities co-ordinator. We spoke with four relatives after the inspection and received written feedback from four relatives. We looked at a number of records relating to individuals care and the running of the home. These included eight care plans, medicine records for eight people, three staff recruitment files, accident/incident reports and audits. We observed staff practices and walked around the home to review the environment people lived in.

Is the service safe?

Our findings

At the comprehensive inspection in June 2015 there was not sufficient numbers of qualified, competent, skilled and experienced staff employed to meet people's care and treatment needs. At the focused inspection in September 2015 the provider had reviewed the staffing levels and had increased them. At this inspection the home still had a high number of staff vacancies and were actively recruiting into them. We saw a number of staff had been appointed subject to the required recruitment checks. Bank and agency staff were used to cover gaps in the rota and regular staff worked overtime. The deputy manager monitored the rota to ensure that the required staffing levels were maintained. Each morning the deputy manager or a nominated person in charge visited each of the units to get a handover on people's well-being, staffing levels and what was planned. Staff told us the deputy manager had a visible presence in the units. They covered shifts and supported people to go for appointments when required.

We received mixed feedback from relatives regarding the staffing levels at the home. Some relatives spoken with told us that there had been an improvement in staffing levels. Comments included "There is definitely more staff around". "There was always a team leader or shift leader in charge of a shift now and they found this reassuring"

Other relatives told us the staffing levels were still not sufficient. Comments included "Whilst they could see the staffing levels had increased they were not able to see the benefit of that for their relative in that they still did not get the opportunity to go out often". "The staffing levels at the weekends were not as good and a lot of bank or agency staff were on shift at the weekend which they found concerning" "Staff are frequently having to do double shifts due to being short staffed, which they find very tiring".

The majority of staff felt there was enough staff to meet people's needs. Comments included. "I think we do have enough staff – four residents, three staff. I think staffing's fine". Staff told us they worked long days and overtime but felt that was monitored and managed. Staff on one unit felt the staffing levels were still not sufficient to enable them to provide the level of observation and person centred care people required.

The deputy manager told us the minimum staffing levels on the unit with high levels of one to one observations was three staff on the morning shift and a fourth staff member from 10am till 6pm. This was because some people choose to stay in bed later and more staff were required late morning and afternoon. Four staff were provided on the afternoon shift. We looked at the shift planner and saw occasions including day one of the inspection where one staff member was responsible for carrying out two one to one observations at the same time. We saw this staff member assisted in the meal preparation whilst rostered to provide two one to one observations. We saw another occasion on the shift planner where one staff member was allocated to carry out three one to one observations at the same time. The person who required two staff to go out in the community for four hours each day could only have this in the afternoon rather than when they required it or was becoming agitated as was indicated on their care plan. The home did not have sufficient staff who could drive the minibs. On day two of the inspection we saw one staff member had to drive the minibs and take a staff member and a person who used the service to a community based activity. During this time two staff were left on the unit with three people on one to one observations. We

discussed our findings with the provider. They confirmed the staffing levels on this unit should have been four on each shift as opposed to three on the morning shift. They agreed to address it immediately. We were sent copies of rotas after the inspection which confirmed the required staffing levels of four staff on each shift had been maintained.

The home had administration staff, cleaners who were responsible for cleaning the communal areas of the home and support staff who were responsible for the meal preparations. Each unit had a team leader or shift leader who was nominated in charge of the shift. The team leaders had two administration days per week. Generally team leaders felt this was sufficient but acknowledged they did not always get the two days they were allocated due to demands on the unit. They felt this would improve once the new management structure was in place.

Staff told us they had completed an application form, attended for interview and checks were carried out on them before they could commence employment. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Staff files included application forms, records of interview, two references and a recent photograph. Improvements were required to recruitment practices. We saw references were not routinely taken from a previous employer and the dates on references that the referee said the staff member was employed by them did not correspond with the date on an application form. The provider confirmed after the inspection this had been addressed and systems put in place to ensure those issues were identified and managed.

People were supported by staff to take their medicines. People's care plans outlined how people took their medicines. We saw medicines were given as prescribed. Daily audits of medicine records took place which enabled staff to pick up any gaps in administration of medicines in a timely manner. Alongside this monthly medicine audits were completed and the deputy manager or person in charge carried out weekly checks on medicine administration. Some people required their medicine to be given covertly. The decision to do this was made at a best interest meeting and signed off by relevant professionals involved in the discussions and the person's care. The home used buccal midazolam which is a controlled drug. Some staff were aware it was a controlled drug, others were not. The storage and administration of buccal midazolam is not as required for other controlled drugs but good practice guidance is that there needs to be a robust process for recording the quantity and movement of buccal midazolam. Systems were in place to record all medication in and out of the home, including buccal midazolam. We carried out a stock check on a person's buccal midazolam and found it to be correct. The medicine policy made no reference to how buccal midazolam was to be managed and what processes should be in place to monitor the movement of this medicine.

There were clear PRN (as needed) protocols that gave directions for when a medicine should be given. It outlined when the medicine should be given, interval between doses and maximum dosage in twenty-four hours. One person's medicine records indicated they had an allergy to a specific medicine. We saw they were prescribed that medicine. Staff told us the prescribing consultant had spoken to the family to establish previous reaction to that medicine and agreed to trial it again. The medicine had been regularly administered and no reaction had been noted. We saw the discussion was recorded in the person's medical notes but the medicine record had not been updated to reflect they were not allergic to it. This had the potential for the person not be given the required medicine when required.

We observed senior care staff administering medicines on three units. The procedure was carried out competently and sensitively. Staff we spoke with who administered medicines were knowledgeable about the drugs they gave. They also communicated with people during the process and encouraged people to take medicines which would help meet their health needs. A relative commented "Any need for medication

changes and any medical issues appear to be addressed promptly".

People told us they felt safe living at the home. One person commented "Staff help keep me safe". People had access to information about safeguarding and how to stay safe. This was reinforced to people at the resident meetings. We observed that there were bleep handsets in, for example, bathrooms. This meant that staff could summon assistance to help meet a person's needs.

Relatives told us they believed their relatives were safe. One relative commented "We are not aware of any instances where our relative was unsafe". Another relative told us from their own observations, good care plans and processes put in place since the previous inspection in June 2015 they felt reassured safety issues should now be addressed. Other relatives expressed concern that their family members were not always getting the one to one care and observation they required which they felt impacted on their safety. This caused distress and anxiety to the families. A relative told us they had worked hard behind the scenes to ensure their relative was offered opportunities to do the things they enjoyed whilst on one to one care. They did not feel that this was consistently maintained. Another relative told us "I am not completely sure that my relative receives safe care as they have on occasions sustained unexplained bruising". The provider was made aware of this feedback for them to address.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. They were aware what was considered abuse and of their responsibility to report any incidences of poor practice which put people at risk. One staff member told us how they had reported poor practice and action had been taken. Staff told us they had received training in safeguarding adults and this was updated every two years. All the staff we spoke with had a good understanding of whistleblowing and said they would report concerns to the manager, or "go higher" if necessary. Another staff member told us they would "generally report to (my) senior. If it involved them, I'd go one above." We looked at the staff training matrix. Staff had safeguarding of vulnerable adults training and updates were booked for staff who needed it. The provider had policies and procedures in place in relation to safeguarding which provided guidance for staff on action to take to safeguard people.

At the comprehensive inspection in June 2015 risks to people were not properly managed which meant safe care and treatment was not provided. At the focused inspection in September 2015 we saw risks to people were identified and managed. At this inspection we saw this was sustained. People's care plans contained a range of risk assessments. These were person centred and addressed appropriate risks to individuals. Management plans were in place to manage the identified risks. These were kept up to date and reviewed. Staff had signed to confirm they had read and understood people's risks and management plans. Staff spoken with were clear of risks to people and actions required to manage and minimise risks. We saw staff supported people appropriately and in line with the risk management plan contained within the care plan.

At the comprehensive inspection in June 2015 we saw the laundry room which was meant to be locked was left unsecure and cupboards and drawers containing hazardous cleaning solutions and knives were unlocked. Throughout the two days of this inspection the laundry room, cupboards and drawers were kept locked. Staff were aware of their responsibilities to do this and it was consistently maintained.

At the comprehensive inspection in June 2015 we saw staff did not follow the medical advice in relation to observations of a person following a head injury. At the focused inspection in September 2015 we saw guidance had been provided for staff on what to do if a person had an accident resulting in a potential head injury. At this inspection we saw completed accident and incident forms were audited and signed off by the deputy manager. Where appropriate action was not taken or recorded this was followed up and addressed with staff. The home had introduced an individual log of accident and incidents. This enabled them to pick

up trends in accidents. Action was taken to prevent reoccurrence and manage the risk. Staff demonstrated during discussion with us they were aware of their responsibilities for reporting and recording accidents, incidents or concerns. Senior staff told us where necessary they contact the person's GP. Staff we spoke with were aware of the importance of documenting e.g. injuries on a body map and in the incident form. A senior member of staff referred to the role of the local authority in safeguarding and to notifications to the Care Quality Commission.

People were kept safe from the risk of emergencies in the home. Each person had a personal emergency evacuation plan in place which was up to date and reviewed. Records were maintained which showed equipment such as fire safety and moving and handling equipment was regularly serviced and fit for purpose. The home had a risk assessment document which identified environmental risks and how these were managed to promote people's, staff and visitors safety. Each unit carried out a range of health and safety checks of the environment and fire safety checks. At the comprehensive inspection in June 2015 we saw the water temperature records regularly exceeded 44 degrees centigrade which is considered by the Health and Safety executive to be the maximum safe temperature for water outlets in care homes. At this inspection we saw the water temperatures were regularly checked and action taken when it exceeded the safe temperature. The health and safety department had responded to a national alert in relation to fire equipment such as self-closing doors and fire signs. This had been reported to the maintenance department to complete.

The home had a contingency plan in place, dated December 2013. It provided guidance to staff on the action to take in the event of a major incident at the home such as fire, flooding, electric, gas or water supply failure. Staff spoken with were clear of their responsibilities in relation to health and safety.

The home was clean and areas of the home had been decorated. Other areas were in need of decorating. A refurbishment plan was in place. This outlined the areas of the home that were due to be decorated. The kitchens were in the process of being refurbished to make the dining area larger and more suitable to people's needs. Each unit was bright and welcoming. The activity coordinator had involved people in painting designs on the walls and making it more personalised to them. People's bedrooms were nicely decorated, personalised and reflective of individual's personalities and interests. Cleaning schedules were in place which showed communal areas of the home were routinely cleaned and equipment was cleaned and safe to use. At the previous inspection in June 2015 the home had a person who had an infection. Staff were not aware of that or their responsibilities in preventing cross infection. At this inspection no one at the service had an infection. Staff were clear who the infection control lead was. They were trained in infection control and were aware of their responsibilities for managing infections.

A relative commented "The changes to the kitchen and dining area will be very beneficial and will enable the residents of our relative's flat to all sit down to meals together along with their support workers. This will be a vast improvement". They also told us that in their view the entrance to the house is not welcoming and is an area which they consider needs improvement. This feedback was given to the provider to consider following consultation with people who use the service and relatives what improvements can be made.

It is recommended the provider ensures the required staffing levels are consistently maintained on each unit.

It is recommended the provider improves its recruitment practices to ensure safe recruitment processes are followed.

It is recommended the provider reviews their medicine policy to ensure guidance is provided to staff in all

areas of medicine management and that medicine records accurately reflect people's allergies to medicines.

Is the service effective?

Our findings

Relatives told us permanent staff had the skills. They felt agency and bank staff did not always have the required skills. One relative commented "There are new staff, they need more experience and training". Another relative told us "Staff did a great job". A third relative commented "Currently stable staff team who are able to understand and meet our family member's needs". A fourth relative told us the team leaders appeared more skilled and trained but felt some staff required more in depth training in learning disabilities and communication.

New staff told us they felt suitably trained and skilled to meet people's needs. They told us they had completed an induction which included induction training and they worked in a supernumerary capacity alongside experienced staff. We saw on the rota that new staff were given two weeks supernumerary shifts and were not included on the rota. Staff told us being supernumerary gave them the opportunity to get to know the people they would be supporting. New staff told us they worked through an induction booklet which was signed off by their team leader/supervisor.

People's needs were met by staff who had access to the training they needed. Staff told us they had the training they required to meet people's needs. Staff had received training the provider considered mandatory. This included Mental Capacity Act 2005, Deprivation of Liberty Safeguards, safeguarding of vulnerable adults, fire safety, food handling, moving and handling, epilepsy awareness, medication and safe administration of buccal medicine, health and safety, infection control, eating and swallowing, positive approaches and support planning.

At the inspection in June 2015 we saw on one unit a low percentage of staff had the required training. At this inspection we saw 100 percent of staff had some of the required training in all units and across the units the percentage of staff with the required training had improved. Systems were in place to highlight when updates in training were due. Staff were then booked on the next available training course.

Staff were trained in training specific to their roles such as supervision and appraisal training. Shift leaders were trained and assessed prior to being confirmed in role. Staff were assessed, trained and deemed competent in medicine management and administration. Staff had access to specialist training such as autism, non-abusive physical, psychological intervention, communication, active living and diplomas in health and social care. All staff told us they were clear of their roles and responsibilities. They felt suitably trained for their role and for specific responsibilities. A senior member of staff told us that training was "some classroom, some online" and that staff were up to date in training such as infection control and moving and handling training. Team leaders told us they felt they were given more time to carry out their role.

People were supported by staff who had supervisions (one to one meetings) with the deputy manager/ team leaders. All four team leaders were suitably trained to carry out supervisions and appraisals. Shift leaders had also received this training to enable them to supervise bank staff. Staff told us supervisions were carried out every other month. It enabled them to discuss any concerns they had. Staff told us they could approach

the deputy manager or team leaders in between supervisions if they had any issues that needed to be addressed urgently. We looked at a sample of supervision records. We saw staff were provided with supervisions. There were some gaps in supervisions which were not line with the provider's policy on supervision. The provider had identified that and was addressing it with supervisors in their one to one meetings. New staff had six monthly reviews of their performance and existing staff had annual appraisals. We saw 25 out of 31 staff had an annual appraisal. The remaining six were booked to take place during March 2016.

A health professional involved with the home told us "Some of the staff have been around for years and show lots of leadership. They keep morale up for residents and themselves. I think staff are well supported from others on site and the organisation in general".

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. People's care plans outlined whether they had capacity or not. We saw best interest meetings took place where someone lacked capacity to make a specific decision on their care. Staff were trained in the Mental Capacity Act 2005 (MCA). We observed staff members sought consent and explained care to people. Staff we spoke with showed an understanding of consent and of the decision specific and fluctuating aspects of capacity. A staff member told us that capacity "varies day to day". Another staff member told us it was important "to guide, to help (people) make decisions".

We observed a notice about an advocacy organisation called 'PohWer' who could provide independent mental capacity advocates (IMCAs). This demonstrated that the provider was aware of the importance of representation, especially when there were no family members involved in the person's care.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS aim is to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. It ensures the service only deprive someone of their liberty in a safe and correct way and this is only done when it is in the best interest of the person and there is no other way to look after them. The service had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body. We saw some of those applications had been approved. Staff had been trained in DoLS. They had a good understanding of what it meant and how it related to the people they supported. However they did not know who had a DoLS approval in place and people's care plans did not reflect that either.

People had access to other health professionals such as the GP, dentist, optician and podiatrist. Records were maintained of health appointments and the outcome. The consultant and psychologists visited the home and people had access to therapists on site such as occupational therapists, physiotherapists and speech and language therapists. Guidance from professionals were included in care plans. Staff had a good knowledge of how people liked to be supported and worked in line with the guidance available to them. We saw a person who used a protective helmet to enhance their safety was wearing this. It was important that the helmet was worn when the person was walking in the flat or outside.

Staff we spoke with gave an example of a person whose behaviour had been "really challenging" but now "enjoys going out, enjoys doing stuff and showers every day". The person's "parents said he's completely different. I've seen a big improvement." Another staff member told us that another person "didn't speak" initially when they came to the service but their family was "so pleased in how (the person) had come on" subsequently. We observed that this person was relaxed when they came into the living room, sat down and spoke with staff.

Relatives told us they were informed if their relative had an accident, was unwell and required hospital admission or treatment. One relative told us they felt reassured that each home had a defibrillator to manage medical emergencies. One relative commented "Permanent staff are quite good at informing, new or temporary staff not so good. We consider being informed promptly of great importance".

A health professional involved with the home told us "Staff at Russell house are very clued into people's needs and always only involve me when required. They advocate well for people and are aware of background context of relevance".

Another health professional confirmed appropriate referrals were made. They told us their staff observed care staff implementing professional recommendations and there was excellent communication between one unit and a member of their team.

Systems were in place to promote good communication within the staff team. Staff told us communication within the home was effective. They felt they worked well as a team and supported each other well. Handover, team meetings and clinical review meetings took place and staff were encouraged to contribute to those. The clinical review meetings highlighted changes in people's health and well-being. Action was taken in response to those changes. There was a designated person in charge on each unit and on each shift. Shift planners were in place which outlined staff member's responsibilities for the shift and to ensure tasks were completed. Some relatives told us the communication between them and staff were good. Others felt there was still room for improvement. They told us key information on people was not always handed over which they felt could have implications for people. This feedback was given to the provider to address.

At the previous inspection in June 2015 people's nutritional needs were not met. People were not weighed as required and their food and fluid intake was not monitored. At this inspection people's care plans outlined the support they required with nutrition. It outlined if people were at risk of malnutrition and what measures were in place to manage those risks. People who required it had their food and fluid monitored. Records were maintained of foods and fluids taken. We saw these were totalled and audited daily. People who required it were weighed monthly. The weights were audited and weight losses and gains were highlighted.

Some people had special nutritional requirements. For example, a person had a food supplement 'ensure plus' (200mls three times daily) to enhance their nutritional intake. We saw two people had drinks thickened with 'resource clear' to syrup consistency. A person's care plan stated that their drinks 'must always be thickened using resource clear to syrup consistency'. A staff member we spoke with was aware of the drinks consistency the person needed and how much thickener should be added to achieve this.

Staff were responsible for the meal preparation and cooking. People could choose what they wanted for breakfast. The main meal was provided at lunch and sandwiches/ soup or jacket potato was provided in the evening. People had a choice of what was on the menu or an alternative. We observed meals being served and people being supported with their meals. Staff engaged positively with people whilst supporting and encouraging them to eat their meals. Equipment was provided to promote people's independence. People had access to hot and cold drinks throughout the day and fruit and snacks were available, eaten and enjoyed by people.

A relative told us drinks and food intake appears to be better monitored now. They commented "Indeed we are now asked for details of any drink and food which our relative has whilst out with us on site."

Is the service caring?

Our findings

People told us they were happy with the care they received. They appeared happy and contented. We saw a person return from a shopping trip with a staff member. The person looked happy and was listening to music on their headphones.

Relatives told us they were happy with the care provided. They described the care as good and all staff as very caring. One relative commented "From my observations staff take the time to understand what my family member is saying, their needs and my family member's responses to the staff all indicate good care". They commented "We also see staff responding kindly to other resident's needs". Another relative told us staff were caring. They provided us with two examples of when their relative was ill and staff persisted on getting them the medical care they needed. They described the staff as showing genuine concern for their relative and were a credit to the unit they worked in. They told us the care the keyworker provided to their relative was inspiring and caring. They kept in touch with them during their relative's hospital admission and visited their relative in their own time whilst they were in hospital. A third relative commented "Staff are very caring. They do the best they can, they need more support, they also need to be valued more by senior management". A third relative told us "The permanent staff are very caring and connect with people, the bank and agency staff do not seem be as caring". A fourth relative commented "Some staff are caring and want to see the residents happy. Other staff are detached from the residents, unmotivated to get involved in activities, others are too controlling and disrespectful to the residents. I have heard staff raising their voices to residents and treating them like naughty children". This feedback was given to the provider to address.

A staff member told us "I love the work. I love the people." Another staff member told us staff were "Very kind, caring and work as a team". Staff told us they help each other and ask each other if they are not sure about something. A third staff told us "Everyone I've met has the resident at the forefront."

A health professional involved with the home told us "Staff are loyal, kind and supportive. They have a wealth of experience. Obviously mistakes get made, arguments and debates happen, but on the whole for the task in hand supporting complex vulnerable people to live life the best they can, I think they put in a great effort to make it happen".

Another health professional told us staff were caring. They told us a member of their team observed a caring attitude from staff and saw they carried out specific interventions in line with the person's care plan.

We saw staff were kind and considerate in their approach to people. They understood people's needs and knew them well. We observed examples of positive interactions between staff and people who used the service. For example, we saw a person was doing a jigsaw puzzle while a carer sat with them having a conversation. We saw staff sat next to people whilst supporting them with their meal. They maintained good eye contact with them, appropriate touch and offered them lots of encouragement to eat or encouraged them to be independent and feed themselves.

People's care was not rushed. Staff were gentle, patient and allowed people the time they needed to

complete tasks such as eating and drinking.

In one unit we noted lunchtime was disorganised. The afternoon staff had come on duty and they got involved in assisting with the lunch. As a result different staff were supporting individuals with their meal at that time. At the same time a staff member was washing the dishes, saucepans and making lots of noise in the background which was not conducive to people trying to eat their meal. A relative raised a similar concern with us that their relative was extremely sensitive to noise yet staff seem oblivious to it and talk loudly, shout outside their bedrooms and clatter around the kitchen. This feedback was given to the provider to address with staff to ensure people were able to eat their meal in a relaxed environment.

Staff sought to engage with people and responded effectively to their communication. People's care plan outlined how they communicated and most staff promoted this. Staff engaged with people by listening and talking, and by using non-verbal communication and prompts. We saw staff encourage people with non-verbal communication to make choices and decisions in relation to drinks, food and activities. Support staff on all units had a good rapport with people. They were aware of people's needs and were sensitive to changes of mood or behaviour. For example, we saw that staff respected a person's choice to spend time alone in their room after lunch.

During our inspection, we saw staff supported people's privacy and dignity. Staff we spoke with told us they would explain care to be given and seek the person's consent. We observed they did this. People had en-suite bathrooms, with toilet, washbasin and shower. These facilities helped support their privacy and dignity.

People's visitors were made welcome and were free to visit any time of the day or night. One relative commented "We do not tend to look at it in terms of whether we are able to visit at any time. Russell House and {named flat} in particular are our relative's home where they live with their friends and the staff who support them in their home life. They have their own activities which they enjoy. We see our relative every week and fit around those activities. We normally take them to the coffee shop where they can see other residents and tenants who live on site, the coffee shop staff etc and of course in better weather are able to go locally off site with them".

Is the service responsive?

Our findings

At the previous comprehensive inspection in June 2015 updated information was not provided for respite admissions. Respite admissions are where people are admitted to the home for a short period of time to give their relative a break. At the time of this inspection the home had one respite admission. We saw the family had been contacted prior to admission and it was established if the person's needs had changed.

At the previous comprehensive inspection in June 2015 care plans lacked details, were not kept up to date and showed no evidence of peoples' or relatives involvement in them. At this inspection we saw improvements had been made. Care plans were personalised and detailed daily routines specific to each person. They outlined people's likes, dislikes and people important to them. They contained a pre-admission assessment and followed the 'activities of daily living' model. Care objectives included sections on e.g. eating and drinking, toileting, communication, maintaining a safe environment, and mobility. They provided clear guidance for staff on how people liked to be supported with all aspects of their care. People's needs were reviewed regularly and as required. Where necessary health and social care professionals were involved. Care plans indicated if people were involved in them and if they were able to sign them. A note was made where the person was unable to sign.

People had annual reviews of their care. Relatives told us they contributed to people's care plans and were invited to their reviews. One relative told us they were not invited to their relative's annual review and wished to be. Another relative told us historically reviews did not happen and they had to chase and follow them up. They told us there had been a recent review and felt confident these would be maintained.

People had a named keyworker. A key worker is a named member of staff that was responsible for ensuring people's care needs were met. This included supporting them with activities and would spend time with them. Some people were able to tell us or indicate to us who their keyworker was. Relatives were aware who their family member's keyworker was. One relative described the keyworker as key to maintaining links with them and keeping them informed. Another relative told us they received weekly activity updates by e-mail from their family member's keyworker. A third relative told us they were working on improving communication with their relative's key worker to enable them to get the best outcome for their relative. A fourth relative was very complimentary of their relative's keyworker. They commented "The staff member had a brilliant relationship with their relative and went the extra mile to improve their relative's quality of life".

People's care plans included protocols on the management of seizures. We saw these were dated and signed by the consultant involved in the person's care. Monitoring charts were in place to record seizure type, duration of seizures and if protocol medication was required. This enabled them to monitor increases or change in seizure activity. During the inspection we saw people had seizures and staff responded promptly, appropriately and in line with individuals protocols.

People's care plans outlined challenging behaviours they presented with and how staff were to de-escalate and manage those. Some staff were trained in managing behaviours that challenged and other staff were

scheduled to go on that training to ensure there was always sufficient suitably trained staff on duty. Records were maintained of incidences of challenging behaviour. They outlined the trigger, the behaviour and intervention and indicated if protocol medication was required. This enabled them to monitor changes in people and respond appropriately.

People were supported to make choices and decisions on their care. Care plans outlined how people communicated their needs and contributed to making choices and decisions. Some staff were very motivated and proactive in using aids, prompts and objects of reference to promote people's involvement in choices and decisions. Other staff were not and tended to speak to people as opposed to using the tools available to promote people's engagement.

A health professional involved with the home told us staff seek appropriate support from the therapy department in response to people's needs. They commented "The staff at Russell House react to issues by involving therapy services". They said there has been a good take up of therapy services over recent months in reaction to people's needs such as request for occupational therapy, physiotherapy and speech and language therapy. They felt an area for improvement would be to see a more pro-active approach to picking up changes in behaviour, investigating causes and instigating relevant referrals to Therapy for this topic. They had discussed this directly with the provider for them to act on.

People's independence was promoted. Care plans outlined the support people required to maintain their independence. Risk assessments were in place to manage risks associated with people doing things for themselves. People were provided with aids and equipment to promote their safety and independence. Relatives felt people had the required equipment.

Relatives told us people had access to activities. One relative commented "Staff do try to encourage our family member to go out and seem to be remarkably successful generally but in the end it is how our family member is feeling on the day". Another relative commented "Staff support our relative in going out into the local community and further afield, including returning to places they know from the past". Some relatives told us access to community based activities could be better. One relative commented "The activities team is wonderful and make a difference, but very little links exist with the local community". Another relative told us there was not enough opportunity for their relative to go out. All of the relatives were positive about the activities coordinator and the positive difference they had made in improving the activities available to people. Relatives described the activity coordinator as "Super, creative, wonderful, motivated and get things going".

People had an individual programme of activities. The home had a named activity coordinator. They had developed the activity programme and were responsible for facilitating activities. During the two days of the inspection we saw a range of activities were provided such as an exercise group, baking and a film club. The activity co-ordinator was committed, highly motivated and enthusiastic. They had a good relationship and understanding of the people they supported and had the skills and ability to motivate people to take part in activities. People had access to activities out of the home such as swimming, bowling and horse riding. One staff member had supported a person to attend football matches and they were keen to further develop the person's community involvement.

A relative told us there is an issue with a shortage of drivers to take residents out on trips to access the community. Their family member is funded for staff support to access the community on a daily basis. They told us that for six out of 15 days this month, there had not been a driver available to allow their relative to have the community access by car that they felt they needed. They confirmed they had raised this as an issue with the provider and are awaiting a response.

The home had a lack of drivers and it was mainly senior staff who were assessed and deemed competent to drive. Staff told us the lack of drivers made access to community based activities difficult. Some staff felt there was no benefit to them in taking the driving test as any accident impacted on their own insurance. This would be the case for any individual as you have to disclose all accidents to insurers. The provider told us they were reviewing the transport arrangements for the organisation as a whole with a view to having people employed specifically to provide transport.

People told us they would talk to staff if they had any concerns or worries. The relatives we spoke with told us they were aware of the complaints procedure and would speak to the deputy manager, team leaders or person in charge if they had any complaints or concerns. They also felt they were able to raise general concerns about Russell house at the relative meetings.

The home had a complaints procedure in place. This was available in a pictorial format and was displayed on notice boards throughout the home and made accessible to people. We looked at the complaints log. Complaints were logged, investigated and responded to. Systems were in place to audit complaints which meant trends in complaints were picked up and complaints were managed in line with their policy. Relatives told us they knew how to make a complaint. One relative told us they felt comfortable approaching the management to raise concerns and complaints and felt complaints were dealt with to their satisfaction. Another relative commented "Any issues have been more concerns than complaints and have been satisfactorily resolved".

Is the service well-led?

Our findings

The deputy manager and manager overseeing the service were aware of their registration responsibilities. They are required to notify CQC of significant events such as accident/ incidents concerning people who use the service. They had notified CQC about significant events. However we saw DoLS applications that had been approved had not been notified to us. We were told this was because there was a delay in the local authority informing the home. However at the time of the inspection those notifications had not been completed.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4). This was because the provider failed to notify the Commission that the request to the supervisory body for a standard authorisation had been approved.

At the comprehensive inspection in June 2015 it was pointed out to the provider that the service was registered for regulated activities that it no longer provided. The provider was aware they need to remove those regulated activities from their registration but are unable to do this until the previous registered manager is deregistered.

People referred to the deputy manager as the manager of the service. They told us they were "Friendly and helpful". We saw the deputy manager had a good relationship with the people using the service.

One relative commented "The current management team in Russell House are very approachable if we have a problem". Another relative told us the service did not yet have a registered manager to lead the service but knew one was appointed. They commented "However I do feel that all the staff in Russell house have coped really well over what has been a very difficult period for them all". A third relative described the deputy manager as "Accessible, approachable and had really stepped up to the mark". They felt they were a positive role model who was valued by the staff team.

A fourth relative told us the approachability of the management team is clearly far more closely monitored and addressed than before and gives much more reassurance. They commented "We have no difficulty in approaching and addressing any relevant issues with the deputy manager. Most day to day issues we raise with the flat team leader or appropriate support staff who are always willing to discuss and address matters. The house needs a permanent on site registered manager and the lack of one has inevitably had an impact on the running of the house since last June. However enormous efforts have clearly been made by everyone to improve the things that were wrong and, speaking in relation to our relative's flat with which we are very familiar, we are fortunate that the staff and team leader are very conscientious, caring and supportive and willing to engage with us".

A fifth relative commented "It is hard to know who is management and if they have been at the house long enough to have answers to questions. Right now the junior level staff can provide the best answers". They told us "Staff are terrified in case they get things wrong, they are traumatised, fear for their jobs, feel undervalued and scared". During the inspection we spoke to a number of staff who did not express those views to

us. This feedback was given to the provider to explore further with staff.

Staff expressed dissatisfaction with the lack of consistency in management since the previous inspection. The home had two interim managers during that time. They told us how they were given mixed messages in how to do things which lead to confusion and frustration. They also told us the deputy manager had been managing the service since November 2015 with support from another registered manager on site. They felt this had helped provide some stability as the deputy manager knew the service, people being supported and staff really well. They told us the deputy manager was accessible, available, approachable and knowledgeable. They felt able to ask them for assistance, support and advice when required. A staff member commented "The deputy manager was approachable and "always helps you". They thought the service was well-led "in the last few months". Another staff member told us that they felt well supported but "To have a service manager floating between two houses is difficult."

The management promoted an "Open door policy" and this was reinforced to staff in their one to one meetings and team meetings. Throughout the two days of the inspection we saw the office door was kept open and the deputy manager regularly visited the units and provided assistance where this was required. A relative told us they had seen a slow but noticeable change in the culture of how the home operates. They commented "Before, it seemed to us to operate on the basis that management said what would happen and the staff were there to do that. Slowly but gradually there seems to us to have been a change where both higher management and house staff seem to recognise that they are all part of the process and they all need to contribute to getting it right. Importantly there seems to have been an acceptance that higher management needs to be more visible. In this way staff begin to feel that they have a voice in the process and that their value is more recognised. In parallel with this there has also been an improvement and greater recognition of the importance of communication between management and families and trustees and families which has facilitated more open discussion of important issues. Hopefully this will result in a more communicative way of working across the site".

A health professional involved with the home told us they have confidence in two particular team leaders, as they demonstrates an ability to follow-through with advice and take initiative, using a methodical approach in problem solving.

The service did not have a registered manager. We were told a manager had been appointed subject to the required recruitment checks and they would start the process of applying to be registered with the Commission. A second deputy manager had also been appointed. This meant a deputy manager would be available to provide day to day management support on both floors. Staff were looking forward to a new manager starting and to consistent management being provided.

Since the inspection in June 2015 the nominated individual had put a recovery plan in place to improve the service. This was regularly reviewed, updated and actions outstanding transferred on to the homes development plan. Auditing and monitoring of the service had improved. The deputy manager/ person in charge carried out a daily check on each unit to establish staffing levels and ensured they were suitably staffed. They checked on people's welfare and provided hands on support when required. Weekly managers audits were also completed and helped identify issues in a timely manner.

Internal audits took place. These included audits of medicines, care plans, catering, accidents, incidents, health and safety, infection control, training and supervisions of staff. We looked at a sample of those and saw action was taken to address shortfalls identified in the audits.

The provider also monitored the quality of care at the service. Senior managers audited the service monthly

over a number of days. Comprehensive reports of their findings were available which highlighted what the home did well and what areas needed improvement. They also gave the service a rating in line with the ratings used by the Commission. Actions from all of the audits were added to the homes development plan and signed off by the deputy manager and line manager when completed. The home development plan was kept under review and monitored by the nominated individual.

Annual surveys were completed. The last relative survey was completed in June 2015. An action plan was in place to address issues highlighted in the surveys.

People were given the opportunity to comment on the care and service provided. They were supported to be involved in residents meetings and pictorial minutes were provided to make them more accessible to people with limited communication. Relative meetings took place bi-monthly. Minutes were provided which were sent to all relatives including those who were unable to attend the meetings. Relatives confirmed this was the case. One relative commented "Regular meetings for parents and relatives of the residents of Russell house take place. A suggestion box is provided and there is easy availability to discuss any issues with staff via e-mail, telephone or face to face contact". The relative felt generally their views and suggestions were listened to and acted on. Another relative told us they were given the opportunity to feedback on the quality of the service through the relatives' annual survey. They commented "There are also quarterly Russell House family meetings and occasional Trustees/Families meetings which give similar opportunities. Our views and suggestions and those of others are welcome and respected and have in quite a few instances been accepted and/or resulted in changes in processes". A third relative indicated they were given the opportunity to feedback on the quality of care sometimes and felt their views were listened to and acted on sometimes also.

At the previous comprehensive inspection records required for regulation were not up to date and suitably maintained. At this inspection we saw care plans were person centred, up to date and reviewed, risk assessments were in place to manage risks and daily monitoring charts were well completed. Record keeping training was scheduled to further improve staff practice.

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 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify the Commission that Deprivation of Liberty Safeguards had been approved. |