Central and Cecil Housing Trust

Rathmore House

Inspection report

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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 carried out an unannounced inspection on the 4 February 2016. At our last inspection 23 April 2015, we found that improvements were required in relation to risk assessments that were not person centred and not reviewed regularly. A general risk assessment of the building had not been carried out since 2013. Care plans and risk assessments were not being checked and audited to ensure a high quality service was being provided.

At this inspection we saw improvements had been made. Risk assessments and care plans were person centred and reviewed regularly and care plans and risk assessments were being regularly audited by senior staff and managers. Risk assessment relating to the building had been undertaken in 2015.

Rathmore House is residential care home for up to 20 people over 65 years of age. Some people or their relatives paid for the care, whilst others had their care commissioned by local authorities. The home is situated in a residential area near Chalk Farm in Camden, North London. The provider, Central and Cecil Housing Trust, runs seven other homes throughout London and the southeast. On the day of our inspection 16 people were using the service.

Steps had now been taken to de-register the current registered manager as they had resigned from post. A new manager had been appointed and was due to start in mid-February 2016. We were assured that the new manager would apply for registration soon after they start.

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.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf for people who may lack the mental capacity to do so for themselves. 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 procedure is for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We could not be sure that managers and staff fully understood their responsibilities for gaining consent to care and treatment and for legally depriving a person of their liberty if they lacked capacity. This meant they did not act in accordance with the MCA and the DoLS application procedure.

There were systems in place to safeguard people and staff had a good understanding of the different types of abuse and how they would look out for signs.
Risk assessments formed part of the person's agreed care plan and covered risks that staff needed to be

aware of to keep people safe.

People had a Personal Emergency Evacuation Plan on their record (PEEP). Their PEEP identified the level of support they needed to evacuate the building safely in the event of an emergency.

Recruitment practices ensured staff were appropriately checked prior to employment to ensure they were suitable to work with the people using the service.

Medicines were stored, administered and recorded appropriately by staff who had undertaken relevant training.

Staff received training and support to help them carry out their work role and demonstrated good knowledge on the subjects they were asked about.

People were supported to eat drink and maintain a balanced diet and they were supported appropriately during meal times.

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. Staff knew how to report concerns or allegations of abuse to ensure appropriate procedures were used to keep people safe.

Individual risk assessments were prepared for people and measures put in place to minimise the risks of harm.

There were sufficient numbers of staff available to meet people's needs.

There were suitable arrangements for the safe recording, storing and administering of medicines, in line with the provider's medicines policy.

Is the service effective?

Requires Improvement

The service was not always effective. Managers and staff did not fully understand their responsibilities for gaining people's consent to care and treatment and for legally depriving a person of their liberty if they lacked capacity.

People had access to a visiting GP and were assisted to receive on-going healthcare support.

People were supported safely at meal times and were able to indicate their preferences regarding food and drink to maintain a balanced diet.

Is the service caring?

Good

The service was caring. Staff understood people's individual needs and supported people in a dignified way.

Staff ensured they used information from assessments as well as talking to people about lifestyles, beliefs and history to ensure equality and diversity was upheld.

Is the service responsive?

Good

The service was responsive. People received personalised care that met their needs.

People had a 'Hospital Passports' that contained detailed information about them, including likes and dislikes, their means of communication and all medical history.

People's voices were heard through a number of ways including meetings between staff and people using the service. Feedback was considered and acted upon.

Information regarding how to make complaints was available to people using the service and their relatives.

Is the service well-led?

Good

The service was well-led. The service promoted an open and honest culture and was well run.

People and their relatives were consulted and encouraged to be involved in the service development via regular resident and relative meetings.

There were effective audits and checks to assure a high quality service and identify any potential improvements to the service being provided.

Rathmore 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 4 February 2016 and was unannounced. The inspection team included two inspectors.

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 the information we held about the service including people's feedback and notifications of significant events affecting the service.

During the inspection we spoke with three people who used the service one friend and two relatives. We spoke with six members of staff including the area manager and deputy manager. We also spoke with a visiting professional and a volunteer. We also gained feedback from local commissioners.

We reviewed four care records, five staff records as well as policies and procedures relating to the service. We observed interactions between staff and people using the service as we wanted to see if the way that staff communicated and supported people had a positive effect on their well-being.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person said, "I'm very happy here and feel safe, staff know what I need and do what they can for me."

Staff had received training in safeguarding people. They were able to describe the process for identifying and reporting concerns and were able to give example of the types of abuse that may occur. One care worker said, "I would not tolerate anyone physically hurting or verbally abusing our service users" they also said "no matter how challenging a person can be, we must always ensure they do not hurt themselves at that time." Another said, when asked about whistleblowing, "If I was worried about something I would go higher and higher until something was done and if need be report it to the Care Quality Commission." They explained that if they saw something of concern they would report it to the deputy manager, as well as recording what they saw and, if relevant, complete a body map. Staff understood how to whistle blow and one told us, "I am confident about how to do this, we have had recent training on it."

There were up to date policies and procedures in place for safeguarding adults and managers understood their responsibilities for reporting safeguarding concerns. There were good links with the local authority safeguarding team and managers were also clear that the local authority were the lead agency for coordinating safeguarding investigations and that they should also report concerns to the Care Quality Commission.

There were comprehensive risk assessments on each of the care records we looked at. These assessments were specific to the individual. For example, where a person put themselves at risk by going into another's bedroom, there was guidance for staff about how to support the person in the least restrictive way. We also saw there were falls risk assessments where a person was in danger of falling when they refused to use their walking aid. Risk assessments were reviewed monthly, or when there had been a change in a person's condition, in line with the policies and procedures at the service. Each person had a Personal Emergency Evacuation Plan, which were held in a folder in the office for easy access.

We saw there were adequate numbers of staff on duty on the day of our inspection. One care worker told us "At the moment we have five residents who need the assistance of two carers; I think this should be reflected in the current staffing levels." Another staff member told us that the deputy manager was always willing to assist with care tasks when staff were finding the workload difficult. We discussed the impact this had on people and staff with staff members and were told, "I really do not think the residents suffer, because staff work very hard to make sure they remain safe; however, this sometimes puts staff under pressure to get everything done." The deputy manager told us that there were some vacancies that were in the process being recruited to and that staffing levels were constantly reviewed as well as consideration given to people's dependency levels.

Medicines were administered safely. We observed a member of staff whilst they administered medicines to people. This process was carried out safely and carefully. Before starting the medicine round, the care worker went through each person's Medicine Administration Records (MAR), "Because the GP came recently

and there are likely to be changes in people's prescriptions." Each person using the service had a MAR which was up to date, accurate and there were no gaps evident.

Staff we spoke with could describe how to administer medicines safely and understood what it was for. We saw from training records that those senior care workers who administered medicines had done the appropriate training. We also saw that each staff member had an up to date 'Medication Administration Competency Assessment'.

The majority of medicines were administered to people using a monitored dosage system supplied by a local pharmacist. We checked the balances of loose medicines stored in the cabinets against the MAR for four people and found these records were up to date and accurate, indicating people were receiving their medicines as prescribed by health care professionals. Other medicines, such as creams, were kept in a locked fridge at the recommended temperature, which was recorded daily, as was the temperature of the medicine room.

There were safe systems for storing, administering and monitoring controlled drugs, which were stored securely in a locked cabinet. We saw a controlled drugs record book. This had been signed by two members of staff each time a controlled medicine had been administered to people using the service. They also signed the MAR chart. We saw how the balance of stock of the controlled drug was recorded after each dose and this correlated with what remained of the drug in the cabinet. In most cases, people received their controlled drug in accordance with their prescription. However, on one occasion, a weekly prescribed drug was administered two days late, with no explanation given for this omission. We drew this to the attention of the deputy manager, who confirmed that he would explore this further. We looked at the drugs return book and saw this was completed accurately and those drugs for return were stored appropriately until collected by the pharmacy. There was a medicine policy and procedures that was due to be reviewed in July 2018.

A local pharmacy which supplied the medicines for the home carried out a recent audit. There were no major issues identified and the deputy manager told us all recommendations would be initiated as soon as possible.

Appropriate practices were in place to ensure safe recruitment. We saw a confirmation that all staff had recently had renewed Disclosure and Barring Service certificates (DBS) and also two references and identity checks had had been taken up before staff started working at the service.

The home was clean and we saw it being cleaned throughout the day. Infection control measures were in place and we saw staff using gloves and protective clothing appropriately.

Requires Improvement

Is the service effective?

Our findings

People and their relatives we spoke with told us they felt staff had the skills and knowledge to enable them to support them or their relative effectively. One person said, "Staff are excellent and care for people well."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf for 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 lacked 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 procedure is for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

However on the day of the inspection we saw that one person was clearly asking to go out of the home and when we asked staff why they could not be allowed to leave they told us they were not safe to go out unaccompanied. The care records for this person confirmed there had been an incident where a staff member had taken the person out but they refused to come back to the home and during this incident the person had a fall and was taken to hospital. There was no injury sustained. The person had also been seen by the GP recently and it was recorded that they had capacity but this was not decision specific. After discussions with the deputy manager, they decided to request an urgent authorisation under the DoLS application procedures to ensure they were not unlawfully depriving this person of their liberty.

Staff we spoke with were familiar with the Mental Capacity Act 2005 and the need to obtain consent from those who used the service. However, we saw there was conflicting information on some of the records we looked at. For example, on one person's record, all their consent forms were signed by a person noted as having responsibility through the Court of Protection. We subsequently saw evidence to confirm this was for financial matters only. This meant that the person was not entitled to sign consent forms relating to, for example, care and treatment, as they had done. We also saw on this same record where a care worker had recorded 'I am able to give my consent' on behalf of the person. There was no specification as to what the person was deemed able to consent to, particularly in the light of all consent forms being signed by the financial deputy.

There were 'Do Not Resuscitate' (DNR) forms on file. These were signed by the GP but there was no evidence of any discussion having taken place with the person or their representative, as required.

We could not be sure that managers and staff fully understood their responsibilities for gaining consent to care and treatment and for legally depriving a person of their liberty if they lacked capacity. This meant they did not act in accordance with the MCA 2005 and the application procedure for DoLS.

The above was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Although we saw there were people that had been assessed in line with Deprivation of Liberty Safeguards and authorisations were recorded on care records, the Care Quality Commission had not received notifications about the DoLS request that had been granted as they should. The deputy manager agreed to send the notifications to us immediately and before the end of the inspection day.

We recommend that robust systems are put in place immediately, to inform the Care Quality Commission of all DoLS requests that had been granted in line with the registration regulation 18, notification of other incidents.

All staff were required to complete an induction programme, which for staff who were recruited some time ago, was in line with the Common Induction Standards (CIS) published by Skills for Care. We saw from the training matrix that newly recruited staff were in the process of completing the recently introduced Care Certificate Standards (CCS).

The training matrix evidenced that staff were up to date on their mandatory training, including Safeguarding of Vulnerable Adults, Mental Capacity Act 2005, Manual Handling, Food Hygiene and Nutrition, Pressure area care and Introduction to dementia. It also included Effective Communications, Infection Control, Emergency First Aid and Medication Awareness. In addition, the deputy manager had completed an Introduction to Dementia Training, in order to "become a dementia champion and help staff to develop their skills in working with people living with dementia." A care worker told us, "Training is very effective; it really helps to develop my knowledge and apply it to my work."

We saw that staff should receive supervision six times per year according to the provider's supervision policy. However, we saw this did not happen for all staff, some of whom only had three supervisions in the year, and in the case of the deputy manager, just one. He told us he had discussed this situation with the Human Resources department, but the situation had not improved. The newly appointed area manager assured us that this situation would be addressed with immediate effect. We did however see there had been regular team meetings and staff told us they were a helpful forum to raise issues regarding people they supported as well as general concerns about the home. We also saw people had an annual appraisal. One care worker told us she found the experience to be, "uplifting and good for my professional development." Another said, I can always talk to the deputy manager if I needed help with anything, he is approachable and supportive."

Care workers filled in fluid and nutrition charts where this was needed to monitor people's intake of food and drink. However, we noted how intake was recorded in different ways for the same person. For example, on one chart, intake was written as a mixture of cup, glass and millilitres. There were no measurements given for a cup or glass, although the person's total intake for the day was totalled given in millilitres. This was raised with the deputy manager who confirmed he would ensure staff were recording consistently.

We observed lunchtime and saw how people were supported to decide what they wanted to eat and drink. For example, a care worker offered each person a choice of drinks from a tray of jugs they were carrying around. These made it easier for a person to point and choose by the colour of the drink. People's choice of food was also discussed with them and the care workers explained to individuals what was on the menu. A care worker told us how people had chosen their meal the evening before, when they were also shown a pictorial representation of the dish. When staff assisted people to eat, they positioned themselves in an appropriate way so that the person was able to eat safely and comfortably. There was good interaction, with the care worker explaining what the food was, and taking their time in between spoonful's to allow the person time to swallow. Some people changed their mind about their choice of meal and an alternative was

immediately offered to them.

The chef went around the dining room after lunch with a 'catering comments' book. Some people were able to write their comments about the lunch and for those who were not able to do so, the chef encouraged them to verbalise their views, it was apparent that they had a good relationship with the people and actively sought their views on the food provided. We later spoke with the chef and they demonstrated a good knowledge of people's dietary needs and how to accommodate them. We were told that the menu changed three times per year. Prior to the introduction of a new menu, a meeting was held with those who used the service and their relatives, "To hear what they would like on the next menu."

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. One person said, "Staff are fine, they make up for the lack of conversation I have with others." Relatives we spoke with told us, "It's like a palace here and the staff team are lovely."

Throughout the day of our inspection, we saw how staff interacted with those who used the service in a kind and respectful way. They took time to engage with people and responded to any questions asked. A visitor told us "The staff are very kind to the residents and hospitable to the visitors" and "they never give up on my friend, no matter how difficult they are." There was a relaxed atmosphere around the home and we noticed how gentle staff were when redirecting a person to where they needed to be. A visiting professional told us "I love coming here. Staff are really caring and cheerful."

Staff gave us examples of how they respected people's dignity by making sure they were covered during personal care activities, and all doors and curtains were closed. A care worker explained how they administered certain medicines in a person's room "To maintain their privacy." A visiting professional told us how "Staff always speak appropriately to people, no matter how advanced their dementia may be." Relatives told us they were actively involved in decisions around care and support for their loved ones at the home and staff tried hard to involve people as much as possible.

There was good 'dementia friendly' signage around the building. For example, the activities noticeboard was large and activities for the day were in picture form, as well as written. Bedroom doors were in different colours and there were large signs on the bathrooms. There were memory boxes outside people's rooms that contained pictures and items that were important to each person. The music centre and DVD player were housed in retrospective wooden casing, similar to that of the 1950s.

Equality and diversity was an integral part of people's care plans and staff were aware of how to ensure peoples differences were respected, valued and upheld. They received training on rights risks and choice and were able to tell us how they put what they learnt into practice. One staff member told us, "Some people can't express their needs so we speak with family members and get information to form life histories". Other staff members told us it was important to finds ways of communicating with people as individuals and really listen to ensure they understood people's unique needs in terms of what was important to them, their lifestyles, culture and their beliefs.

Good

Is the service responsive?

Our findings

People and their relatives told us they felt the care and support provided was responsive to people's needs. One person said, "Staff discuss my care plan with me and we agree what is needed to best support me."

We saw that pre-admission assessments informed how a person was supported and formed the basis of the person's care plan. Care plans were detailed; person centred and provided good information for staff to follow. There was evidence on records that relatives were involved in the development of care plans, particularly where the person was living with dementia. The information was easy to locate, as the files were separated into individual sections for ease of access. Records also included a section relating to people's Life Story, though the information in some was limited. Staff told us it was often difficult to gain life histories from people and some didn't have relatives and friends that visited often. A care worker told us how they made sure people were at the centre of their own care, "It is important to remember that they are individuals, and as such, have differing needs, and like different things."

Records contained a daily support plan which included people's unique information, including choices and preferences and how they wished to be supported. Where a person specified the name by which they wished to be called, we heard care workers use this name consistently throughout the day. We were told that the information in the support plan was used by care workers to ensure people were supported in a safe, effective, person centred way. It was especially useful for people with communication difficulties and dementia as it minimised the risk of people receiving inappropriate or non-person centred care. Daytime care workers and night duty care workers wrote a comprehensive update on each person in a daily record folder. This included an account of a person's mood, diet, general well-being and sleep pattern. A care worker told us "Care plans are so important. They describe people's needs and this helps us support them in ways which are best for them."

We saw evidence on care records of multi-disciplinary work with other professionals including GPs, dentists and chiropodists. However, a visiting professional told us, "I think staff could be more proactive about calling the GP when they notice signs of deterioration. This is more a matter of training rather than unwillingness." We discussed this with the deputy manager and area manager who told us training around care plans and identifying risks was ongoing and that they would ensure that matters of accessing the GP were covered. People had a 'Hospital Passport' which went with them if they were admitted to hospital. This contained detailed information about them, including likes and dislikes, their means of communication and all medical history.

Activities for the day were displayed on a large noticeboard in the entrance hall. There was a morning, afternoon and evening activity on each day. However, on the day of our inspection, it was apparent that the afternoon activity had not been pre-planned. An inspector heard care workers query what was on (arts and crafts) and what should be done during this session. There was some confusion about where the activities cupboard key was. The arts and crafts session did however take place on a one to one basis for people who were interested. We also saw care workers painting a person's nails and another read a newspaper to a person. One staff member told us that they had been trying to up the activity programme since they started

and things had improved and another told us that they felt individual activities provided one to one were often better. A visiting professional told us, "I have never seen a lot of activities going on when I come, for example, any group work like reminiscence." We spoke with the deputy manager, who acknowledged that activities, dementia specific activities in particular, needed improvement. He told us he had completed an intensive dementia awareness course, and it was his intention to develop the activities programme with a focus on those who were harder to engage.

A copy of the complaints leaflet was available at the service. Staff were able to tell us how they supported people to make a complaint and would ensure that any issues or concerns were reported to management promptly. The complaint records showed that there had not been a complaint in the past year. There was a log that recorded the nature of the complaint as well as an outcome to be fed back to the complainant. We also saw that any learning from complaints was used to improve the service provided for people. There had been some compliments received from people and their relatives.

Good

Is the service well-led?

Our findings

People and their relatives we spoke with told us they thought the home was well run. One person said, "It's well run and staff do their best." A relative said, "Management are open and honest."

Although there was a clear management structure in place, the service had been without the presence of a registered manager for several months due to sickness and more recently resignation from post. This meant that although there had been an interim manager for a while, the deputy manager had been the only permanent manager at the service for some time. We heard from the area manager that a new manager had been appointed and would start in mid-February, he also confirmed that they would be applying to become the registered manager soon after they start. People and their relatives told us they thought the deputy manager had done a good job in keeping up standards in the home as well as supporting staff do their job.

Staff told us they felt supported and one care worker said, "It has been quite difficult and unsettling recently. We have had many changes of management" and "the deputy has been doing an amazing job. He has held it all together, even though it is a huge amount of work for him." Staff felt confident they were listened to by the deputy manager. One person said, "He pushes us to do our best and is very supportive of our professional development."

Regular meetings took place with people and their relatives and also staff to ensure there were mechanisms in place to feedback on service developments as well encouraging the active involvement of key stakeholders in the decisions made regarding the future of the service. Relatives we spoke with told us they felt the meetings were useful and that they were able to have their say on important issues regarding the service. We heard that one person had been a member of a scrutiny panel for the provider and this involved regular meetings as well as giving their views and feedback on policies and procedures and other issues.

We saw evidence of regular audits and spot checks undertaken by the management team, including checks of care record and staff practice. Outcomes and learning from audits as well as incidents and investigations were shared with the staff team in one to one supervision and team meetings. Checks were also carried regularly by the area manager, who told us about a new initiative involving home managers conducting peer reviews across each other's homes. He explained that this would also promote a more consistent approach to care and support across the organisation.

We reviewed accident and incident records, and saw that each incident and accident was recorded with details about any action taken and learning for the service. There had been eleven incidents since the beginning of 2016. These had been reviewed by the manager and action was taken to make sure that any risks identified were addressed. There were policies and procedures relating to accidents and incidents for staff to refer to when necessary.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not gain the necessary consent to care and treatment and to lawfully deprive people of their liberty. They did not act in accordance with the MCA 2005 and the application procedure for Deprivation of Liberty Safeguards (DoLS). Regulation 11 (1) - (5)