Caulfield & Gopalla Partnership

Riverside House

Inspection report

The Annex, 337A Seven Sisters Road
London
N4 1QR

Tel: 02075035978

Date of inspection visit:
24 April 2017

Date of publication:
26 May 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Riverside House on 24 April 2017. The inspection was unannounced and carried out by one inspector. Our last inspection took place on the 30 September 2015 during which we found that people's care plans did not always clearly state how people would be supported to achieve their goals.

Riverside House is a forensic mental health service that provides accommodation, supervision and support for nine males with complex mental health needs. At the time of the inspection there were nine people living in the home. The home was laid out over three floors, with shared communal bathrooms, lounge and kitchen. The manager's office is housed in the communal garden and the staff office is located in the premises. The home does not have a lift and there is CCTV on site in communal areas.

The service had a registered manager who was present during the day of the inspection. 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.

Clear guidance was in place to make certain the likelihood of potential risks was reduced and there was a planned multi - agency approach to monitoring and responding to risk. Risk assessments were reviewed when there had been a change in people's circumstances. Safeguarding practices was followed to protect people from abuse and staff understood how to protect people from harm. Care was delivered by staff who had received specific training and skills that were reflective of the needs of people who lived in the home.

Staff were deployed to support people when this was needed and background checks were carried out to assess the suitability of employees before they began work. Medicines were managed safely and staff had obtained the necessary training to administer these. Referrals were made to health professionals when there were concerns about people's healthcare needs. People's nutritional requirements were met and they were encouraged by staff to eat a well - balanced and healthy diet.

Environmental checks were carried out on the premises and people were updated on matters affecting the home. Care plans were personalised and showed how people attained their achievements and participated in the interests that suited them. Positive interventions were sought when people needed support and

advice. People were aware of who to raise their concerns with and complaints were investigated and responded to within a reasonable timescale.

Staff used the least restrictive measures when people's capacity required assessments under the Mental Capacity Act (MCA) 2005. Deprivation of Liberty Safeguards (DoLS) authorisations were in place for two people and the conditions of these were adhered to. Easy read information was accessible for people and their confidential records were safely stored. People had access to their own personal records when they chose.

People's independence was encouraged to enable them to take steps to make their own decisions and choices. Staff sought to engage people and when this was refused, their decisions were respected. They listened to people's views and sought their opinions and ideas through the use of surveys; however these had not been evaluated. Staff ensured people's privacy was respected and advocates were used so people's views could be heard.

Staff were committed to delivering quality care and people felt confident about the ability of staff to support them when this was needed. The registered manager established good links with partner agencies, and people and staff spoke positively about the registered manager's ability to provide good care. Quality assurance systems were in place to effectively improve the quality of care delivered.

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 understood how to protect people from abuse and people told us they felt safe. Systems included a multi-agency response to manage potential risks.

The provider deployed enough staff to support people when this was needed.

Protocols were followed to ensure the safe management of medicines.

Checks were undertaken by staff to make certain the environment was safe.

Is the service effective?

Good

The service was effective.

People's capacity had been assessed and best interests meetings held to consider the circumstances relevant to them about their care.

Staff were knowledgeable about the care they provided and had attended training to update their skills.

People were supported to cook healthy meals and took part in preparing meals that met their preferences.

People accessed professional healthcare appointments with guidance from staff support.

Is the service caring?

Good

The service was caring.

People told us when they required help staff were available to assist them with their needs. Staff were committed to providing care to enhance people's wellbeing.

Staff respected people's decisions about how they wished to spend their private time.

People were given information to inform them about their rights and responsibilities.

Advocacy was sought to make certain people's views were heard. Information was provided in accessible formats and there was no restrictions placed on people viewing their own personal records.

Is the service responsive?

Good

The service was responsive.

People monitored their own progression with guidance from staff to show how they attained their goals and achievements.

Care plans were personalised and focused on maintaining people's wellbeing. Staff implemented preventative measures and were responsive to people's needs

Positive interventions were sought to empower them to make their own decisions and choices.

People were given the opportunity to raise any concerns, and were concerns were raised, these were resolved.

Is the service well-led?

Good

The service was well led.

The registered manager was held in high regard by staff and the people in the home.

Surveys had been sent to people to obtain their views and opinions about the quality of the provider's service.

Quality assurance systems identified improvements that were needed and these were acted on.

The provider had worked in partnership with external organisations to ensure the quality of care was maintained.

Riverside 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 24 April 2017 and was unannounced, and carried out by one inspector.

Before the inspection, we checked information the Care Quality Commission (CQC) held about the service including the previous inspection report and notifications sent to us by the provider. The notifications provide us with information about key changes to the service and any significant concerns reported by the provider.

During the inspection, we arranged and chaired a house meeting and spoke with three people. We also spoke with a further two people who did not attend the house meeting and chose to speak with us on their own. We looked at the records in relation to five people's care including their medicines records and observed how care was provided to them. We also reviewed four staff recruitment and training records, minutes of meetings, quality assurance audits and some of the records relating to the management of the service.

After the inspection we contacted the local authority and spoke with one health and social care professional to establish their views on how the provider delivered the service in the borough.

Good

Our findings

People told us the reasons why they felt safe living in the home and commented, "The house has improved, I feel safe because I build confidence in myself to be more positive" and "I feel safe here because if I have a problem we go to the staff, having the staff here is much better."

Safeguards were in place to protect people from abuse. Staff described the interventions they had put in place when a person was at risk from financial abuse and they understood the systems they had to follow if they suspected a person was at risk of harm. One staff member commented, "We are all really observant and make sure things go well so people are protected." Records confirmed staff had completed safeguarding training and the registered manager explained they had attended a safeguarding forum facilitated by the local authority and explained they found a questions and answers session to be useful. There had been no recent safeguarding concerns and the provider understood their responsibility to report safeguarding concerns to the Care Quality Commission (CQC). The whistleblowing policy was fit for purpose and staff explained they would report workplace concerns to external organisations if the provider did not take their concerns seriously.

Specialised multi - agency risk assessments were in place for some people; these assessments had been obtained from their previous placements. The provider's risk assessments had been developed to include this information and these plans were updated frequently when people's needs changed and/or there were incidents relating to the identified risks. They included the context and consequences of people's behaviours, medicines, nutrition and their physical health and mental well - being. Assessments had been written that took into account any recent incidences, the support put in place to reduce the risks and if this worked. Reduction strategies showed how the risks should be managed; for example, outings and trips were planned in advanced so that any risks could be discussed and steps taken to manage these.

Risks associated with the home environment were recorded and management plans were in place to mitigate these. Routine room checks were carried out to ensure the environment was safe for people to live. Records showed that people had agreed to this and guidance was in place. Where people were at the risk of hoarding, they were supported with this area of their care and the provider raised awareness of the possible dangers associated with this such as fire. Some people gave us permission to view their rooms and we saw that they were orderly and tidy and the registered manager reminded people about trip hazards in their rooms.

Where serious incidents had occurred the provider had notified CQC of these and we found that they had

taken steps to prevent the recurrence of these. There was an emphasis placed on enabling people's recovery and independence with multi agencies such as the police and probation services to protect people when they were at risk to themselves or others. Protocols were followed where people were reported as missing from the home and a coordinated response from the multi agencies was implemented to ensure people were kept safe.

Staff records confirmed that thorough background checks had been carried out before candidates were employed. Criminal record checks had been completed, two suitable references had been obtained and the employee's right to work status had been checked. People told us there was enough staff working in the home to support them when this was needed. When the registered manager was on leave the deputy manager was present to oversee the day to day operation of the home.

Systems were in place to ensure people's medicines were managed safely. Medicines were delivered by a local pharmacist; contained in blister packs and checked by the staff on arrival to confirm the correct medicines had been received. Medicine administration records (MARs) were signed by staff and the relevant codes applied where this was applicable. Medicines were safely stored in a locked cupboard in the office and when the pharmacist collected any surplus medicines, notes were signed by the pharmacist to confirm receipt of these. Records showed that staff had received specific medicines training to understand the risks associated with people's medicines if these were not administered safely. Regular checks were made on the MARs to ensure were being safely managed. Annual audits were carried out by the pharmacist and the most recent identified no specific concerns with people's medicines but had recommended that the provider purchase an up to date British National Formulary (BNF) reference book to ensure that staff had current information about medicines. .

Areas of the home were observed to be clean, however, one area in the garden was not free from malodours and one person had raised a concern about this during the inspection. The provider explained the specific reasons for this which were being professionally addressed, with health professionals and we saw there was a cleaner on site to make certain this area was regularly cleaned. To ensure the safety of the home environment contractors carried out repairs and maintenance which included lighting, gas, fire equipment and legionella testing. Portable appliances were routinely checked and this included people's own equipment when they first moved into the home. Fire testing and evacuation drills were conducted, and fire safety signs were visible so people knew how to evacuate the building safely in event of an emergency.

Good

Our findings

People's capacity was assessed in accordance with the Mental Capacity Act 2005 (MCA) and the principles of the MCA were followed. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Records showed that where people were under a Community Treatment Order (CTO) and had refused their medicines their capacity was assessed by health professionals and records showed where people had been readmitted to hospital to reduce to risk of harm to themselves or others. A Community Treatment Order is where people have received treatment in hospital under the Mental Health Act and must follow the conditions to have supervised treatment when discharged from hospital to help them stay well.

Guidance advised staff they were to exhaust all therapeutic interventions to ensure people received care that was effective. Conversations about better health prevention techniques were discussed and offered to people. For example, the registered manager explained that when they recognised signs that people were becoming unwell he would hold one to one discussions with people to inform them that a GP could attend the home to talk about their health concerns; signpost them to specialist services and/or support them with a voluntary admission to hospital. This demonstrated that the provider supported people to make their own decisions and access effective interventions wherever possible.

Two people were authorised for restrictions under the Deprivation of Liberty Safeguards (DoLS) procedures to be supervised to access the community with assistance from members of staff. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). There was an assessment of one person's capacity that was completed during their Care Plan Approach (CPA) meeting to form a balanced view about their accommodation, and records showed that person did not fit the requirement for DoLS.

Some people had appointees to ensure their finances were safely managed, and records showed where the provider had supported people to appeal decisions in relation to their financial welfare. Consent forms had been signed by people to agree to share their information with acute hospitals, the community mental health team and ambulance services and these records were kept under review.

People were supported by staff who had the knowledge and skills required to meet their needs. Staff received a five day induction that included shadowing senior members of staff in the provider's other homes. Training comprised health and safety, first aid, fire training, MCA and DoLS, mental health, and anxiety and infection control. The training programme was regularly reviewed and updated. In addition to this staff received bespoke training on safeguarding, risk assessing and missing persons' procedures that was facilitated by the management team. Staff spoke with us about the higher qualifications they had obtained and were further supported with regular supervisions and appraisals to advance their work practices, knowledge and skills.

Most people were able to cook for themselves and people told us they all took part in preparing the main Sunday meal and ordered a take away once a week. One person commented, "We decide what we want every Sunday and sometimes order Chinese food." Staff supported people to cook their preferred dishes where required and staff were flexible about when they assisted people to prepare their meals. People received a shopping budget so they could purchase their own foods and staff helped them write the shopping list as a reminder of what they wanted to buy. Where people's health was a cause for concern, they were supported to make a healthier version of their favourite meals, for example, suggestions were made for a reduction in their caffeine and sugar content to ensure a well-balanced diet was sustained.

Menus showed the healthy meal options that were available and each person held the keys for their own food cupboards so they could store their own foods. To meet a person's cultural needs there were separate cooking and storage appliances to prepare their meals and records noted they used a 'meals on wheels' service, which showed the provider took steps to ensure their cultural and nutritional requirements were met. The kitchen was clean, foods were appropriately stored and fridge/freezer temperature checks were carried out routinely.

People's health care needs were met. As part of the conditions attached to people living in the home they were required to attend health appointments to help manage the risks associated with their mental and physical health. Records advised staff to be proactive in ensuring people attended their appointments and any missed healthcare appointments should be followed up with immediate effect. Dependency tools and equipment were used by the provider to regularly check and monitor their health and an attendance record of appointments was kept up to date to show when and how often people had accessed primary and secondary health care services.

Details of health and social care professionals involved in people's care were documented and records highlighted their healthcare needs and the type of support they had received. For example, one person had been referred to a specialist clinic by the dentist for people with complex needs to manage their oral health care and two people had accessed support from a psychologist, however, one person had refused. An occupational therapist had assessed another person's needs and made recommended adaptations after they had received a referral from the provider about the person's changing needs. Where people had diabetes we saw their health was checked to mitigate against the risks associated with this by enabling people to attend visits to the opticians and chiropodists. This demonstrated that people's healthcare needs were monitored and responded to appropriately.

Good

Our findings

People told us staff were considerate and responded to their needs. People commented, "They say good morning to you when I get up early and I'm an early riser" and "They always want to help, that's the best thing about them, if I need something they will help me with it."

We observed that when people wanted their own personal space and did not want to engage with others or speak with staff this was respected. The registered manager said, "People should be non-judgemental and be able to express their ideas without interruption." People told us they could use their rooms if they needed their own space and private time away from others and we saw that staff sought permission from people who accompanied us to view their rooms. Staff listened to people when they asked questions and responded in a courteous and polite manner. Continuity of care for people was maintained as some staff had worked in the home for several years and they explained why they enjoyed working with people in the home. A staff member commented, "The way I deliver care here, I feel that I give my best so people can live a better life."

People were provided with a copy of the provider's expectations and their responsibilities in relation to the house rules alongside the conditions of their care. They received a welcome pack when they first moved into the home which described the services offered and how staff would support them during their stay. Inventories of the belongings that people brought with them were signed to show there was an accurate description of their belongings should they be misplaced. Three people allowed us to look at their rooms which were personalised to their preferred tastes and pointed out their favourite items and explained why they were valuable to them.

Efforts had been made to provide a welcoming and homely environment that was non-restrictive. Patio doors in the lounge area led out to the garden where people gathered to socialise and included a shelter for them to smoke. They were encouraged to build positive relationships with each other and one person commented, "I like having my mate [person's name] around me and living here." Wi-Fi facilities were available for people to view cable television and the use of these facilities was regularly monitored by staff and the provider had reasonable restrictions such as the use of social media sites due to people's forensic history which people had consented to.

Resident meetings were held to discuss matters of interest to people, recent updates and to consult people about any changes to the home. One person explained, "At the meetings we talk about holidays, and anything we need for our rooms." Previous meeting agenda items were discussed to show what action had

been taken and what further action was required. Records noted that conversations took place about the decor and adaptations to the home such as choosing the colour of the flooring and the installation of CCTV. Where a person had died during their time in the home people were informed that staff were available to discuss their well- being and concerns and people were offered professional assistance, such as counselling to guide them through the process of bereavement.

Records showed that the provider supported people to access appropriate advocacy services when this was needed. One person had accessed a counsellor and advocate to help support them during an assessment to make a decision about their current placement before they moved into Riverside House.

Information was provided in easy read formats and was accessible for people to view, for example, there were easy read guides to the Human Rights Act 1998 and safeguarding information visible on the kitchen noticeboards. People could access their personal records when they chose and their records noted they could view any of the care records the provider held about them when they wished. Staff had received training about the importance of maintaining confidentiality and people's confidential records were stored securely in the premises.

Good

Our findings

At our last inspection we found that people's care plans did not always include specific detail about how people could reach their rehabilitation goals. During this inspection we found that the provider now used the mental health recovery star to show how people achieved their goals. Recovery star shows the journey of change and pathways and tracks how people attain their goals and measure their own progression with the help of others. People can choose from ten areas of support such as identity and self-esteem, choice of social networks, employment, managing mental health and addictive behaviour.

People's progress whilst living at the home was regularly checked and we saw that outcomes were recorded. Two people told us they worked three days a week volunteering at the local gardening centre and we saw that one person had their certificate for their qualification in gardening displayed in their room. This had led to them taking on the role of maintaining the general up keep of the communal garden in the home, and we observed them happily tending to the garden whilst informing us keenly of their responsibilities. Another person held a membership for their favourite football team and posters of their team were pinned up on their bedroom wall, and we saw key working notes that one person would like to attend a numeracy and literacy course. One person was regularly supported to maintain their independence by an outreach worker to access the community and attend their chosen place of worship.

The office diary contained records of how people had been supported with their daily routines such as food shopping, budgeting, support to open their mail and the general maintenance that was required in the building. They had designated days to complete their own laundry and cleaning duties and during the afternoon a staff member accompanied three people in the community to play football in the local park and to enjoy a meal afterwards. One person commented, "It's nice we can go out here, sometimes we also go bowling and for lunch."

Care plans contained mental health action plans which recorded people's diagnosis, if they had insight into their health needs, their medicines and the effects of this and the actions that were required to support people. Staff knew people's relapse indicators and circumstances in which they might be exposed to visible or verbal conflict. The registered manager explained how the staff team managed to predict the type of behaviours people presented with when they experienced positive and negative symptoms of their mental health diagnosis and were aware of what the signs and triggers would be. During the course of the day we observed the registered manager respond quickly to de-escalate a situation when two people became verbally abusive towards each other. They dealt with this in a calm and appropriate way by diffusing the situation skilfully with a discussion with both parties, and concluded by reminding them of the importance

of each other's personal space and boundaries. One staff member commented, "What we do here is more of a preventative approach, it's about what we observe, we talk about it and address the key issues."

Where people disengaged from services due to a number of contributing factors, staff sought to re-engage them in the process of accessing preventative services and people's records noted they should be supported to 'build trust among people and have hope for the future'. Referrals were made by health professionals to seek support and advice with health specialists who offered positive interventions regarding the impact people's actions had on others. For example, records showed a psychologist had made a referral to a specialist service for one person to have a one to one conversation about learning from their forensic history and their insight into the marked effect on others. People were encouraged to maintain their independence as far as practically possible. Written care notes showed that people should take responsibility for their own actions, for example, if the person made their own health care appointment, and could not attend, staff should guide the person to reschedule their own appointments. This demonstrated people were empowered to take accountability for the choices and decisions they made.

The provider's complaints process was displayed on the noticeboard and the people we spoke with told us they had no concerns and were aware of who they could speak with if they had any complaints. They commented, "I wanted to make a complaint a long time ago to staff, but there is no need now because everything is good here," and "I just speak to my keyworker or the manager." The complaints procedure stated that people could take their complaint to the Care Quality Commission (CQC) if they were not satisfied with provider's response, however the CQC does not investigate individual complaints, but is interested in hearing people's views. The registered manager agreed to update this. There was one written complaint made by a person and we saw this had been investigated and actioned through the process of a three way meeting and resolved within an appropriate timescale.

Good

Our findings

People spoke positively about the registered manager, who was held in high regard by people using the service and the staff team. People commented, "He is a reasonable guy", "The best staff is the manager here," and "He's a nice man, when I do not get on with another person, I go to him and he sorts it out."

Team meetings were regularly attended by staff and the minutes showed a range of topics were discussed including plans for outings and trips. Communicating effectively with people and being mindful of how staff talked to people was also discussed along with staff training and development needs and good infection control. We saw action was taken in relation to staff opinions about the night duties, for example, staff explained they found it difficult to complete their cleaning duties as people were unsettled during this time. The registered manager had asked staff to give the night staff a more transparent handover about any concerns they observed during the day, and the registered manager was to be assigned night duties once a month to observe the concerns the night staff had identified.

Staff surveys had been sent to the team to obtain their opinions and ideas about the service, and showed an overall good level of satisfaction. The staff we spoke with placed an emphasis on receiving good support from the registered manager and the development of their skill set due to the registered manager's level of experience and skills. They commented, "The manager is very good, hands on, we have staff meetings to improve on our practice, and have good links with other organisations, who also support people who live here", "I am happy here it is a good environment to work and we are very much supported" and "The management are very helpful here and have helped me achieve a lot." Surveys had been sent to people using the service in January 2017 and the provider had received four returned questionnaires, which contained questions about their nutrition, personal care, and the overall management of the home; however these had not yet been evaluated. The registered manager explained they sought different ways to obtain the views of people such as feedback during residents meetings and a suggestion box, and recognised the need for a more thorough evaluation in relation to seeking people's views to learn from and make improvements to way the provider delivered the service.

The provider's audits had been carried out routinely for people's medicines, finances and care records. An environment action plan was used to address any health and safety concerns. The plans comprised addressing the security of the home, monitoring of the hot and cold water temperature checks, the disposal of perishable foods and malodours on the home and we found these issues had been acted on. The registered manager told us about the changes that had taken place in the rear garden and we saw records to show that people had been consulted about this before the work commenced.

The provider had established good working relationships with external stakeholders such as the Community Mental Health and local Policing teams and explained they quickly responded to staff requests and people's needs when there were concerns. They worked in joint partnership which in turn contributed to the effective care people received. The registered manager maintained a visible presence around the home and was always willing to step in and assist when needed and we observed this during the day of our inspection. They were aware of their legal requirements to notify the Care Quality Commission of significant incidents and changes to the service and we had been promptly notified of these.