Roland Residential Care Homes Limited

Roland Residential Care Homes - 6 Compton Road

Inspection report

Winchmore Hill
London
N21 3NX

Tel: 02083606517

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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

This inspection took place 15 March 2016 and was unannounced. At our last inspection 7 March 2013, we found that the provider was meeting all regulations that we inspected.

Roland Residential Care Homes, 6 Compton Road, is registered to provide accommodation and personal care for a maximum of seven adults with mental health needs. On the day of inspection there were seven people using the service.

The home did not have a registered manager. However, an interim manager was in place and was present during our inspection. A new manager had been appointed and was in the process of registering with the Care Quality Commission as a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe within the home and well supported by staff. We saw positive and friendly interactions between staff and people. People were treated with dignity and respect.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report it to if people were at risk of harm. Staff had an understanding of the systems in place to protect people who could not make decisions and were aware of the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

People received their medicines safely and on time. People were encouraged to be involved with their medicines and understand what they were for. Staff completed regular medicines audits. Staff had completed training in medicines and administration.

People were supported to maintain a healthy lifestyle and had healthcare appointments that met their needs. These were recorded and monitored on a regular basis.

People were involved in writing their care plans and risk assessments and were able to express their care needs. Care plans were person centred and gave guidance for staff to provide appropriate care.

People's personal like and dislikes were incorporated into their care plans. People had individual activities timetables that reflected their preferences. The home also provided a wide range of group activities.

Staff were appropriately trained and skilled to care for people. Staff had regular supervision and annual appraisals that helped identify training needs and improve the quality of care

The interim manager was accessible and spent time with people. We were saw that there was an open culture within the home and this was reflected by the staff. Staff felt safe and comfortable raising concerns with the interim manager and felt that they would be listened to.

There were systems in place to identify maintenance issues. Staff were aware of how to report and follow up maintenance.

Audits were carried out across the service on a regular basis that looked at things like, medicines management, health and safety and the quality of care.

There was a complaints procedure as well as incident and accident reporting. Surveys were completed with people who use the service and their relatives. Where issues or concerns were identified, the interim manager used this as an opportunity for change to improve care for people.

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 were able to tell us how they could recognise abuse and knew how to report it appropriately. People were actively encouraged and supported to report concerns.

There were sufficient staff to ensure people's needs were met.

Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were mitigated against.

People were supported to have their medicines safely.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role.

Staff received regular supervision and appraisals. People were supported by staff who regularly reviewed their working practices.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DoLS).

Peoples healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

People were supported to have enough to eat and drink so that their dietary needs were met.

Is the service caring?

Good

The service was caring. Staff were knowledgeable about individual support needs, their interests and preferences.

There were individual and group activities. People's preferences were listened to and acted upon.

People were encouraged to have full and active lives, be part of the community and maintain relationships.

A system for complaints was in place and people were encouraged to complain.

Is the service responsive?

Good

The service was responsive. Staff were knowledgeable about individual support needs, their interests and preferences.

There were individual and group activities. People's preferences were listened to and acted upon.

People were encouraged to have full and active lives, be part of the community and maintain relationships.

A system for complaints was in place and people were encouraged to complain.

Is the service well-led?

Good

The service was well led. There was good staff morale and guidance from management.

The home had a positive open culture that encouraged learning. Best practice was identified and encouraged.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

Roland Residential Care Homes - 6 Compton Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 March 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we looked at information that we had received about the service and formal notifications that the home sent to the CQC. We looked at four care records and risk assessments, five staff files, seven people's medicines charts and other paperwork that the home held.

We spoke with five people who use the service, four relatives and three staff. We observed interactions between staff and people who use the service.

Good

Is the service safe?

Our findings

People told us that they felt safe. One person said, "Of course, why wouldn't I? They're alright here." A relative told us, "[My relative] is definitely safe there." Staff were able to explain how they would keep people safe and understood how to report it if they thought people were at risk of harm. One staff member said, "It [safeguarding] is protecting service users from abuse. I would report to the local authority or Care Quality Commission (CQC) if I needed to." Staff understood what whistleblowing was and how to report concerns if necessary.

Risk assessments were person centred and written in collaboration the individual. Staff told us that where possible, people had input into how risks were managed and mitigated against. Risk assessments were detailed and gave guidance for staff on how to support people in the least restrictive way. Risk assessments stated what could happen of the identified risk occurred and how the risk could be mitigated. Staff were able to tell us about specific risks for each person that they worked with.

Risk assessments had a specific section around non-compliance with medicines. What actions staff should take and what heath care professionals should be informed in case of people refusing their medicines. One person said, "I know what it [risk assessment] is. I need to take my medication." The person was also able to tell us what could happen if they did not take their medicines.

There were records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. Risk management plans had been put in place to mitigate the incidents occurring again. Following one incident, the provider had changed a specific policy to improve quality and safety of care for people. Staff meeting records showed that incidents and accidents were discussed with the staff team. The interim manager told us that this was to improve learning and ensure that information was discussed and shared.

There were sufficient staff to allow person centred care. There were two staff throughout the day with one sleeping-in at night. A sleep-in shift is where the staff member is on the premises and available in case of emergency but not awake. The interim manager assessed people's needs on an on-going basis. If a higher level of support were needed an extra member of staff would be put on shift overnight.

The service followed safe recruitment practices. Staff files which showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role.

Staff had access to a clear medicine administration policy. People's medicines were recorded on medicines administration record (MAR) sheets and used the blister pack system provided by the local pharmacy. A blister pack provides people's medication in a pre-packed plastic pod for each time medicine is required. It is usually provided as a one month supply. We looked at MAR sheets for December 2015 and January 2016 and found that there were no omissions in recording. Medicines were given on time. One person told us,

"They give them [medicines] from the medicines room. I know what time and I'm usually there but they'll [the staff] tell me if I forget."

There were records for 'as needed' (PRN) medicines. As needed medicines are medicines that are prescribed to people and given when necessary. This can include medicines that help people when they become anxious. We looked at four people's PRN medicine records. There was detailed guidance for staff on when to offer as needed medicines to people. Each person had a separate sheet with information on what the PRN medicine was that they had been prescribed and in what circumstances it should be offered. Information also included what side effects could occur with each medicine and symptoms staff should be aware of if a person was to develop side effects. Information sheets were in people's care files and in the medicines folder. Staff were able to tell us in what circumstances they would offer PRN medicines and what specific PRN medicines were used for. Records showed when PRN medicines were administered and the reason that they were given. For example, headache, person was feeling anxious. There were no omissions in recording on the MAR charts. Staff completed regular stock checks of PRN medicines.

The home promoted people's independence by ensuring that they were fully involved in their medicines. There were regular documented meetings with people and their keyworkers that focused on people's medicines. The interim manager told us that it was important for people to understand what medicines they were taking and the reasons that they had been prescribed. The interim manager told us that having meetings with people about their medicines was, "To educate about the side effects and ensure that people understand why they are taking their medication. We can get their [people's] opinion and how they feel about their medicines."

Some people had medicines that required the person to have regular blood tests. Records showed when people had their blood tests and when the next one was due. Staff told us that they accompany people to their appointments if needed.

The home had up to date maintenance checks for gas, electricity, electrical installation and fire equipment. Fire alarms were tested and recorded weekly. A fire risk assessment was in place. The home had a dedicated 'handy man'. All staff were aware of how to report any maintenance issues. We looked at maintenance records and saw that issues were dealt with in a timely manner and signed to say that they had been completed.

The home was clean and tidy on the day of our inspection. Staff and people told us that they cleaned daily. There were cleaning rotas that people told us they had helped devise. One person told us, "We all help to keep it clean." People were responsible for cleaning their bedrooms. This was included in people's individual care plans.

Good

Is the service effective?

Our findings

People were supported by staff that were able to meet their needs. Staff told us, and records confirmed they were supported through regular supervisions and yearly appraisals. Supervisions were used to look at people's care and support and identify training and development. Staff told us that they had supervision every two to three months but were able to request supervision at any time if they felt that they needed to. One staff member said, "I can discuss what I want [in supervision] they [management] listen to what I say and listen to my ideas." Another staff member said that appraisals were, "Helpful, it's for my development, to review myself and look at areas I want to develop."

Staff had a comprehensive induction when they started to work at the home. This included, getting to know the people who lived at the home, understanding policies and procedures, medication training and specific mental health awareness. Training records showed that staff received regular training that supported them in their role. Staff had completed training in supporting people living with mental health needs. On the day of our inspection, staff were attending external training in first aid.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

Staff had received training in to understand circumstances where people could be deprived of their liberty. Staff were able to tell us the procedure if a person were unable to make decisions regarding their care. One staff member told us, "Capacity is assessed on individual decisions and not overall. It's about when people are not able to make decisions. You need a best interests meeting and an advocate." Another staff member said, "We cannot assume that people do not have capacity. It must be assessed."

Where people required a Deprivation of Liberty Safeguard (DoLS), these were in place. There were dates noted for when the DoLS needed to be reviewed. The home had detailed MCA assessment forms that had been created following appropriate professional guidelines. Where people were unable to make decisions regarding their care there were records of best interest meetings. A best interests meeting is when people have been deemed unable to be involved in aspects of their care and staff, healthcare professionals and relatives, make decisions on their behalf and in their best interests.

There was an electronic keypad on the front door that required a code for people to be able to leave the

home. Where people had capacity and were not subject to a DoLS, they were aware of the code and had a house key. People that we spoke with confirmed that they were able to come and go as they wished. We observed people going out throughout our inspection. Where people needed support to go out, we also observed staff taking people out.

Staff were trained in restraint techniques. All staff had received specific training called 'Management of Actual or Potential Aggression (MAPA). Staff told us that MAPA should only be used as a last resource. Staff were able to talk us through how they would restrain someone and the techniques that were used. Staff said that before using any form of physical restraints, they would use other techniques first. This meant that although staff were trained in physical restraint they used other techniques, such as talking and as required medicines, to support people when they became distressed. Staff told us that although staff had received the training, physical restraint had never been used within the home.

People were supported to have enough to eat and drink. We saw a four week menu plan that showed a diverse range of foods. Vegetarian options were always available. Menu plans were clearly displayed in the kitchen area. Staff told us, and records showed that people were consulted in resident's meetings to choose what they wanted to eat. One person said, "I'm not a very good cook. I used to be okay. Staff encourage me."

People's dietary needs were noted in their care plans. One person's care plan noted that the person was being supported to eat healthily and control their weight. There was clear guidance for staff on how to help people if they needed support when eating.

Where people did not wish to eat the communal meal, they were supported to go shopping and buy what they wanted to eat. People were given choice and encouraged to eat healthily.

People's personal files had details of healthcare visits, appointments and reviews. Guidance given by healthcare professionals was included in peoples care plans. Records showed that people had access to healthcare such as podiatry, opticians, and dentists. There were details of action plans for staff following healthcare visits. These were documented in people's daily records. We saw that people had regular, recorded meeting with community mental health teams.

Some people had specific medical conditions that required staff to be aware of symptoms that could occur and how the person experienced those symptoms. There was detailed information available for staff in people's personal files on each condition. We asked how management ensured staff understood people's physical medical needs. The interim manager told us, "It is covered in induction if people are new but we also inform staff when things change. Staff are required to read the medical information."

There were 'ambulance forms' for each person noting their medical history, relevant contact details, current medicines and other information that was necessary, in case people were admitted to hospital. These were updated on a regular basis or when things changed.

We looked at two people's bedrooms. Bedrooms were personalised according to people's wishes. There were personal photos, televisions and ornaments. One person said, "It's not like having my own home but I've got all my things I want here." When people moved in, they were able to choose the colour of their room and staff said that they tried to make it as, "Homely and comfy as possible."

Good

Is the service caring?

Our findings

People were treated with respect and their views about their care were understood and acted on by staff. A person told us "They're alright here, staff are alright." One relative told us "We're pleased with the care, [my relative] seems happy there. The people [staff] looking after him are very nice." Another relative said, "They do the best they can for people, I can't fault them."

We observed positive and friendly interactions between staff and people throughout the inspection. Staff often sat with people for tea and coffee and talked about a number of subjects. We observed people smiling and laughing with staff.

People told us that staff knew them well. Care records had a section with people's personal histories, likes and dislikes. Staff were able to tell us, in detail what each person liked and enjoyed. This was reflected in the interactions that we observed between staff and people.

Each person had a key worker. A key worker is someone who is responsible for an individual and makes sure that their care needs are met and reviewed. One person told us "My keyworker is nice." There were regular recorded key working meetings that ensured people were being appropriately supported. Staff told us that people chose where they wanted to have their key working meetings, it could be in the home or outside in the park or café. People were given choice about receiving support.

People's care files noted if they had a faith. People were independent and able to attend a place of worship if they wanted. Staff said that if someone needed support to practice their faith, this would be included in the person's care plan and staff would ensure that their wishes were met. One person's care plan noted that staff took the person to church every Sunday. The interim manager told us that staffing levels were adjusted to accommodate the person attending their chosen place of worship regularly. One relative said, "They incorporate everyone's beliefs there."

Care plans noted if people needed prompting with their personal care and how the person liked to be prompted. Care plans showed that some people had agreed to attend to their personal care on certain days. Staff were aware of what days people required prompting and were able to tell us how they prompted people.

We observed and people told us that they were involved in planning their care. Care plans noted what people's interests were and people were encouraged in key working and daily by staff to go out and engage with the local community. A relative said, "They really listen and try to do things with [my relative] that he enjoys."

We asked staff how they would work with gay, lesbian or bisexual people. Staff told us that this would not make any difference to how the person was treated. One staff member said, "There's no difference, we're all human beings. I would respect them as I would expect them to respect me." Another staff member said, "It makes no difference to the care people receive."

Relatives said that they could visit whenever they wanted. One relative said, "They are very accommodating, I go when I wish. They always make me a coffee" Another relative said, "We're always very welcome, no problems at all with that." One relative told us that staff had arranged for a local transport service to take the person to visit them and pick them up.

There were up to date records of monthly residents meetings. The complaints procedure was regularly discussed and people reminded how to complain if they needed to. People were also informed about advocacy services and how to access them. Food, décor of the home and activities were also discussed. People told us that they had access to the minutes from meetings if they wanted to read them.

We saw records of what people's wishes were if they were to pass away. This included their faith and who they wanted to be contacted in the event of their passing. One person had refused to complete the form and their wishes not to do so had been respected and recorded. End of life wishes were updated yearly.

Good

Is the service responsive?

Our findings

Care plans were detailed and person centred. People told us that they were involved in creating their care plans. Care plans contained practical information as well as information on people's personal preferences. This included what people wanted to achieve in the future. Care plans were written yearly following multi-disciplinary Care Programme Approach (CPA) meetings. CPA meetings provide a way in which services are assessed, planned, co-ordinated and reviewed for people living with mental health needs. If there were any changes to people's care, these were updated as and when necessary.

Care records showed that people and their relatives had been involved in the initial assessments and on-going reviews of people's needs. As part of the initial assessment, people were able to spend time at the service on a trial basis so that staff could become familiar with their needs. This included day visits and overnight visits. This also allowed people to become familiar with the staff and the service. There was a detailed, step by step, referral procedure for both healthcare professionals and people. This was given to people when they were referred and explained what they could expect from the process and what their rights were.

Each person had their own activities plan that had been tailored to their preferences. One person enjoyed swimming and the interim manager ensured that a female member of staff was roistered on to take the person on a weekly basis.

People had specific tasks that they completed on certain days such as; laundry, cleaning bedroom, cooking and going out for coffee.

We observed a baking group. This was run by a staff member and people were learning to make a pasta dish and a chocolate tart. People were encouraged to participate. There was a friendly atmosphere during the group.

The home had a staff member that was responsible for planning activities. There was a trip to Paris, France, being organised for summer 2016. People had been consulted about where they wanted to go and helped plan the trip. People had been supported to apply for passports.

The activities coordinator told us that once a month trips out were planned. This was discussed and planned in collaboration with people. People had been to the Royal Air Force Museum, on cinema trips and visited the zoo and further outings were planned.

The home also provided group activities. Some of the group activities were done in partnership with nearby sister homes that the provider ran. Groups included a film group where people would decide what film they wanted to watch and have snacks and refreshments. A yoga group, art and crafts, and a meditation group that was run by staff. People told us that they liked the activities that the home provided but also felt comfortable not attending if they didn't want to.

Staff told us that people had a 'service user forum'. This was set up by people who use the service. People met weekly and staff did not attend. People from other locations where services are provided by the same provider are also invited to attend. Following the meetings there was a representative of people use the service who had fed back to the staff. Staff were able to explain how these meetings and suggestions enabled people to be involved in running the service and how their care was delivered. For example, people said that they wanted different colour in certain room. The provider consulted people and painted room according to people's wishes. People asked for an exercise group, this is now in place documented on the activities timetable.

Staff had encouraged and supported people to become registered to vote in political elections. Staff told us that they had discussed this with people and would support people to attend polling stations if identified that the needed help.

The home had a clear complaints procedure. The interim manager told us that relatives were given copies of the complaints procedure. People who lived at the home were also aware of how to make a complaint. We saw that this had been discussed at resident's meetings. In the hallway of the home, the complaints procedure was prominently displayed. We looked at the complaints records and found that there had been no complaints. The interim manager told us that people did not complain although they knew how to if they wanted to. We asked if people felt comfortable to make complaints. One person said "Yeah, I would." One relative told us "I know who to complain to if need be, they gave me information but I would just pick up the phone. They're very good."

Good

Is the service well-led?

Our findings

The home had an interim manager in place at the time of the inspection. The provider had appointed a manager who was in the process of registering with the Care Quality Commission as a registered manager.

The home had an open and empowering culture. One staff member told us "Whenever there is an issue [the interim] manager is very supportive. He always has time to listen and support me." Another staff member said, "It's a great team. We focus on the service users." A relative said, "The [interim] manager is very good. He always calls me if there's anything." Another relative told us, "The [interim] manager is great. I trust him."

There were systems in place to ensure that staff training was up to date. Training records showed when staff needed to refresh training. Supervision records showed that staff were able to identify and request training. We saw that where a staff member identified training that would improve their care practices, this was provided.

During induction, staff were trained in the values of the home. Training records showed that staff were encouraged to maintain and update care skills and knowledge. Staff told us that the feedback they received during supervision and appraisals from the manager was constructive and supported them in their role. Staff also received feedback outside supervision where necessary. This allowed staff to be clear on actions that they needed to take in their day to day work. Staff that we spoke with were able to tell us how they had put their training into practice. Staff told us that the manager was supportive and addressed any mistakes fairly and professionally.

There were systems in place to ensure that staff training was up to date. Training records showed when staff needed to refresh training. Supervision records showed that staff were able to identify and request training. We saw that where a staff member identified training that would improve their care practices, this was provided.

There were records of regular team meetings. Team meetings were often held with staff from across the organisation. This allowed an opportunity to share experiences and good practice. Staff told us that they felt able to raise issues and felt listened to by the interim manager and the provider.

The interim manager completed regular audits. People's finances were audited by staff at shift handover, weekly and monthly. Medicines were audited weekly. There were monthly and quarterly health and safety audits that were up to date. This included a 'visual inspection'. Staff walked around the premises and looked at areas, documenting if they are safe. If there was something identified as needing action, a time frame was put in place by when the issue would be addressed and the outcome noted. The interim manager had a good oversight of the service and the care that was being provided. Any issues that were picked up were addressed quickly and where appropriate, used to change practices in the best interests of the people that were being supported.

Accident and incident logs showed that the interim manager used accidents and incidents as an

opportunity for learning and to change practice or update people's care needs. Procedures relating to accidents and incidents were clear and available for all staff to read.

All policies and procedures held by the service were up to date and included date for review. The provider updated policies as and when necessary according to legislation changes and reviewing care practices within the service.