Epilepsy Society

Russell House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 25 and 26 June 2018 and was unannounced. At the previous inspection the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). At this inspection we found there was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). This was because records were not suitably maintained, accurate and up to date and the governance of the service failed to bring about the improvements required for them to become compliant with this regulation.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective and well –led to at least good. The provider sent us an action plan telling us what improvements they intended to make. At this inspection we found the improvements were not sustained and the service was again rated requires improvement. This is the third inspection where the service has been rated "Requires Improvement."

Russell house is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Russell house accommodates 20 people across four separate units, each of which have their own facilities. At the time of this inspection there was nineteen people living in the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The service was required to have 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. In this report the name of a registered manager appears who was not in post and not managing the regulatory activities at this location at the time of the inspection. Their name appears because they were still a Registered Manager on our register at the time. The registered manager had recently left the organisation and the provider was actively recruiting into the position.

Relatives were complimentary of the permanent staff and felt they were skilled, kind and caring. However, the service had a high number of staff vacancies which meant a high use of bank and agency staff were used to cover shifts. Relatives felt those staff did not always have required skills and training and the use of agency staff led to inconsistent care for their family members.

Whilst the required staffing levels were maintained on each unit staff were not deployed appropriately which

meant some units had a high number of agency staff on shift. This put a lot of pressure and responsibilities on the permanent staff members who felt they were working under extreme pressure. They were expected to be drivers, administer medicine, act as shift leaders as well as providing personal care and support to people. The provider confirmed after the inspection they had moved staff around to provide a better skill mix of experienced staff across all the units. They were continuing to recruit into vacancies and they were currently consulting on a pay review which they hoped would help with the retention of staff.

Staff were not suitably inducted, skilled, trained and supported in their roles. The agency staff were not appropriately trained in that they did not have training such as epilepsy awareness and learning disabilities which the provider considered was mandatory for the service. A number of staff were in acting roles. Whilst a series of training had been provided to them an assessment of their skills and competencies had not been completed to ensure they had the required skills to do the job. New staff were not supported to complete their care certificate induction and have their competences signed for. Staff felt supported but supervision of staff was not happening at the frequency outlined in the providers policy.

Permanent staff were knowledgeable about people and the support they required. Staff were kind and caring. However, we observed poor practice which did not promote people's privacy, dignity and show them respect. We have made a recommendation about this in the report.

People had care plans in place but some care plans lacked specific details on how staff were to manage situations such as challenging behaviour. People's care plans included guidance on how people communicated but this was not routinely promoted by staff. We have made a recommendation about this in the report.

People were supported to make day to day choices and decisions. The service did not always work to the principles of the Mental Capacity Act 2005. We have made a recommendation about this in the report. People's health and nutritional needs were identified but some relatives felt changes to their family members health were not always responded to in a timely manner.

Systems were in place to promote safe medicine administration. There was a delay in a person getting their required antibiotic medicine. The provider have since put a protocol in place around the management of interim prescriptions to prevent delays in medicine administration.

People had access to activities but access to community activities was limited due to lack of drivers.

A complaints procedure was in place and people and relatives felt able to raise complaints. However, some relatives did not feel that their complaints were always acted on as similar complaints were raised by them.

The provider had systems in place to get feedback on the service. Meetings and surveys were completed annually.

The service was purpose built, it was homely and welcoming with arts and crafts displayed at the entrance and on individual units. The standard of cleanliness varied across the four units and a number of areas requiring refurbishment were over due to be refurbished since 2017.

The provider had systems in place to audit and monitor the service. Whilst some of the issues we found in relation to staff supervisions, inductions and record management were identified and being dealt with, this was not done in a timely manner to bring about improvements.

Systems were in place to safeguard people and risks to them were identified and managed. Staff were suitably recruited to further safeguard people.

At this inspection the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014). and there was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). We are taking action against the provider and will report on that action when the timescales for representations have passed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not receive consistent care due to the high use of agency staff used within the service.

People's risks were identified but the reliance on agency staff had the potential for risks not to be consistently managed.

People were safeguarded from the risk of potential abuse.

People were supported by staff who were suitably recruited.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not supported by staff who were suitably inducted, trained, skilled and supported in their roles.

People were consented on their day to day but staff did not work to the principles of the Mental Capacity Act 2005.

People had access to a range of health professionals to meet their needs. Some aspects of their health and nutritional needs were not always addressed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff who were kind and caring however, some staff did not always show people respect and promote their privacy and dignity.

People had their own bedrooms and en- suite bathrooms.

People were provided with information on advocates to support them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had care plans in place which outlined their needs and support required. They lacked details around the management of behaviours that challenged.

People's communication needs were identified but staff did not consistently use aids and pictures to promote people's involvement in the service.

People had access to activities but community access was limited due to the lack of drivers within the service.

People's end of life needs were identified and the service had positively supported a person on end of life care to remain at the home.

Is the service well-led?

Requires Improvement

The service was not always well led

People's records were not suitably maintained and accurate.

People were not supported by a service that was suitably monitored to bring about improvements.

Russell House

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 June 2018 and was unannounced. This meant the service did not know we would be visiting. The inspection was undertaken by three Adult Social Care Inspectors on day one and two Adult Social Care Inspectors on day two.

Prior to the inspection we requested and received a Provider Information Record (PIR) on the service. The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed other information we held about the service such as notifications and safeguarding alerts. We contacted health care professionals involved with the service to obtain their views about the care provided. We have included their written feedback within the report.

Some people who used the service were unable to communicate verbally with us. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with three people who used the service, the deputy manager, four team leaders, two shift leaders, five support workers and a housekeeper. After the inspection we spoke with two relatives by telephone and had email feedback from four relatives.

We checked some of the required records. These included care plans, risk assessments and medicine records for eight people, three staff recruitment files including three agency staff profiles, eight staff supervision and training records. Other documents included records of complaints, staffing rotas, daily allocation sheets, audits and monitoring visits and records which showed the upkeep and maintenance of the premises.

We asked the provider to send further documents after the inspection. The provider sent us documents which we used as additional evidence.

Requires Improvement

Is the service safe?

Our findings

At this inspection we found the staffing levels deemed appropriate by the provider for each unit were maintained. One to one staffing and two to one staffing for people in the community was provided. However, a relative told us the community access for their family member was not consistently provided due to lack of drivers. The provider confirmed after the inspection a driver had recently been appointed to support community activities.

The home had a high turnover of staff since the previous inspection. Fourteen permanent staff had left the service and six permanent staff had been appointed. This meant the service had lost a high proportion of skilled and experienced staff. The service had a total of seventeen staff vacancies. Bank and agency staff were used to cover the vacancies and the provider had block booked agency staff to enable them to get the same agency staff regularly to promote consistency of care. At the previous inspection we had recommended that the provider ensured staff were suitably rostered and deployed to provide a good balance and mix of regular and agency staff across all shifts. This was not addressed and from review of the rotas and discussion with staff, shifts were still not appropriately managed to ensure staff were deployed appropriately. An acting team leader and an acting shift leader were rostered to work on one unit. Both were new to the acting up roles and the service had not considered if they had the required skills and competencies or would they be better placed working with an experienced team leader and shift leader. On day one of the inspection on one unit we visited the acting team leader who was meant to be supernumerary was on duty. There was one support worker and three agency staff on that unit. On another unit four staff were on duty, three of whom were agency staff. A permanent support worker was out to pick up a person who had been staying with family. Some units did not always have a medicine trained staff member on shift and staff from other units were responsible for medicine administration across more than one unit. We observed on the second day of our inspection that there was no medicine trained member of staff on duty on one of the units.

Staff confirmed the required staffing levels were maintained but as permanent staff they worked under extreme pressure. They told us they were expected to do so much in their role such as act as drivers, administer medicine, provide personal care as well as supporting and guiding agency staff. The service had six shift leaders employed to work on day shifts with three of those shift leaders acting up in the role. There was two shift leaders on the night shift. This meant there was not a shift leader on every shift. Support workers were expected to act as shift leaders when there were no shift leaders on shift. Some support workers felt aggrieved by that and were dissatisfied that all of the acting shift leaders were not medicine trained either.

Even though the required staffing levels were maintained staff were not deployed appropriately to ensure they had the right skill mix of staff across the service. This lead to inconsistent care for people and had the potential to be unsafe. Relatives told us they were unhappy that so many experienced staff had left the service and the use of agency staff led to inconsistent care for people. Relatives commented "More permanent staff are needed and agency staff are inefficient and poor value for money." "There is just not enough permanent staff to ensure good quality care is consistently given to my [Person's name]." "Over the

last year, [name of unit] has lost most of its best support workers and its Team Leader. The permanent staff who remain are trying to do the best job they can given that they have to work with agency staff most of the time." ""There is seldom a full team of permanent staff on a given shift. ""The current staffing issues are impacting on the morale of the staff and the quality of care my family member and I imagine other residents receive. Another relative commented "The Epilepsy Society is doing the best they can to recruit staff but they will never get it to 100%."

The provider confirmed after the inspection they had moved staff around to support staff in acting up roles. They were consulting on a pay review and were continuing to attempt to recruit permanent staff. They hoped the pay review would help to retain staff.

A system was in place to carry out a stock check of medicines twice a day, following administration. This enabled the provider to pick up on any discrepancies in the medicine administration records. We saw a person was prescribed an antibiotic on a Friday lunchtime but stock of the antibiotic was not available until late morning on the following Monday. This meant the person missed twelve doses of their prescribed antibiotic. The service used their own pharmacy on site to supply medicines. The pharmacy had no stock of the prescribed antibiotic which resulted in the delay in administration. However, this was not communicated and escalated to senior staff of the service or the organisation to enable supplies of the prescribed antibiotic to be obtained from a community pharmacy. The delay in the supply and administration of the antibiotic had the potential for the person's condition to worsen. The provider confirmed after the inspection measures had been put in place to prevent reoccurrence.

A person was prescribed medicines to manage behaviours that may challenge. The protocol for administration of that medicine was to give one to two tablets up to a maximum of four tablets in 24 hours. There was no supporting guidance as to how staff would know whether they had to give one or two tablets and staff spoken with were unsure on the protocol for administration of that medicine. The person had not been given the medicine since January 2017 and the provider agreed to seek clarity from the Doctor on its administration, in case it was required.

The provider had systems in place to promote safe administration of medicines. Reference to medicine allergies were recorded on the medicine administration record. Records were maintained of medicines ordered, received, stored and disposed of. The cupboards containing medicines were maintained at the correct temperature and action taken when the temperature was too hot. One person had their medicines administered covertly. This meant medicines were administered in a disguised format without the knowledge or consent of the person receiving them. Records were maintained which showed a best interest decision meeting had taken place and people involved in the decision had signed to confirm the rationale for this and how the medicines were to be given. We reviewed a sample of medicines and found those reviewed showed no gaps in administration.

A range of safety measures were in place for people. These included safety helmets, safety mats, seizure monitor, bed exit monitor and sound monitor. People's care plans contained a series of risks assessments. The risk was identified and measures put in place to mitigate risks.

Permanent staff had a good knowledge of the people they supported and their risks. Agency staff were less informed and were observed to not support people appropriately particularly at lunchtime. We observed an agency staff member supporting a person who had a thickener in their fluids to take their drink. They attempted to get them to drink it from the cup as opposed to spooning it to them. A permanent staff member eventually intervened and provided guidance to the agency staff member on what they needed to be doing and why. The provider confirmed after the inspection they had the learning and development team

based at the home and working along staff especially the agency staff to address those findings.

An environmental risk assessment was in place and people had Personal Emergency Evacuation Plans (PEEP) in place. An emergency grab bag was available which contained information staff would require in an emergency such as PEEP's and contact details. Health and safety checks took place such as water temperature, nurse call bell and window checks. Equipment such as the fire safety equipment, gas and electricity was serviced.

The service had a fire risk assessment in place dated 1 May 2018. Fire checks and fire drills took place. The last recorded fire drill took place in April 2018.

Systems were in place to safeguard people. Staff we spoke with had undertaken safeguarding training and an agency staff member told us their agency provided training and updates. Staff were aware of types of abuse, signs of possible abuse and their responsibility to report and record any concerns promptly. Safeguarding posters were displayed on notice boards and included as an agenda item at meetings.

Accident and incident reports were completed when required and body charts were completed when marks were noted on people. Staff were aware of their responsibility to report and record when an incident or an accident had occurred. We saw the providers monitoring visit picked up on trends in the accident reporting and questioned learning from incidents. Clinical review meetings took place where incidents were further discussed to promote learning from incidents.

Safe recruitment practices were promoted. Staff files contained an application form and potential new staff attended face to face interviews. Staff completed a written exercise and the required checks such as references from previous employers; medical health questionnaire and a disclosure and barring check was completed before a staff member commenced employment. There was a one-page profile for agency staff which showed the required checks were completed. It outlined the training they had received and dates.

The service had a cleaner who was responsible for cleaning the communal areas of the home. Other cleaning tasks and lists were included on the handover records to prompt staff as to what cleaning tasks they were responsible for. Staff supported people to clean their bedrooms. The level of cleanliness varied across the units with some areas such as behind ovens, fridges and freezers were in need of a deep clean. Some relatives raised concerns with us about the level of cleanliness and tidiness of their family members bedrooms. They felt this was variable and not carried out as regularly as it should be.

Systems were in place to prevent cross infection. The service had a designated infection control champion and staff were aware who that was. Staff were trained in infection control and gloves and aprons were supplied to manage cross infection risks. A monthly infection control audit was completed with actions completed to manage the risks. During the inspection we noted on one unit they had an infestation of ants. This was immediately addressed and a risk assessment put in place to manage the risk during the warm weather.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection staff appraisals were overdue and supervisions of staff were not happening in line with the provider's policy. The registered managed in post at that time confirmed this was being addressed and systems were in place to monitor it. At this inspection staff told us they received supervisions but they were not sure of the frequency. The supervision matrix for 2018 showed 14 staff had not had a recorded one to one supervision. However, the monthly reporting failed to highlight that. Instead it indicated they were 100% on target for supervisions in January, February and April 2018, 88% in March and 93% in May 2018.

The provider's policy indicated one to one supervision meetings with staff should take place every eight weeks. The supervision records viewed during the inspection showed gaps in the frequency of supervisions which was not in line with the provider's policy. For some staff new in roles and in acting up positions there was no evidence on their files of them been inducted and supported into those roles. The deputy manager had recorded in their diary occasions where they had supportive discussions with individual staff but these were not followed through into supervisions. After the inspection the service sent us records of some of the supervision records that were missing from staff files during the inspection. However, there was still a number of staff for whom no records existed of one to one meetings that had taken place. The provider agreed to audit all the staff files per unit to establish who did not have regular supervision and commence formal one to one meetings.

Staff had access to training the provider considered mandatory such as epilepsy awareness, fire safety, health and safety, safeguarding and infection prevention. Alongside this staff had specialist training in Non-Abusive Psychological and Physical intervention (NAPPI), medicine administration, autism, pressure ulcer prevention and eating and swallowing. The training records provided showed a low percentage of staff had autism training on three units whilst on one unit 100% of staff had completed that training. Other units had low percentages of staff with medicine training and all of the units had a low percentage of staff with care vocabulary and report keeping training. Agency staff were provided with training by the agency they worked for. Their training covered safety topics such as fire safety, safeguarding, health and safety but not specialist training such as epilepsy awareness and learning disabilities. The service had a high use of regular agency across all of the units. However, the provider failed to provide agency staff with that training either even though they were considered mandatory for their services. During the inspection we observed a person had a seizure. The agency staff on duty on the unit did not know how to manage it. They relied on the one permanent staff member on shift on the unit that morning to take the lead, which they did whilst carrying out other tasks such as medicine administration.

Relatives told us the permanent staff were very good and had the skills to do the job. However, relatives told us agency staff did not have the required skills. A relative commented "Agency staff are not sufficiently trained for this speciality of severe epilepsy care." Another relative gave us an example where they saw an agency staff member attempt to lift their family member from a sitting position on the couch by pulling her hands. A third relative told us an agency staff member did not know who she was. The agency staff member was working with her family member and commented to the relative "[person's name] is throwing a wobbly, he wants something but I haven't a clue what he wants. I don't know him". Other relatives told us agency

staff did not notice when their family member was incontinent and a number of relatives told us agency staff failed to maintain one to one observations on people and they leave people alone and unobserved.

A number of staff had been temporarily promoted to more senior positions. There was no assessment of their competencies to ensure they had the skills to take on the acting roles and to identify what support they might need to fulfil the role. We were provided with evidence after the inspection that they had been inducted into the role and for some staff in those acting positions they were given regular support, guidance and training. Other staff were dissatisfied that they had not been given the same opportunity to act up to a more senior position. They told us the acting up positions were not advertised and this created conflict and disharmony among the team. The provider confirmed the acting team leaders were advertised but they had little interest in the positions.

The Care Certificate is a recognised set of standards that health and social care workers adhere to in their daily work. This involves observations of staff performance and tests of their knowledge and skills. At the previous inspection Care Certificate inductions were not taking place. The deputy manager told us then training was being provided to enable them to support staff to work through the Care Certificate inductions and sign off their competencies.

At this inspection the service had six new staff who had been in post longer than six months. Some of those care certificate inductions were started but none were completed and competencies signed off. The deputy manager told us the learning and development department were taking over assessing and signing off the Care Certificate inductions. The nominated individual confirmed after the inspection that they had arranged for the learning and development team to be based at the service the week after the inspection. This was to support agency staff and permanent staff with workshops including record keeping, Mental Capacity Act 2005 and good practice. Their remit was to carry out observations, support and implement good practice and attend handovers. They would also be completing the observations and signing off Care Certificates inductions that had been completed.

This is a breach of regulation 18 of the Health and Social Care Act Regulations 2014.This was because staff were not suitably inducted, skilled, supported and trained in their roles.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At the previous inspection we had recommended that the provider ensures staff understand and work to the principles of the Mental Capacity Act 2005. At this inspection we found this was not the case. For one person the best interest decision in relation to having a blood test was completed two months after they had their blood test. Another person's mental capacity assessment indicated they had capacity with support. There was no indication as to what support was required. It went on to say the person can make day to day choices and decisions, however needs their family or a member of staff to make important life decisions regarding medical treatment, medicine changes and any large expenditure. That is not in line with the principles of the Mental Capacity Act 2005.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Each of the units was accessed via key coded doors. People were supervised

by staff on a twenty-four-hour basis. These measures were in place for people's safety in the context of their care needs. A register was maintained of DoLS applications that had been made, approved and when they expired. The majority of staff were trained in the Mental Capacity Act 2005 and associated Deprivation of Liberty safeguards with extra workshops provided on it. However, staff's understanding of the Mental Capacity Act 2005 and associated safeguards varied with some staff not aware who had a DoLS in place or why.

It is recommended the provider works to the principles of the Mental Capacity Act 2005.

Care plans outlined people's religious and cultural needs. We saw that a staff member communicated with a person in a language other than English. This enabled them to have involvement in the service.

The home had two new admissions since the previous inspection. People were assessed prior to admission and a transition to the home was arranged. This varied depending on the person's needs and what was appropriate for each person. People's cultural and diverse needs were assessed and met. A relative commented "The transition was carried out satisfactorily from home to the Epilepsy Society. I would say it was a positive experience."

A health professional commented "[Name of unit] welcomed a new resident and was successful in working with the therapy team in problem solving and putting everything in place to ensure a safe transfer of care. Very soon after the person settled in, they experienced a significant decline in health, to which the team was responsive and which meant the team had to learn and implement new health care strategies with which they were not previously familiar. During this time, they collaborated well with therapy, the medical team and family to ensure the persons health care needs were met."

Another health professional told us they were involved in the assessment of a person admitted to the home. They told us "Staff were guided by a real interest in finding out what the person was going to need when living at the home, so that they would be safe, and their new room could be made as homely and functional as possible. They commented "I was impressed by the communication between the staff in both units and particularly the team leaders were taking a lot of responsibility in the preadmission and admission process."

People had access to health professionals such as the GP, dentist and opticians. Their care plans outlined the support they required to meet their health needs. People had access to a range of other professionals on site such as a physiotherapist, occupational health therapist and a speech and language therapist. A nurse was provided on site to support staff in managing day to day medical issues, incidents and accidents. Each person had a hospital passport which outlined key information on individuals such as the medicine they were taking, any allergies, their communication needs and key people involved in their care. This was taken by staff on transfer of a person to hospital.

Relatives told us they were informed if their family member was unwell. One relative felt the service needed to be more effective in getting their family member seen by a GP or nurse when they were unwell with a suspected urine infection as this impacted on their seizures Another relative told us they had asked staff to talk to the GP to review their family member. They advised this was not followed up on. They went on to tell us their family member was due to see a community dentist which was cancelled by staff but the appointment was not rescheduled despite staff been reminded to.

A GP had made four complaints during 2017. The complaints were about people not attending for booked appointments, staff arriving late for appointments and being supported for an appointment by staff who did not know the reason why they needed an appointment. The complaints log indicated an apology or an

explanation was provided and the provider confirmed managers were informed by email of the need to complete health appointment records. The provider confirmed they met every six months with the GP practice and that relationships and communication with them was improving.

People's care plans outlined their nutritional needs and risks. People who required it had access to speech and language therapy assessments. Measures were put in place for individuals to reduce any potential risks of choking or aspiration such as thickeners in drinks and food chopped into bite size pieces. The service had identified people who were at risk of malnutrition. A malnutrition universal screening tool (MUST) was used to establish the level of risk for individuals. A person who was a low weight had not had their MUST completed since March 2018. The monthly weight records showed the person had lost 3.4 kilogrammes from March 2018 to April 2018. This went unnoticed and no action was taken. The person's weight had subsequently increased slightly in May and June 2018. The provider contacted the dietitian during the inspection who advised they would not have changed their recommendations for that person following the weight loss in April. However, the service needs to be more effective in picking up changes to promote people's well-being.

Staff were responsible for cooking meals. Each unit had its own weekly menu. The menu was person centred and took account of people's likes. The menu was displayed on notice boards in units. People were reminded at each meal time what was on the menu and given the option to have an alternative meal choice if they wished to. The meals provided and cooked food temperatures were recorded.

During the inspection people were offered meal choices and ate well. Drinks were offered regularly and people were offered support with meals where required. Fresh fruit was available. A staff member prepared iced coffee on a warm day for people which they enjoyed.

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A relative commented "Meals are cooked by permanent staff and they are excellent when we see them, usually at weekends. Unfortunately, sometimes [person's name] refuses meals. Another relative commented "The quality of the meal depends on which staff member is on shift and has cooked it. Some staff take pride in cooking a nice meal but not all staff do" They went onto say that they did know if their family member got the diet they required and that their individual preferences are not given any consideration. This was because their family member was given food they knew they did not like. They commented "I mention this to staff, nothing changes." This was fed back to the provider to explore further with the relative and their family member.

The service was purpose built. It was homely and welcoming with various arts and crafts displays throughout the service. Areas of the home such as the kitchen in some units showed signs of wear and tear such as the worktops being damaged. The service had a refurbishment plan in place which showed details of work to be carried out and dates to be completed. However, the majority of the work required to be carried out in 2017 was not completed. This was fed back to the provider to act on.

Requires Improvement

Is the service caring?

Our findings

Relatives told us the permanent staff were kind, patient, helpful, welcoming and caring. They felt confident when permanent staff were on duty their family member received compassionate care.

Relatives commented "Care is good but only excellent when permanent staff are available and engaged with residents." "Good staff get involved with residents and make their life a dream." "Some bank staff are good, but agency staff do not engage enough with residents and should be trained by Epilepsy Society before being assigned to a resident." "Some regular agency staff are getting better but highly trained staff are needed for all these severe epilepsy residents." "Permanent staff do try their best to care for [Person's Name]. Their fundamental sincerity to give good care is there." "Permanent Staff do care and try hard to engage with residents whenever they can." "There are some caring staff in [units name], particularly one staff member, who is one of the few, who seems to have an empathy with [person's name}."

A health professional told us they were pleased with the level of care Russell House provided to people. Another health professional told us staff were very caring and sensitive to the parents of both new admissions. They told us they had positive experience of observing and working with two support workers in one of the units. They commented "The staff members involved were very sensitive, caring and responsive during a joint intervention with myself and the Physiotherapist. They followed up on all we had suggested to good effect. They were extra responsible and you could see that they communicated very well with each other."

We saw that some staff were kind and considerate in their approach to people. They engaged with people, gave them eye contact and provided them with explanations, distractions and reassurance. A staff member told us that regular staff understood people's needs and knew them well.

However, we observed some negative interactions also. At lunchtime on one unit an agency staff member sat with a person to support them with their meal. They did not engage with the person throughout. Instead they chatted with another person at the table and other staff in the room. They did not provide any explanations to the person and instead attempted to put spoonful's of food in their mouth. The person was squeezing a ball and they attempted to put it in their mouth. They then got hiccups. The staff member laughed at them on both of those occasions as opposed to supporting them in a positive and caring way.

Another agency staff member stood over a person to assist them to finish their lunch. There was no indication the person needed that support as they had up to that point been feeding themselves. They later supported another person with their lunch and failed to clean the person's mouth after they had finished eating and prior to having their drink.

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On the second day of the inspection we overheard a staff member telling other staff members about a person's toileting needs during the day trip they had been on. They did this in the corridor and in the person's presence with no consideration for confidentiality or the persons privacy and dignity.

The provider confirmed after the inspection the individual staff members had been spoken with and they had enlisted the learning and development team to carry out observations of staff practice to address poor practice.

It is recommended the provider has a system in place to monitor staff practice to ensure they work to best practice in supporting people to promote their privacy, dignity, confidentiality and always show respect.

People's care plans outlined people who were important to the person. They were supported to remember family members birthdays and special occasions. Relatives said they could visit at any time.

People's care plans included reference to risks with life skills and promoting independence. People required staff to assist them out in the community but they were supported to be independent within the home within a risk assessment framework. People were supported to make choices and day to day decisions on aspects of their care such as food, drink and activities.

People had ensuite bathrooms, with toilet, washbasin and shower. Each unit had a large accessible communal bath. These facilities helped support people's privacy. Staff we spoke with told us they would explain care to be given and seek the person's consent.

Information on advocates was made available to people. It was visible on notice boards and the deputy manager was aware how to access advocates for people if required.

The provider had policies, guidance and systems in place to promote people's confidentiality in line with the data protection act. The provider was aware of the General Data Protection Regulation (GDPR) which had recently come into force.

Requires Improvement

Is the service responsive?

Our findings

Care plans contained a 'one-page profile' including 'What's important to me' and 'How best to support me'. Care objectives included sections on consent to care, eating and drinking, personal hygiene, toileting, communication, maintaining a safe environment, and mobility. A relative told us they believed their family members care plan had not been followed as the level of supervision the person required was not maintained and regular staff were not provided to support them. They confirmed they had already raised that as a complaint.

Some care plans were detailed, person centred and provided clear guidance for staff on the management of personal care and health needs such as epilepsy. Detailed protocols were in place to provide guidance to staff on the emergency management of individuals seizures. We observed a staff member respond to a person's seizure appropriately and followed their protocol to aid their recovery. However, two of the care plans viewed around the management of challenging behaviours lacked detail. A person's care plan on challenging behaviour referred staff to the person's "as required" medicine for managing their behaviour however there was no clear protocol in place on its use. It was not clear as to what challenging behaviour would result in the need for the "as required medicine" to be used. Antecedent-Behaviour-Consequence (ABC) Charts were in use but the care plan made no reference to these and when they should be completed. Another person's care plan included a 'Behaviour Summary', dated 2014. It detailed preventative measures including understanding the person's likes and dislikes but it was not clear what the triggers were for the person expressing particular emotions. The care plan described the person as "cross". It was not clear whether this was an opinion or based upon behavioural assessments and emotion indicators with input from relevant professionals. A second document entitled 'How to look after [person's name] without too much stress', refers to preventative approaches including hobbies and relaxation, general preferences and states the person confuses 'yes' and 'no'. This was dated 2011 and next review was due 2012 but there was no reviews recorded.

Care plans were reviewed monthly but generally it was recorded "no change". Where a change was noted the care plan was not updated. For example, in one person's care plan review it indicated there had been a re-introduction of sensory stories. The care plan made no reference to these, what that meant for the person, when they would be used and for what purpose. Relatives gave mixed feedback on their involvement in care plans and reviews. Some relatives confirmed they felt able to contribute to their family members care plan and were invited to reviews. A relative told us "We submitted parent contribution to care plan and wrote a suggested Health Passport." Other relatives were unaware of their family members care plan and if a review had taken place. A relative commented "Other than Continuing Health Care reviews, we have not been asked to attend any reviews about [person's name} care or been asked for input to care plans in the past few years."

A keyworker is a named member of staff who supported the person to coordinate their care. People had a named keyworker. Relatives confirmed this was the case. Relatives commented "The Keyworker my son has is fantastic", "[Person's name] has got a keyworker who is very good and they get along very well. Another relative told us the team leader was their family members key worker. They commented "We have a very

good relationship with keyworker but she is hard pressed and not always on duty in the flat."

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People were provided with written information in an easy read pictorial format to promote their understanding of procedures such as fire safety, activity programme and the complaints procedure. People's care plans included communication guidance and for some people communication passports were in use. Whilst we observed during the inspection people were offered a choice of drinks and food, prompts, pictures or aids were not consistently used to promote their communication and involvement in the service. Some staff sought to engage with people and responded effectively to their communication, whilst other staff did not support people's communication. in one person's care plan there was reference to a communication passport that must always be used to help understand the person's mood and learn about them, however, this was not observed to be used by staff with the person during the inspection.

It is recommended the provider works to best practice in ensuring person centred care plans are in place and that staff routinely refer to communication passports to promote people's involvement in their care.

People had individual programmes of activities which were person centred. The service had two activity workers, one who supported in house, on site and community activities whilst the other activity worker concentrated mainly on in house sensory activities with people.

During our inspection we saw people had access to a range of in-house, on-site and community activities which included a day trip to the seaside, meals out, a bakery session, a healthy eating group, an exercise session and a music group.

People we spoke with were happy with the activities provided. One person told us about a holiday they had been on and how they were planning another holiday. Some relatives were happy with the activities provided and were complimentary of the activity workers. A relative commented "The range and availability of activities is excellent. Recent skiing activity was excellent. Planned activities are on the wall and regularly updated."

Other relatives were dissatisfied and felt the high use of agency staff and lack of drivers impacted on the community access that their family members had access too. A relative told us their family member did not routinely get their daily designated community access time. They confirmed they had raised this as a complaint as it was impacting on their family members well- being. Another relative commented "[Person's name] is going out less due to staff shortage of drivers and medication issues." The provider confirmed a driver had been appointed. The progress and value of this will be reviewed at the next inspection.

People had access to an accessible and pictorial complaints procedure. It was displayed on notice boards throughout the home. Relatives confirmed they were aware of the complaints procedure. Some relatives felt their complaints were not always responded to in a timely manner or always suitably resolved.

The service had a complaints log in place. There was 11 complaints logged since the previous inspection in May 2017. The complaints log for 2018 did not show where complaints had been responded to if they had been closed and if any action was still required. A relative told us they had raised three complaints in June 2018 which had not been responded too. This was fed back to the provider to act on.

The service had a recent death. They worked closely with the palliative care team to ensure the person

received the right level of care, intervention and support. We saw in care plans viewed that discussions had commenced with some relatives about their family members wishes in the event of their death.

A health professional involved with the home told us staff had supported the person to die at the home as opposed to in a hospice. They confirmed staff provided around the clock care and had liaised with the palliative care team every step of the way They commented "I could not commend staff more for the care and compassion they offered this lady and her family. "

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection the provider was in breach of Regulation 17 of the Health and Social Care Act Regulations 2014. This was because records were not dated, accurate and complete. Quality auditing systems were not fully established and actions from audits completed. The provider sent us an action plan telling us how they would become compliant with Regulation 17 but compliance with Regulation 17 was not sustained.

At this inspection we again found records were not suitably maintained and accurate. Guidance and protocols in people's files were not always dated and reviewed. There was duplication of information and it was not clear which was the current guidance staff were to work too. In one person's file a document called "Things about me' document was written in the first person which suggested the person had been able to write it themselves or quoted what they wanted recorded. However, the Team Leader did not think the person had been involved in writing the document, rather staff had written this based on their knowledge of the person. Both documents were undated and were not signed off by management. This meant it was not possible to tell if records were up to date and accurate, and lacked evidence of the Provider's oversight.

The administration of prescribed creams were not signed to indicate it was given at the prescribed times. A cream that was directed to be applied twice daily had on most days been given only once. Another topical application due to be given twice daily had been given only once on 24 and 25 of June. The team leader told us they relied on the staff who supported the person with personal care to apply the creams. There was no indication that was followed up.

Mental Capacity Assessments were contradictory as to whether people had mental capacity or not and they were not clear as to what decision was to be made. A mental capacity assessment had yes recorded for the four questions about the decision. However, no detail was provided on how the answer had been arrived at, although the form stated, 'Please provide evidence of how you decided yes or no to each question'.

People's health appointment records did not include the time of the appointment and they lacked detail around the outcome of an appointment. For example, it indicated a person was prescribed antibiotics but not the name of the antibiotic, dose or frequency.

The malnutrition universal screening tool (MUST) used to calculate if a person was at risk of malnutrition for one person had been wrongly calculated. It showed the person was a low risk of malnutrition instead of a medium risk. Another person's MUST assessment was meant to be reviewed and updated monthly. It was not completed since March. 2018.

Fluid charts were not always fully completed. In one person's fluid chart it indicated they had cups of tea but not how much which meant the total fluid consumed could not be calculated. Another person's fluid chart was completed up to 12:45 (1050mls) on 23rd June and there was no entry for the 24 June 2018. We asked the team leader about this. They told us that the person had gone home overnight on Saturday 23 June. They confirmed the person was "back at half past three" on Sunday and the fluid chart should have been

completed for the rest of the day on the 24 June 2018.

Accurate records of the number of complaints logged were not maintained. A relative told us of three complaints they had made in June 2018, two of those were not logged. The complaints were reported to the organisation monthly but there was no evidence of learning from complaints as similar issues were being consistently raised about the staffing levels, quality and skills of agency staff, medicine administration, failure to turn up for GP appointments, community access and cleanliness of people's bedrooms.

Staff supervision and induction records were incomplete and disorganised. Some one to one meetings were recorded on a diary page whilst formal supervision records were not routinely stored in staff files. They were unable to be located during the inspection. There was no audit trail for induction records with some staff keeping their own, others kept at the service and no one having an oversight of whose inductions were completed.

Keyworkers were required to complete monthly reports. On one unit the monthly keyworker reports on file were dated 2017. The team leader was unsure where more recent ones would be or if they were completed. However, some current information such as ABC charts were archived whilst older information dating back to 2012 was left on file.

Aspects of the service were being audited such as care plans, medicines, catering, health and safety and infection control. The service reported monthly to the organisations key issues such as the number of safeguarding referrals, accident and incidents, complaints, staff supervisions, appraisals and vacancies. However, as some records were not accurate such as the complaints log and staff supervisions, the monthly reports were not accurate and a true reflection of what had happened in the service. The provider carried out quality monitoring visits. A visit was carried out in November 2017 and January 2018. The quality monitoring visit report for November 2017 had picked up some of the issues we found in relation to supervisions, inductions and records such as mental capacity assessments. The visit in January 2018 showed some improvements but concerns remained. The provider confirmed the quality manager or the nominated individual had carried out weekly visits to the service to continue to support and bring about improvement. These had been taking place from February 2018 onwards but improvements had been slow and were still underway at the time of this inspection.

These are continued breaches of Regulation 17 of the Health and Social Care Act Regulations 2014. This was because records were not fit for purpose and systems and processes in place to monitor the service had not brought about improvements in a timely manner.

The registered manager had left the organisation the week prior to the inspection. Their departure was planned and the provider had already commenced the process of looking to recruit another manager. There was a deputy manager and each unit had a team leader. There was at least one shift leader on each unit with some units having a maximum of two shift leaders. The provider told us "Whilst the service is short of shift leaders, we do have a number of trained medication givers to maintain one on each flat during the day and at least two at night. We are working on increasing this." A team leader told us there were sometimes "No shift leaders on duty on day shifts - the issue is raised for many years with management." They (staff) understand there is huge pressure on me. They know how it is."

We received mixed feedback on the management of the service. Staff told us the manager and deputy manager were accessible, approachable and always willing to offer guidance and support. Some staff felt the management were overwhelmed with their role and therefore things did not always get done. Staff felt the high turnover of staff and lack of permanent staff had a huge impact on the managers ability to manage

the service.

A staff member commented "Expectation from higher management is that everything is up to date but we don't have time. Forms change, sometimes you don't know why." Another staff member told us "I feel supported within the network of team leaders and (deputy manager). Within the Society, there needs to be a lot more support and understanding." They added "I do love my job." Staff told us changes were introduced without consultation "It's brought in – deal with it. Why can't there be collaborative working?"

Relatives were concerned about the recent departure of the registered manager. Relatives commented "The deputy manager is excellent, they keep the place afloat." "The deputy manager is excellent but overworked, particularly now the registered manager has left. Upper management are failing in duty to recruit suitable permanent staff with the excellent quality needed or provide enough training to bank and agency staff for them to be able to engage with residents." "Recruiting and retaining good staff needs to be addressed with some urgency. Recruiting a Manager, who will inspire staff and who staff can respect and take guidance from is essential". They went onto day that "Senior Management need to recognise that staff in Russell House have a very responsible job caring for very vulnerable people with a medical condition and should pay them well above the going rate for general support workers." Another relative felt the organisation was trying new things to recruit staff and found senior managers of the organisation generally receptive to feedback.

A health professional involved with the home commented "The house Manager, who has just left, was effective as a manager and supported her teams well. She communicated well with the therapy team and was always receptive of input. Her deputy, is also responsive to residents' and teams' needs and advocates strongly for them." Another health professional told us the registered manager was very effective, and communicated very well with them and the therapy team.

At the previous inspection a recommendation was made that the provider needs to have a system in place to satisfy themselves that staff regularly update themselves with people's care needs and risk assessments. At this inspection we found there was still gaps in staff signing to say they had read and understood people's care plans. In one file viewed only five out of 11 staff had signed to say they had read the person's care plan.

Systems were in place to promote communication within the team. A daily handover record and shift planner was in use. These were used to record which people staff were supporting and observing. It outlined which staff were responsible for other tasks such as medicine administration, cooking and appointments. A communication book was in use on each unit. The purpose of that varied from unit to unit. On one unit where it was viewed it was used to inform staff on key changes in the unit or in individuals. On another unit it was used to express frustrations at tasks not been done. Staff told us communication in their units was generally positive however they felt there was a lack of communication, joint working and team working across the home which impacted on people. This was because staff objected to being moved across units and refused to do tasks required of them. We saw this was discussed at the April team meeting but there was no evidence this had been followed up on and monitored.

The provider confirmed unit team meetings should take place bi- monthly. Minutes of all the meetings were not available at the inspection. After the inspection we were sent further sets of minutes. The minutes viewed showed meetings were not always taken place in line with the organisations guidance on meetings. The whole home team meetings were scheduled to take place monthly. The minutes of the whole home team meeting minutes in April 2018 had raised issues about handovers not been inclusive of all staff on duty. There was no indication this was followed up and reported on at subsequent meetings.

A health professional involved with the service told us "Communication and information sharing, especially

email correspondences, is sometimes a challenge for staff. The team leader, is aware of the problem and is actively putting measures in place to improve the situation. This problem stemmed from the fact the unit were required to respond to a high increase in health care needs of their residents and provide care to a new resident, all of which drew their full attention and energy. "

Systems were in place to get feedback on the service. Monthly resident meeting took place which were facilitated by one of the activity workers. The minutes were developed in a pictorial format and included discussions on forthcoming activities and events as well as reinforcing procedures to people such as the fire alarm, complaints and what safeguarding means. Family meetings took place but the frequency of them varied. The last family meeting had taken place in March 2018 and one was scheduled to coincide with their annual barbeque in July 2017.

A relative commented "There are Russell House meetings held with the Manager, Deputy Manager and Families several times a year, when issues are raised but how well the issues are resolved I cannot say as mainly they have concerned the recruitment and retainment of staff, which remain on-going issues."

The provider told us the annual surveys are completed from August to December of each year. The last relative survey was completed in December 2017 and a staff survey was completed in October 2017. The service user survey responses were undated. An action plan was in place to address issues raised from the surveys. The provider told us they linked to the home's action plan.

The service was aware of their responsibilities under the Health and Social Care Act 2008 to notify CQC about significant events. We used this information to monitor the service and ensure they responded appropriately.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not suitably maintained and the governance of the service had not brought about improvements.

The enforcement action we took:

Imposed positive conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not suitably inducted, trained or supervised.

The enforcement action we took:

Imposed positive conditions.