Mr & Mrs A J Bradshaw

Rydal House

Inspection report

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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 on 19 July 2016 and was unannounced.

Rydal House is a care home for people with learning disabilities or autism spectrum disorder. A maximum of eight people can use the service. At the time of our visit, eight people lived in the home.

The service had 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.

Staff understood safeguarding policies and procedures, and followed people's individual risk assessments to ensure they minimised any identified risks to people's health and social care. Checks were carried out prior to staff starting work at the service to reduce the risk of employing unsuitable staff. Staff received training to help them meet people's needs effectively.

The provider understood the requirements of the Mental Capacity Act and Deprivation of Liberty safeguards and the service complied with these requirements. Medicines were administered safely to people, and people had good access to health care professionals when required.

There were enough staff to meet people's needs. People enjoyed activities within the home, and enjoyed going out to the pub, cinema, undertaking sporting activities, and going on other day trips. They had also been supported to find employment.

People received care and support which was tailored to their individual needs. They enjoyed the food provided, and helped with meal planning, preparation and cooking.

Staff were motivated to work with people who lived at Rydal House. People and staff enjoyed good relationships with each other which were supportive, friendly, and caring.

The registered manager was open and accessible to both people and staff. There were sufficient informal and formal monitoring systems in place to ensure quality of service was maintained. People and relatives felt able to raise concerns.

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.

There were enough staff to meet people's needs. Recruitment practice reduced the risks of employing unsuitable staff. The risks related to people's health and social care were identified and managed well. People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff had been trained well to support the needs of people who lived at Rydal House. They understood and worked within the principles of the Mental Capacity Act. Where possible, people were involved with planning and cooking meals, and told us they enjoyed their meals. People's healthcare needs were met.

Is the service caring?

Good

The service was caring.

Staff had a good understanding of people's needs, and had positive, supportive relationships with people who lived at the home. People's dignity, privacy and human rights were respected by staff. Visitors were welcomed at any time.

Is the service responsive?

Good

The service was responsive.

People were supported to take part in activities which reflected their preferences and interests. People had good opportunities to give feedback about the service, and people and relatives felt able to raise concerns.

Is the service well-led?

Good

The service was well-led.

The provider made regular informal visits to the home, and the registered manager had checks in place to assure the quality of

care. Management were seen as open and supportive of people and staff.

Rydal 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.

The inspection took place on 19 July 2016 and was unannounced. One inspector undertook the inspection.

We looked at information received from statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The information in the PIR reflected what we saw during our visit.

On the day of our visit we spoke with six people who lived at the home, the two staff on duty, and two other members of staff by telephone. We also spoke with the registered manager. After our visit, we spoke with two relatives and the provider by telephone.

We reviewed three people's care plans to see how their care and support was planned and delivered and looked at the medicine administration records of people. We looked at other supplementary records related to people's care and how the service operated. This included checks management took to assure themselves that people received a good quality service, complaint records, and accident and incident records.

Good

Is the service safe?

Our findings

There was enough staff to care for people safely. Eight people lived at the home, most of whom had low dependency needs. Two staff were on duty during the day and one member of staff was on duty at night time. People and staff told us this was usually enough to meet people's needs although sometimes, if a member of staff had to take a person to an appointment outside of the home, it meant people who were in the house only had one member of staff to support them. The registered manager informed us they were recruiting a bank member of staff (a staff member who covers staff absences), and if necessary, they could call on staff from one of the provider's other homes to fill any staffing gaps.

People were protected by the provider's recruitment practices. There were no, new staff at Rydal House. Newer staff had previously worked at the provider's other homes. We checked the recruitment records of two of the most recently recruited staff. We found the registered manager checked staff were of good character before they started working at the home. The provider obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. It was previously known as the Criminal Records Bureau (CRB). The registered manager confirmed staff were not able to work alone until the recruitment checks had been completed.

The administration of medicines was managed safely and people received their medicines as prescribed. One person gave permission for us to observe them having their medicines administered. We saw this undertaken safely. People told us the staff always gave them their medicines at the right time. We looked at the storage of medicines. Whilst medicines were stored in two lockable cabinets, and were stored safely and securely, we were concerned that they were in an unsafe place for staff. Staff had to stand on the top steps of a set of stairs to open and retrieve the medicines from the cabinets. We discussed this with the provider who told us they would consider where best to re-site the cabinets.

The registered manager supported people, where possible, to administer their own medicines. One person took responsibility for one of the medicines which had been prescribed to them. There were systems to check these medicines were taken by the person.

We looked at the medicine administration records (MAR). These had been completed correctly. There were systems to check whether medicines had been administered as prescribed. We looked at medicines given on an 'as required' basis. There was clear and comprehensive guidance given to staff to inform them why these medicines had been prescribed. Records showed when staff should consider giving people these medicines and the signs and symptoms which indicated the person might require them. This reduced the risks of staff having an inconsistent approach when administering these medicines to people.

People were safe and protected from the risks of abuse because staff understood their responsibilities and the actions they should take if they had any concerns about people's safety. We gave staff different scenarios of people not being safeguarded from harm and asked them what they would have done in those situations. Staff knew what they should do and understood their roles and responsibilities in each of the

scenarios. They knew the importance of informing their manager and external authorities if they had concerns a person was unsafe. The registered manager was aware of their responsibility to notify us when there had been concerns raised about the safety of people.

The service had good financial safeguards to protect people from the risk of financial abuse. This included procedures where two staff booked money in and out of the home, and checked the remaining balance against receipts. A person told us, "Staff look after our money. If we want it out, staff get it and they sign for it." We were told only certain members of staff had access to people's money to provide further financial security and safety.

Accidents and incidents were always logged and appropriate action was taken at the time to support the individual. One person told us of a minor accident they recently had. We saw this had been logged with the details of the accident in the accident log. Action was taken to check for trends or patterns in incidents which took place. This was so that any action required to help prevent them happening again could be taken.

The registered manager had assessed risks to people's individual health and wellbeing. The risk assessments explained to staff what the risks were to each person and the action they should take to minimise the risks. Sometimes the written risk assessments informed of the risk to a person but did not give enough information to help staff understand the background to why a person was at risk. However, the risk was identified and actions were put in place to minimise the risk of harm.

The premises and equipment were safe for people to use. However, in one of the bedrooms we looked at, furniture looked in poor repair and some parts of the wooden front door frames and front bay window looked rotten. The provider told us they were in the process of replacing all of the windows in their group of homes with double glazed windows and the frames would be done at the same time. They were unaware of the bedroom furniture being in poor repair and told us this would be replaced.

The provider had taken measures to minimise the impact of potential unexpected events happening at the home. Their contingency plan to deal with, for example, emergencies such as fire and flood contained clear instructions for staff to follow in the event of emergencies. Staff were aware of these plans.

Good

Is the service effective?

Our findings

Staff had received training to meet people's needs. People told us they felt staff knew how to support them safely. On the day of our visit, just before our arrival, a person had experienced a seizure. Staff were aware of their responsibilities and their practice demonstrated they understood what they needed to do. The person told us they were happy with how staff had acted to support them during and after their seizure.

Staff had received all the training considered mandatory to meet people's health and social care needs. This included training such as infection control and food hygiene. We also saw that training had been provided to meet the specific needs of people in the home. These included people with learning disabilities, autism and dementia. We saw staff had a good understanding of how to support these people.

Staff, including the registered manager had undertaken training such as National Vocational Qualifications in health and social care to further develop their practice as social care workers. The registered manager had recently completed an NVQ level 5, and staff had completed levels 2 and 3. These were in line with the expectations of their roles and responsibilities.

As there were no, new staff at the home, we asked the registered manager to outline how staff were inducted to their roles and responsibilities when they first started working at Rydal House. We were told staff were informed of the policies and procedures of the home, and worked alongside more experienced staff to support them in their work. They said, as there was only one person on duty at night, for safety reasons they would not have a new member of staff work on their own at night until they felt confident to work alone and understood the needs of the people they supported.

The registered manager was not aware of the Care Certificate which replaced the previous 'common induction standards' for new staff. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. There had been no staff new to the service since the Care Certificate had been introduced. The registered manager told us they would ensure any new staff completed this training.

Staff received ongoing help and support from their seniors and registered manager. Regular individual meetings (supervisions) were planned into the diary to give staff the opportunity to discuss their role and responsibilities and to receive feedback about their work performance.

We checked whether the provider worked within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager understood their responsibilities under the MCA. They and staff had a working knowledge of the MCA and where there were concerns that people did not have the capacity to make specific decisions, there had been assessments with relevant professionals to determine whether this was the case. For example, one of the care records showed that healthcare professionals had determined a person did not have the capacity to understand or retain information relating to their health. This meant the staff and healthcare professionals had to act in the person's best interest.

People were asked their consent before any care act or support was given. For example, on the day of our visit, a person went to the dentist for dental work. They had given their consent for the treatment and this was checked again before they went to attend the appointment. People were encouraged to show their consent by signing their care records.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made to the local authority responsible for the approval of the DoLS.

People received food and drink which met their needs. People were involved in menu planning so meals reflected their wishes and preferences. A person told us, "We get asked what we want. If we chose pasta, we get pasta. Staff get us to sign that we've chosen it." Where possible, people were involved in preparing and cooking their own meals. During our visit, we saw one person made toast for breakfast and another made lunch for people. Lunch included a salad, sandwiches, meatballs and ravioli to meet the individual requests of people. The person enjoyed making the meals for people and took great care in the preparation. People had a range of hot and cold drinks available to them. A water container was filled with squash in the lounge so people could easily access a cold drink. People also made themselves hot drinks of tea and coffee, or staff supported them where necessary.

Every person who lived at the home was routinely weighed to determine whether they had increased or reduced their weight. We discussed whether this was necessary as not all people who lived at the home were at risk, and it was not person centred practice. The registered manager agreed with this and said they would look at only monitoring those who were at risk. We saw where people were at other risks related to nutrition, the registered manager had sought the advice of a dietician, and changed the diet of the people concerned.

People received support to maintain their health and wellbeing. People saw other health and social care professionals when necessary to meet their physical and mental health needs. On the day of our visit one person had seen a dentist. People also told us they had seen the GP and had been to the opticians. A relative told us staff had involved a specialist nurse to meet the changing needs of their family member.

Good

Is the service caring?

Our findings

All the people we spoke with were happy living at Rydal House. Relatives we spoke with, told us when their family members visited the family home, they couldn't wait to get back to Rydal House. One told us, "Staff have always been very nice people. They treat the residents nicely." Another said, "They do look after [Person's name] and they are happy."

During our visit we saw a good rapport between people who lived in the home and the staff who supported them. We also saw people treat each other with kindness and consideration. For example, people understood that a person who had visited the dentist that morning was in pain and they looked after them; they also knew another person had a seizure earlier in the day, and were taking care of them too. One person gave another a hug because they could see the person was upset.

Staff told us they felt that Rydal House was like a family. One staff member said, "It is nice and homely and the residents are lovely. I enjoy my job." Another told us, "We're a proper little family." A relative confirmed that the home was," family orientated." We found this ethos was demonstrated with the photos in the lounge. People who lived at Rydal House had recently been on a holiday to the Lake District. A group photo had been taken and this had pride of place on the mantel piece in the lounge to remind people of the holiday they had enjoyed.

People were involved in planning their care and support and told us they were involved in making day to day decisions. We saw where people were able, they were involved in making other decisions such as for holiday destinations, and day trips. The registered manager had set up a key worker system where each person was designated a specific worker who would support them in developing their care plans. People who lived in the home also took part in monthly 'residents' meetings, the minutes of which demonstrated that people had an active say in how they wanted to live their lives.

During our visit we saw people treated with respect. Staff listened to what people had to say, and responded to them respectfully. For example, one person indicated they needed to use the toilet. The staff member quickly took action to support the person in going to the bathroom and at the same time preserved their dignity. Staff used speech, pictures and 'Maketon' (sign language used with people who have learning disabilities) as communication methods to ensure people had a voice and were listened to.

Staff promoted confidentiality with people who lived in the home, reminding them to be cautious about giving information about people who lived in the home, to others who did not live with them. Confidential information about people was kept secure in a locked office.

People were supported and encouraged to maintain relationships important to them, and visitors were welcomed at the home. People told us about their visits to their families and to see their friends, boyfriends or girlfriends. Relatives and friends were also welcome in the home.

There was no one who lived in the home who required the support of an advocacy service, but the registered

manager told us they had been used in the past, and would use them again if people needed it. Advocates support people to speak up about what they want, working in partnership with them to ensure they can access their rights and the services they need. Advocacy information was available to people if required.

Good

Is the service responsive?

Our findings

Prior to being admitted to the home, people's needs were assessed to ensure the service could meet and be responsive to their needs. The service listened to people's views or those of their representatives about what support they wanted and needed, and how they wanted to live their lives.

Staff knew the people they supported well. Care plans included information entitled 'Listen to Me' and 'This is Me'. This gave staff an understanding of people's likes and dislikes and their personal histories to help them build relationships with people and support people in ways they preferred. Care plans were reviewed every three months or sooner, if the person's needs changed. This was to ensure staff continued to respond well to their needs. One person's needs had changed significantly. Staff had involved external healthcare professionals to help them respond to the person's higher dependency needs. Staff had also undertaken further training and requested additional hours to support the person to ensure their needs were met.

Whilst the care given to people was very much based on the needs of each individual, this was not always reflected in the care records. Most of the care records, whilst having the necessary information about people, were not written from the perspective of the individual person (person-centred). However, the registered manager showed us newly written care plans which were much more individualised. They said they would be looking to changing all care planning to reflect this model.

People were encouraged to develop and maintain their independence. One person told us they phoned for the taxi without support from staff. A member of staff told us they tried to maximise people's independence. They told us of a person, who, prior to living at the home, had their family member help them when they went to the bathroom. Now the person could go to the bathroom on their own, with staff standing outside as a precaution. This was in case they required assistance.

People were supported to follow their interests and hobbies and take part in social activities that were meaningful to them. Some of the people who lived at Rydal House went out to work on a farm, supermarket and a local café.

People told us they enjoyed going to different pubs and clubs and eating out. They went to the cinema, played bowls, and participated in sport at a local venue. In the home they were involved in activities such as baking, gardening, jewellery making and looking after the home's rabbit. One of the night staff had taught some people how to knit and we were shown a lovely knitted teddy made by a person who lived at the home. They told us they were going to give this to their Nan.

Birthdays and occasions such as Easter, Halloween, and Christmas were celebrated with parties. During our visit, people showed us an 'Activity' folder with photos of the many and varied activities and achievements of people in the last year. This included a holiday to Prestatyn and another to the Lake District. The folder had been developed by the activity co-ordinator in the home.

Three people showed us their bedrooms. We saw these had been personalised and reflected their interests

and hobbies. One person showed us the football team they supported, another, their range of soft toys, and another, the arts and crafts they had made including a 'heart' to hang on the wall.

People and their relatives told us they would feel able to complain about the service if they were not happy with any aspect of care and support provided. The Provider Information Return informed us that no formal complaints had been made in the last 12 months and seven compliments had been received. We looked at the complaint policy. It informed people about who they could speak with within the home about concerns but did not give people the correct information about furthering their complaint if they were not satisfied with the outcome. People were told to contact us when it should have been the local authority who funded their care. The registered manager told us they would change this immediately.

We saw compliments received into the home. One was from a healthcare professional who said there was, "Always a smile and welcoming staff, enthusiastic about the care of the clients."

Good

Is the service well-led?

Our findings

People and their relatives spoke positively about Rydal House and the staff that worked there. This included the registered manager who they felt was approachable. A relative told us, "I do pop in, they don't know I am coming, but I don't find any problems."

The provider of Rydal House is a husband and wife partnership and family business. The provider is also a registered manager in one of the other three homes run by the partnership. Both partners regularly visited the home to talk with the staff and people who lived there. This was to ensure they received a good quality service and to check the premises were safe.

The visits were not formal and there was no record to support the checks they had made and any actions taken as a consequence. We spoke with the provider by phone about this. They acknowledged they had not previously undertaken formal monitoring visits but said they would put these in place so there would be a written record of what they looked at and any improvement actions taken.

The provider told us they saw people who lived in their care homes as part of a family. This was echoed by staff and relatives.

Rydal House had a registered manager. The registered manager had been in post for two years. They had worked hard to improve the confidence of staff who worked in the home and encouraged staff to develop their skills. As a consequence of this, some management responsibilities had been delegated to senior staff. The senior staff we spoke with welcomed their additional responsibilities. The manager told us, "Staff are proud to be here, they've got pride in the place, we are lucky to have a good bunch of staff." During our visit we saw staff being enthusiastic and proud of what they did to support people.

The registered manager understood their responsibility to send us statutory notifications but was not aware of the need to inform us of Deprivation of Liberty applications and their outcomes. They told us they would ensure these notifications were sent.

The manager encouraged open communication with people, staff and visitors. Staff we spoke with felt supported by the registered manager. One staff member told us the registered manager was, "Brilliant", and that she was always there for the staff. Another told us the home had improved since this registered manager had been in post. We saw people feeling able to speak directly to the registered manager about their feelings and what they wanted to do with their day.

Staff were supported in their roles through regular individual meetings (supervision), team meetings, and senior meetings. The registered manager had incorporated the CQC five key areas of 'safe', 'effective', 'caring', 'responsive' and 'well-led' into the supervisory process to check that staff were working to meet all five key areas to provide a quality service.

Levels of leadership were not always clearly defined in the home in that the registered manager received

supervision from the deputy manager. We discussed this with the provider as we were concerned that the manager was being supervised by a member of staff who they managed. The provider acknowledged our concerns and agreed to formalise supervision with another person in the organisation who was in a senior role.

People who lived at the home were regularly provided with opportunities to tell staff about what they liked and did not like about the home. This was through key worker discussions and through resident meetings. There was also more formal surveys conducted yearly. The results of the last survey were very positive. The Provider Information Return informed us that one person had commented, "Rydal House is clean and I like the food, the manager is good."

The registered manager had systems to ensure people were protected. For example, medicines, hygiene, and fire safety were routinely checked.