Randale Care Limited

Redgate House Residential Home

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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 6 August 2018 and was unannounced. This was the first inspection of this service since registration with the Care Quality Commission.

Redgate 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.

The service provides care and support for up to 20 people living with dementia. On the day of our inspection there were 20 people living in the service. Redgate House had shared communal areas and individual bedrooms on the ground and first floors. There was a secure garden.

There was 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.

Care plans did not always contain suitable risk assessments. Risks had not always been identified and risk assessments contained contradictions which meant that we were not assured that risk were managed safely.

The service had not appropriately applied for authority under the Mental Capacity Act 2005, Deprivation of Liberty Safeguards. This meant that people may not be supported in the least restrictive way possible.

The provider had recognised that the service needed a registered manager dedicated to managing Redgate House. The current registered manager was responsible for overseeing Redgate House and the provider's other service. A new manager had been recruited and was working their probationary period. As part of their probation they were updating care plans with suitable risk assessments. However, this action had not been taken in a timely manner to ensure people were not receiving care and support whilst their risk assessments were deficient.

Family members told us that their relative was safe living in the service. There were systems in place to protect people from abuse. The provider followed safe recruitment practice. Essential documentation was in place for employed staff. Staff received supervision and said they were supported in their role. There were suitable numbers of staff to be able to provide the support personal care people had been assessed as needing.

Care plans did not always contain information about people's wishes regarding end of life care. We have made a recommendation about end of life care planning.

People had sufficient food and drink and were provided with choices at mealtimes. Meals and mealtimes promoted people's wellbeing, as they were relaxed and people were given choices.

There were a variety of activities which people could participate in according to their interests. The service organised outings to places such as the cinema. Outside entertainers regularly visited the service.

People were supported with compassion, dignity and respect. Staff knew the needs and preferences of the people they supported. Relatives were welcomed into the service and some participated in providing entertainment.

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 consistently safe.

Risk assessments did not always contain a consistent reflection of people's risks or show what had been put in place to address any identified risk.

Staff knew how to safeguard people from the risk of abuse and how to pass on concerns to relevant agencies.

Medicines were managed safely.

There were systems in place to ensure staff were recruited safely. Sufficient staff were employed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider was not meeting the requirements of the Mental Capacity Act 2005 (MCA) in relation to the Deprivation of Liberty Safeguards.

Care staff received induction and ongoing training and support.

People were supported to access healthcare professionals.

The environment had been designed to be dementia friendly.

Is the service caring?

Good

The service was caring.

People were treated with respect, kindness and compassion.

Personal and confidential information about people was treated in confidence.

Staff knew people's needs well.

Is the service responsive?

Good

The service was responsive.

Care was assessed and planned with the full involvement of people and relevant others. Care plans clearly reflected people's needs and wishes.

People were given opportunities to engage in activities which interested them.

People had information about how to complain and were confident about doing so if they were unhappy about anything.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems were not always effective in identifying shortfalls.

The service had identified some concerns but prompt action had not been taken to ensure concerns did not continue.

There was an open culture in the service. Relatives and staff were engaged with improving and developing the service.

The provider had a development plan to improve the service.

Redgate House Residential Home

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 was a comprehensive inspection which took place on 6 August 2018. The inspection was unannounced and carried out by two inspectors.

Before the inspection we looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public. The provider was not requested to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection visit we spoke with the provider's general manager, the registered manager, a recently recruited member of staff recruited to become the manager and three care staff. People living in the service were not able to discuss their care with us but we observed interactions between people and care staff. We also spoke with five relatives of people living in the service. We reviewed three people's care records, policies and procedures, records relating to the management of the service, training records and the recruitment records of three care staff.

Requires Improvement

Is the service safe?

Our findings

The service had not assessed risks to people from receiving care and support and put actions in place to minimise these risks. For example, one person had been assessed as at high risk at falls and records showed they had fallen whilst living in the service. No action had been taken to mitigate the risk of this person having further falls. The same person's care plan showed that they required minimal support when getting into bed and moving from bed to chair. However, it also recorded that the person required a lot of assistance when moving in a wheelchair. The care plan did not record what assistance was required. During the day of our inspection we observed this person moving around the service independently. The contradictions and lack of information in the care plan meant that the person may not get the support they required.

Another person had been assessed as independent with eating. However, during the inspection we saw care staff encouraging the person to eat and also to cut up their food. They were clearly aware of what support the person needed. However, there was no clear risk assessment in their care plan as to the support they required and why they required this support. This person had a diagnosis of dementia. The care plan did not contain a risk assessment as to how they managed their food and how their swallowing was monitored.

Where people lived with specific conditions there was no risk assessment in place to show how risks relating to the condition were managed. For example, one person had a diagnosis of epilepsy. There were no risk assessments in place which showed how the risks associated with any seizures were managed. There was a record of this person having an unwitnessed fall with a suggestion from the paramedic that a referral should be made to the falls team. There was no evidence in the care plan that a referral to the falls team had been made or considered by the service. There had been no consideration of a relationship between the fall and the person's epilepsy.

Records showed that equipment was serviced regularly including the lift and fire equipment. Electrical equipment had been checked for safety. People had personal emergency evacuation plans (PEEPs) which meant staff had an overview of what support each person would require if they needed to leave the building in an

Relatives told us that they felt their family member was safe from abuse. One family member said, "I have not seen anything that caused me concern." Another person's family member had raised a concern which they told us, "Was dealt with promptly and effectively." Staff had received safeguarding training and were aware of the different types of abuse. They were aware of their responsibilities to keep people safe from the risk of abuse or harm. Staff knew where to report any suspicions of abuse and how to whistle blow if they had any concerns about the quality of care being provided. The provider's policies on safeguarding vulnerable adults and whistleblowing gave staff guidance on how to report any concerns.

People's relatives had mixed views as to whether there were sufficient staff. Some told us they believed there were enough staff but others raised concerns. These concerns centred around staff not being available to let visitors in and out. The general manager told us that they used people's dependency assessments to calculate staffing levels. We asked them if, in view a recent review of care plans where a number of people's

dependency scores had been revised downwards, staffing levels would be reduced. They told us that staffing levels would not be changed as they had a minimum level they would not go below. Staff we spoke with had no concerns about staffing levels. We saw staff responded promptly when people requested assistance or were seen to need support. They had time to sit and talk with people and engage with activities.

There were recruitment procedures where checks had been completed to help ensure staff were suitable to care for and support people. These included checks with the disclosure and barring service (DBS) which checks if applicants have a criminal record or if they are barred from working with vulnerable people.

Medicines were managed and administered to people as prescribed. The registered manager demonstrated the provider's system for recording medicines storage and administration system to us. There were clear ordering and checking procedures. This ensured that people's medicine administrations had completed accurately. Staff had completed training on the safe handling of medicines and their competencies to administer medicines were checked annually to ensure their practices were safe. Regular audits were undertaken by the registered manager to check on the management of people's medicines. The registered manager gave us examples of three people whose medicines, prescribed to reduce anxiety, had been reduced since moving into the service. We raised a concern with the registered manager that circumstances when people would require medicine to be given which had been prescribed to be given when required (PRN) were not described in sufficient detail to ensure it was administered consistently. The registered manager assured us that they would address the deficiency without delay.

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately, and hand sanitizers and moisturisers were available at points throughout the building. People's rooms and communal areas were clean and tidy. Good standards of hygiene had been maintained throughout the service and there were no unpleasant odours. The kitchen had received a rating of four in the local authority assessment. We asked the general manager why the service had not received the top rating of five. They told us that the assessment was carried out shortly after the service had opened and certain procedures were not fully in place. They told us that these were now in place and that they expected to get a five at the next inspection.

Accidents and incident were recorded. This included a description of the incident and actions taken. The registered manager told us that they monitored these to identify any trends.

Requires Improvement

Is the service effective?

Our findings

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.

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 authorisation 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.

Access and exit through the main door into the service and the areas of the service where people lived and received care and support were controlled by key pad access panels. The general manager told us that nobody living in the service had the code for the key pads. This meant that nobody living in the service was able to enter and leave as they wished. No DoLS applications had been made to the local authority to ensure this restriction on people's liberty were lawfully in place. We discussed this with the general manager and the registered manager. The registered manager and the general manager confirmed that DoLS applications should have been made as they would not allow anybody living in the service to leave independently. The general manager told us that this may have been partly because they had not fully understood their training. The general manager and registered manager confirmed to us that they would immediately put in the relevant applications.

Care plans did not always demonstrate that consent had been obtained from the relevant person or best interest decisions had been made appropriately. For example, one care plan recorded that a person did not have capacity. Consent forms in the care plan relating to the use of photographs had been signed by the person's relative. The care plan recorded that this person had the legal authority for the person's finances but not for their care and welfare which would have been relevant to this decision.

We observed staff offering people choices and obtaining their consent as they provided care and support throughout the day of our inspection. Examples included asking people where they would like to sit and if they wanted to participate in activities such as making a jigsaw.

People had their care and support needs assessed prior to moving into the service. The general manager told us that when they were assessing people before they moved into the service they considered if they would be able to meet that person's needs.

New staff received an induction into their role before they started employment. Induction training was completed in line with the Care Certificate. The Care Certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life. Induction training included an introduction to the service, the job role, going over important policies and procedures, and completing training in safeguarding, health and safety, infection control, dementia awareness and moving and

handling. Staff were appropriately supported through ongoing training, appraisal and supervision. One member of staff told us, "It's a pleasure to work in such a supportive environment." Records showed that refresher training was provided on a regular basis to staff which helped to ensure they were competent in those areas. The training matrix for staff showed that staff were up to date with their training.

A relative told us that their family member enjoyed the food and that the staff were aware of their dietary needs. They told us about a condition that their family member lived with which meant they could not eat pips or seeds and that the staff were aware of this. The general manager told us that nobody living in the service had been assessed as needing a referral to a speech and language therapist due to swallowing difficulties.

We observed the lunch time meal. There was a relaxed and sociable atmosphere. Some staff sat and ate with people, providing support as required.

People were weighed monthly to check that they were maintaining a healthy weight. The service also used the Malnutrition Universal Screening Tool to monitor when people were identified as at risk of losing weight. The registered manager told us that referrals would be made to the appropriate healthcare professional if a need was identified.

Relatives told us that their family member could access healthcare services when needed. A relative said, "They [service] will phone if a problem is brewing." At the staff handover staff spoke about the district nursing attending the service for a person. One relative we spoke with described how they had worked with the service and other professionals to identify the cause of a particular condition their family member was experiencing. However, another family member expressed concerns that the service did not pro-actively identify concerns saying, "They do not always take the initiative." They went on to say that they had requested that their family member was seen by an optician but this had not yet been done. We discussed the support the service received from other healthcare professionals with the general manager and the registered manager. They told us that a number of support agencies did not attend services in their area. This included the dementia intensive support team who supply support to people living with dementia. They told us that if referrals were needed they made these directly through the GP. Records we saw confirmed that GP referrals had been made.

The environment was bright, modern and dementia friendly. Corridors had road names to aid people find their way about. There were clear visual signs is in the communal areas to support people, for example identifying bathrooms and toilets. The service had used a recognised tool to assess if the environment was dementia friendly. People had easy access to a secure garden. On the day of our inspection visit we observed people accessing the garden freely and enjoying the sunshine.

Good

Is the service caring?

Our findings

Relatives told us that staff treated their family member with respect and compassion. One relative said, "I have nothing but praise for them and I was the one who was cynical at first." Another relative said, "All staff are very attentive. They are very friendly." We observed staff interacting with people in a respectful and caring manner.

Staff respected people's choices. We observed the activities co-ordinator speaking with people in a gentle manner, encouraging them to attend activities and trying to persuade them but respecting their wishes when they refused to do. We observed one person sitting on their own for much of the day. We asked staff why this person was not engaging with activities. They told us that this person liked to have time on their own on a Monday as they had visitors most other days.

Relatives also told us that they were always kept fully informed about people's care and were free to visit whenever they wished. It was evident that staff had formed good relationships with relatives who regularly visited the home. The registered manager told us that if a person's family had not visited them for a week they would telephone them to update them as to how the person had been.

During the inspection, we saw that whilst the staff were busy, they delivered care in a compassionate and personal way. We observed a number of positive interactions and saw how these contributed towards people's wellbeing. For example, we saw staff spending the time to talk with people and could see that good relationships had been developed. One relative told us how staff addressed their family member using a title which they had during their working life. They said that this always made the person smile.

Staff we spoke with demonstrated a good knowledge of the people they were supporting. This included their preferences as to how they wanted to receive their care and support and their backgrounds. This supported staff to engage people in conversation and meet their needs as they preferred. The general manager and registered manager told us that they had a stable staff team many of whom had worked in the service since it had opened hence they had known people the whole time they had lived in the service.

People were treated with dignity and respect. We observed staff knocking on people's doors and seeking permission before they entered people's rooms. Staff told us what they did to make sure people's privacy and dignity was maintained. This included keeping people's doors closed whilst they received care, telling them what personal care they were providing and explaining what they were doing throughout.

People's care records were kept in a locked cabinet in the staff room which had key coded access. This ensured that only those with the correct authority could gain access to them.

Good

Is the service responsive?

Our findings

Relatives we spoke with had varied views as to how much they were involved in their family members care and support. One person told us they felt very involved and described how they had worked with the service to identify and resolve a condition their family member had developed. However, another relative told us that they had had no involvement in their family member's care planning.

The general manager told us that relatives were involved in the initial care planning process and that regular reviews were held. However, they told us that after the initial care plan was in place reviews were less formal. Care plans we looked at showed that they had been regularly reviewed but did not demonstrate people's involvement. Care plans contained information on people's likes and dislikes. For example one care plan stated that the person liked to sleep in in the morning, liked to have a big breakfast and their preferred form of address.

During our inspection we observed people engaged in a variety of activities. This included individual activities such as colouring and jigsaws. We saw that these were available for people to pick up as and when they wanted. We also saw people were involved in a singalong. A member of staff was going from one person to another encouraging them to sing and dance with them if they wished. People accessed the secure garden freely and we saw people enjoying the outside space during the good weather on the day of our inspection. One person said their family member was, "Encouraged to do things but not forced. I think they go out to the pictures." The general manager told us that some people chose to help maintain the garden, carrying out activities such as watering the planters.

A number of outside entertainers visited the service. We saw pictures of a visit by a petting zoo and also posters for the forthcoming garden fete with community stalls. People had been involved in making things to sell at the fete. The general manager told us that they were planning to expand the service community involvement with visits from a mother and toddler group as people particularly enjoyed meeting children.

Relatives told us that they knew how to complain and would do so if required. They told us they felt the service would respond to their complaint and take the appropriate action. One relative gave us an example of when this had been done. They said it was, "Dealt with quickly."

On the day of our inspection nobody was receiving end of life care. One care plan we looked at contained detailed information with regard to people's wishes on their end of life care. However, another did not. The registered manager told us that people and their families were often reluctant to discuss this issue.

We recommend that the service seek advice and guidance from a reputable source regarding end of life care planning.

Requires Improvement

Is the service well-led?

Our findings

The provider had added Redgate House to their registration in June 2017. This was the first inspection of the service. The registered manager also managed another of the providers services. The provider's general manager told us that the provider had recognised the need for Redgate House to have its own manager. This was because one manager was struggling to manage both services effectively. They told us, "We filled far too quickly with the management we had." A manager had been recruited for Redgate House and we met them during our inspection. The general manager told us that when this person had completed their probation they would be applying to register as the manager. We received mixed feedback from relatives regarding the management of the service. One relative said, "I've got nothing but praise for this place. I can't speak highly enough of them." However, another relative told us there had been, "Teething problems."

The management team had recognised that care plans were not of a good standard and the new manager was working on these during their probation. They showed us how they were working to improve the risk assessments in the care plans and the overall quality of the care plans. However, the monitoring procedures and provider response had been slow which had resulted in people receiving care and support with poor risk assessments in place. Since the inspection visit the general manager has provided assurances that all care plans would be reviewed by the new manager within three months. They told us that as well as ensuring that the care plans were of a good standard this would mean that the new manager would get to know the people they would be responsible for.

Neither had the provider recognised that their practises with regard to the Mental Capacity Act 2005 (MCA) were not in accordance with best practise and legal judgments before we brought it to the attention of the general manager and registered manager at the inspection. Since our inspection visit we have been given assurances that the service has made the appropriate DoLS referrals to the authorising body. The regional manager has also told us that they will be sourcing further MCA training to ensure they are up to date with current practise.

Staff told us that there was an open culture in the service and that they could approach the management team if they had any concerns. One member of staff said, "I am very lucky to work here." They went on to say that they believed the care was good and that they would have no concerns if a family member moved into the service. Staff meeting minutes demonstrated that staff were involved in developing the service. For example, staff had suggested changes to people's choices for their tea time meal and these had been adopted. Minutes also demonstrated that issues of staff culture were addressed at staff meetings.

Since registration in June 2016 the service had carried out a quality assurance survey which were completed by people's relatives. The service had analysed the responses and the results, which were all positive. These were shared with relatives and staff.

The provider had a service development plan which set out how they planned to improve the service. This included exploring electronic care planning systems.

The registered manager told us that the service had excellent relationships with their local GP service. We received positive feedback from a local GP. We also saw that during the handover carers spoke of how they were working with the district nurses to support one person.