Mr & Mrs A J Bradshaw

Rydal House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

About the service:
Rydal House is a residential care home that was providing accommodation and personal care to seven people in the service. People had support needs such as having a learning disability and those on the autistic spectrum and those who need support with their mental health.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service:
Systems were not always effective or consistent at ensuring areas for improvement were identified or rectified promptly. People were not always supported in line with the Mental Capacity Act 2005 so their rights might not always be protected. The environment was not always enhanced when it had been identified that improvements were needed.

People were supported by a sufficient amount of safely-recruited staff. Risks were assessed and planned for and people were kept safe by staff who knew their needs and who understood their safeguarding responsibilities. Medicines were managed and administered safely. People were protected from the risk of cross infection and lessons were learned when errors had been identified.

Staff received training and support to be effective in supporting people. People had access to a range of other health professionals to keep them healthy. People enjoyed the food and had a choice.

Staff were kind and caring and people had a good relationship with them and each other. People were supported to be independent and relatives could visit whenever they wished. People were treated with dignity and respect.

People had personalised care which catered for their preferences. A range of activities and events were available for people to partake in. There was a complaints procedure in place and the registered manager was aware of their responsibility to respond to complaints. No one was receiving end of life care, but the service had previously worked to support people nearing the end of their life.

The registered manager and management team were well thought of by people, relatives and staff. They felt the registered manager was approachable and ran the service well. The previous rating was being displayed as required.

Rating at last inspection:
At the last inspection the service was rated Good (report published 20 August 2016).

Why we inspected:
This was a routine inspection planned on the last inspection rating.

Recommendations:
• We have recommended the complaint policy or procedure is in an accessible format for people who used the service.

Enforcement:
We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Action we told the provider to take can be seen at the end of the full version of the report.

Follow up:
We will continue to monitor the service and check improvements have been made at our next inspection. For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our Safe findings below.	**Good**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Rydal House

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team:
The inspection was carried out by one inspector.

Service and service type:
Rydal 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 care home accommodates up to eight people in one adapted building with rooms across three floors.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced. The inspection site visit took place on 3 April 2019.

What we did:
We used the information we held about the service, including notifications, to plan our inspection. A notification is information about events that by law the registered persons should tell us about. We asked for feedback from the commissioners of people's care to find out their views on the quality of the service.

Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We spoke with seven people who used the service, two relatives, a senior care staff member, one care staff, the deputy manager and the registered manager. We viewed two care files for people. We looked at medicines for three people. We looked at documents relating the management and administration of the service such as audits, meeting records and surveys.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were safe and protected from avoidable harm. Legal requirements were met

Staffing and recruitment
• Staff had appropriate checks prior to starting their employment, such as their employment history, references and criminal record checks. This ensured staff were appropriate to support people who used the service.
• People were supported by sufficient numbers of staff. Staff confirmed they felt staffing levels were appropriate. One staff member said, "It's [staffing] fine. A lot of people are very able. I haven't found we've needed more staff."
• The provider had recently sought advice from an external consultant who helped the registered manager introduce a staffing dependency tool to verify staffing levels were appropriate.

Using medicines safely
• People's medicines were managed safely and they received them as prescribed. One relative said, "They're always organised with medication." Another relative said, "I know they have a chart and give some [medicine] in the morning and some at night. It is regimental and documented."
• Personalised guidance was available to help staff identify when people needed their 'as and when required' medicines. This included detailed plans for someone who was not able to tell staff if they experienced symptoms. Body maps with detailed instructions were also available for topical medicines.
• Medicines were stored appropriately and stock levels matched the records, which meant people were getting their medication as prescribed.

Assessing risk, safety monitoring and management
• People received support to stay safe as risks had been assessed and planned for. For example, a person needed support with their mobility in some instances and their plan detailed this and staff were aware of this.

Systems and processes to safeguard people from the risk of abuse
• People were protected from potential abuse. People told us they felt safe and relatives confirmed this. One person said, "Yes, I feel safe." A relative said, "Yes [my relative is safe]. I have no qualms, there are adequate facilities and staff tend to my relative."
• There had not been any safeguarding concerns at the service recently; however, staff understood their safeguarding responsibilities and knew to report their concerns.

Preventing and controlling infection
• People were protected from the risk of cross infection as appropriate measures were in place. The home was clean and tidy and we saw people got involved in keeping their home clean.

Learning lessons when things go wrong

• Lessons had been learned when things had gone wrong. For example, if there had been a medicine error, these were identified and staff were supported to improve to try and avoid a reoccurrence.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance
• 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.
• People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• We checked whether the service was working within the principles of the MCA. People were involved in their care however people did not always have their capacity assessed when it was thought they may lack capacity. Documentation stipulated some people lacked capacity but there was no evidence this was assessed and there was insufficient documentation to record decisions taken in people's best interests.
• One person had a medical condition that staff would need to react quickly to, to keep the person safe. The person did not have any additional monitoring equipment or staff checks in place due to their choice, when they were alone in their room. The service had not assessed the person's capacity in relation to these specific decisions which could have a significant impact on their health and safety. Neither had they recorded that the person had chosen not to have this monitoring in place.
• There were occasions when a person had signed their consent, however the registered manager told us the person would not have capacity to understand and there were multiple references in the person's file to them not having capacity.
• Some people had DoLS applications, however these applications are only necessary when a person does not have capacity. Being as the service had not assessed some people's capacity, they could not be sure these applications were required.
• Therefore, people were not always being protected by the MCA.

The above constitutes a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Despite this, staff knew what mental capacity and DoLS were, and were aware that some people had DoLS approved and their associated conditions.
• People did not raise any concerns about staff offering choices. People told us they had a choice about what to eat and how to spend their time and we saw this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law. Staff working with other agencies to provide consistent, effective, timely care
• Detailed plans were not always in place to support people with their health conditions.
• One person had a health condition that meant staff would have to react quickly to keep the person safe. The care plan referred to additional guidance from a health professional but this guidance was unavailable. Staff gave differing accounts of how long they would wait before seeking emergency assistance, which put the person at risk of receiving inconsistent support. This meant the person's health and well-being was at risk. Following our feedback, this guidance was found.

Adapting service, design, decoration to meet people's needs
• The environment needed improving to keep people safe and to provide a pleasant place for people to live. It had been identified that multiple radiators did not have covers over them. This meant if a person fell against one, it could cause an injury. For one person, this posed a risk to their health and well-being. Immediate action had not been taken to rectify this prior to our visit.
• Some bedrooms and communal areas required re-decorating as they were tired, worn or damaged. One relative said, "It's the facilities. The tables are worn out and the carpet is cheap." One person's bedroom had recently been re-decorated following improvements to the damp course, however other rooms required improvements and some en-suite bathrooms needed improvement.

Staff skills, knowledge and experience
• Staff had sufficient training to support people effectively. Staff told us they had received training and records confirmed this.
• The deputy manager was also the training coordinator, they explained staff had not yet received DoLS training, however plans were already in place to address this, and staff had a basic understanding of what DoLS were.

Supporting people to eat and drink enough with choice in a balanced diet
• People told us they liked the food and had a choice. We observed staff offering choices and people did not always have the same food.
• People could independently access the kitchen and food when they wanted, and if someone asked for tea, coffee or a snack we saw this being provided. A water dispenser was available in the communal area for people to freely access drinks and we saw people use this.

Supporting people to live healthier lives, access healthcare services and support
• People were supported to access other health professionals to remain well. A relative said, "My relative went to see one [a GP] last week for a check-up."
• People regularly saw dentists and attended hospital appointments when necessary, as well as specialists associated with people's health conditions.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners

Ensuring people are well treated and supported; equality and diversity
• All people told us they were happy and liked the staff. Comments included; "The staff are kind" and, "They look after me" and they went on to tell us they liked all the staff.
• People also had positive relationships with the other people who lived in the service. One person said, "We're all friends here." Another commented, "I like the people I live with." A relative commented, "It's a family, they look after each other and support each other. I think it's really good for them." We could see this from interactions between people that liked spending time together.
• The deputy manager had started to develop a 'dignity tree' with people and staff. This explored what dignity meant to individuals in the format of leaves on a tree. Work to display this was in progress.
• There were no restrictions on when relatives could visit. One relative said, "I only have to phone up and let them know I'm coming. I pick my relative up and we go out for the day."
• Although people were not always actively practising a religion, they had the opportunity to visit a place of worship on a regular basis should they have chosen to, and many people did participate.

Supporting people to express their views and be involved in making decisions about their care
• People were clearly involved in their care and making decisions about their support. People chose their meals, decided what to purchase for the food shop and how they spent their time. One person said, "I go out when I want." Another person said, "We go to [shop name] to do the shopping. We do help with the meals."
• People were offered the opportunity to feedback about their support. We saw regular resident meetings were taking place. It had been discussed that a suggestion box be put in place, which a person showed us was now in place. This meant people's feedback was acted upon.

Respecting and promoting people's privacy, dignity and independence
• People were given privacy and treated with dignity, whilst encouraged to be independent. People were supported to be independent with their personal care. People were left in privacy whilst washing themselves or using the toilet and staff would only enter when they needed assistance.
• People were encouraged to be independent. One person said, "I want to be more independent and do my own tea. The staff help me to be independent." For example, some people could go out independently to social events and one person worked. People could change their minds when they wanted to; one person was going to stay in but they then chose to go out with other people they lived with to visit a local attraction and eat out.
• All staff we spoke with could give us examples how they would support people to maintain their dignity. For example, during personal care the door would be kept closed and people covered as much as possible.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs.

People's needs were met through good organisation and delivery.

Personalised care
• People were supported by staff who knew them well and people had a good relationship with them. One person said, "When I'm upset about things they [staff] cheer me up." One relative said, "They [staff] probably know my relative better than I do!"
• People were clearly involved in developing their care plans where they were able as some had been written by people. Staff knew people's support needs well and knew people's preferences.
• People could partake in activities of their choice. Multiple people told us, "We went bowling yesterday." We saw people independently accessing magazines, putting on DVDs of their choice, drawing and colouring. Some people went out to a local attraction and had lunch out together. We were told that people were planning a holiday for later in the year and had been on holidays together in the past.

Improving care quality in response to complaints or concerns
• People told us they felt able to complain. One relative said, "I could go to the deputy or the [registered] manager. It'd be no problem whatsoever. We sit down and have collective conversations."
• There was a complaints procedure in place, however this was not available in a format that would suit all people using the service, which may mean some people might not know how to make a complaint.
• We recommend that complaints information is made available to people in a format they would be able to engage with.
• No complaints had been received recently, however the registered manager knew how to investigate and respond to complaints.

End of life care and support
• No one was nearing the end of their life at the time of our inspection, however a person had recently passed away. The service had worked with another organisation near the end of their life and supported the person to transition to a specialist service when necessary.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Systems were not always effective at identifying areas for improvement or if information was missing. For example, a care plan referred to nurse guidance but this was not present. The plan had been reviewed but this missing information had not been identified. This was later found, following our feedback.

• Systems to monitor people's health were not always being effectively monitored. For example, one person had three occurrences of their health condition symptoms in a day. The professional guidance stated if the person had three or more instances in a day, to seek medical assistance. The records had not been checked to ensure this happened. It was explained that one of the episodes recorded was not a true reflection of what happened, however this had not been recorded and verified at the time.

• There was no monitoring of accidents and incidents to help identify trends and some body maps had not been checked by the registered manager. For example, one body map showed a large bruise on a person. The person was known to get bruises due to their health condition, however this was not checked. We saw other examples where body maps had been reviewed. This meant systems in place were inconsistent to ensure all body maps were reviewed.

• The service had failed to realise that the principles of the MCA 2005 were not being followed and that decision-specific mental capacity assessments were not being carried out, along with best interest decisions.

• The provider had failed to adequately assess the level of risk to some people in relation to uncovered radiators. This meant prompt action was not taken to remedy this and when the décor had declined this had not been resolved. Radiator covers had not been installed despite radiators being a potential risk to people. One person had wallpaper ripped off the wall in their personal room. When we asked the registered manager and deputy manager about this, they said they had reported it to the provider but no action had been taken to resolve it. This meant the person was left to experience damaged décor for a long period of time.

The above constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

• The registered manager understood their responsibility in relation to duty of candour. They had recently developed a display board in the communal area about honesty in the service and admitting if things had gone wrong.

• The provider had asked an external consultant to carry out an audit of the service to identify areas for improvement. It had identified some areas for improvement which work had commenced on, however this had not been completed yet.
• The previous inspection rating was being displayed, as required by law.

Engaging and involving people using the service, the public and staff
• People were able to feedback about their support and people's feedback was acted upon.
• People, relatives and staff all felt positive about the registered manager and staff felt supported. One relative said, "The [registered] manager is calm and collected. They know what they are doing, they are well organised. I think the service is well run." A staff member said, "The registered manager is brilliant – you can talk to them about anything, they don't judge, they're definitely trustworthy." Another staff member said, "I'm definitely supported. The manager is very easy to talk to, don't feel worried to confront them or make requests. They are really accommodating. I never worry about going to them."

Continuous learning and improving care
• Staff competency checks for medicines administration had recently been introduced to ensure staff were supporting people effectively and to help staff improve. Not all staff had yet had this, but plans were in place to ensure this was done.

Working in partnership with others
• The service worked in partnership with other organisations and services to ensure effective care and support for those using the service, such as GPs, pharmacists and health specialists.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity was not always assessed and decisions taken in people's best interest were not always recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not always effective at identifying areas for improvement or ensuring people's care was monitored. Prompt action was not always taken when improvements needed had been identified.