Mr & Mrs L Difford

Red Gables

Inspection report

59 Killerton Road
Bude
Cornwall
EX23 8EW

Tel: 01288355250

Date of inspection visit:
03 December 2018

Date of publication:
01 January 2019

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

We carried out an unannounced comprehensive inspection of Red Gables on 3 December 2018. Red Gables is a 'care home' that provides care for a maximum of 32 older people. 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 accommodation at Red Gables is set out over two floors, access to the upper floor is via stairs or a passenger lift. Some rooms have en-suite facilities. There are shared bathrooms, shower facilities and toilets. People also have access to two lounges, a dining room and a conservatory. On the day of the inspection 25 people were living at Red Gables.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Everyone told us they felt safe living at Red Gables. Risk assessments were completed to identify the level of risk people were at in a range of areas including falls and mobility. Staff knew people well and described to us how they would support people in various situations in order to keep them safe.

We identified some issues with the safety of the environment and have made a recommendation about this in the report. Safety checks relating to fire prevention systems, utilities and the use of equipment were regularly carried out. Personal Emergency Evacuation Plans had been developed for each individual.

Staff told us they enjoyed working at the service and were well supported by the registered manager. They knew people well and treated people as individuals recognising their differences and supporting them according to their preferences. The atmosphere was pleasant and relaxed. Staff and people frequently laughed and chatted together and we observed staff supporting people gently and with patience.

People were supported to take their medicines as prescribed. We identified some shortcomings in how medicines were administered which increased the risk of errors. We have made a recommendation about this in the report. Staff worked with external healthcare professionals to make sure people's needs were met. Kitchen staff had a comprehensive understanding of people's dietary requirements and preferences.

The service was in the process of moving care plans from a paper based system to a computerised system. The registered manager had a clear plan for the transition to avoid any information being overlooked. The new system was not as effective in capturing details of people's emotional well-being and information about how they had spent their time. The registered manager told us this had already been identified and there were plans in place to deliver training to staff to improve this area of recording.

New staff underwent thorough pre-employment background checks and received a comprehensive induction programme. There were sufficient staff to meet people's needs. Staff were appropriately trained and had the correct skills to carry out their roles effectively.

The registered manager and staff understood their role with regards to the Mental Capacity Act (2005) and where applicable the associated Deprivation of Liberty Safeguards.

There were effective quality assurance systems in place. Incidents were appropriately recorded and analysed. Learning from incidents and concerns raised was used to help drive improvements and ensure positive progress was made in the delivery of care and support.

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 entirely safe. Systems to mitigate the risk of medicine errors being made were not robustly applied.

Some areas of the premises were not effectively monitored or maintained and presented risks to people's safety.

Risk assessments in new electronic care plans did not guide staff on the actions to take to protect people from foreseeable harm.

There were enough staff to meet people's health and social needs.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Red Gables

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 3 December 2018 and was unannounced. The inspection was carried out by an inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service. Their area of expertise was in older people's care.

Before the inspection we reviewed the records held on the service. We used information the provider sent us in the 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 also reviewed previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with eight people and two relatives. We looked around the premises and observed staff interacting with people. We also spoke with the registered manager, the cook and six other members of staff.

We looked at six people's care plans and associated records, Medicine Administration Records (MAR), three staff recruitment files, staff duty rosters, staff training records and records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

We identified some concerns about how medicines were administered which increased the risk of errors. Medicines Administration Records (MAR) were used to record when people had received their medicines. Four of the MARs did not have photographs to indicate whose they were. This meant there was a risk staff, who were unfamiliar with people might find it difficult to identify who to administer medicines to. Some entries on the MAR had been handwritten. These had not been signed by the member of staff responsible or countersigned by a second member of staff to indicate the information had been checked as being correct. This is good practice as it helps prevent errors being made on the records. Some creams had not been dated when they were opened. This meant staff might not have been aware when the creams had become ineffective or carried a risk of cross infection.

Some people were prescribed medicines which require stricter controls by law (controlled drugs). We checked the amount held in stock with the records and identified a discrepancy. One person had two patches used for pain relief in stock. However, the records indicated three patches should have been in stock. When checking the MAR we were able to identify the person had received their medicine as prescribed but this had not been recorded in the controlled drugs log.

We recommend that the service consider current guidance on the safe administration of medicines and take action to update their practice accordingly.

Some people chose to self-administer their medicines and risk assessments were in place appropriately. No-one was receiving medicines covertly. Medicines were stored in a locked trolley. The trolley was well organised with no excess of stock. Medicines were administered discreetly and staff ensured people had taken them before recording on the MAR chart. There were clear processes in place for the safe disposal of medicines which were no longer required.

Personal protective equipment (PPE) such as aprons and gloves were available for staff. There were suitable facilities to store cleaning materials when not in use. We saw a mop and bucket and container of cleaning products which had been left unattended. We highlighted this to the registered manager who immediately located the member of staff responsible who then removed the products. Equipment such as wheelchairs was being kept in corridors and stairwells which could have been a trip hazard. There was a raised patio area outside the conservatory, the surrounding fence had been removed and there was a three foot drop to the ground. We discussed this with the registered manager who told us the fence would be repaired and the area made safe before people were able to use it. The door leading to the patio had been disabled to prevent people accessing it unobserved.

We recommend that the service consider current guidance on managing risks in the environment.

The care planning system was being updated and paper care plans were being replaced by electronic records. The care plans included risk assessments for falls, general risks, movement, leaving the service in an emergency and the use of a wheelchair. These scored the level of risk but there was no detail on the

electronic plans to describe how staff could mitigate any identified risk. We discussed this with the registered manager who told us they were working with other registered managers in the organisation to develop ways of making risk assessments more personalised on the new system. Staff knew people well and had a good understanding of how to support people when they were distressed and at risk of hurting themselves or others. For example, one member of staff described how they would talk with someone in a certain way in order to calm them. Paper based care plans contained more detail to support staff to minimise risk.

Staff, people and relatives told us they were confident care and support was provided in a safe way at Red Gables. Comments included; "People are safe, I would be happy for my family to come and live here" and "I feel safe here and with the carers."

People were protected by staff who had an awareness and understanding of signs of possible abuse. Staff were up to date with their safeguarding training and knew who to contact externally if they felt their concerns had not been dealt with appropriately. Comments included; "I'm here for a reason and that's to look after people. I'd report any concerns straight away" and "I would report to CQC if I needed to, but I'm 100% sure [Registered Manager] would sort it."

There were enough staff on duty to help ensure people's needs were met quickly. Following feedback from staff an additional care worker was employed between 7.00am and 11.00am to ease pressure in the mornings when staff were busy helping people get up and ready for the day. Call bell logs showed people's requests for assistance using the call bell were answered quickly, usually within five minutes. A member of staff told us; "I get the time to do the care I think I should be doing." Recruitment checks were completed before new staff started work at the service to help ensure they were suitable to work in the care sector.

Health and safety audits were completed regularly. All necessary safety checks and tests had been completed by appropriately skilled contractors. There were smoke detectors and fire extinguishers in the premises. Fire alarms and evacuation procedures were checked by staff and external contractors to ensure they worked. Records showed there were regular fire drills. Personal Evacuation Plans (PEEPs) were in place which outlined the support people would need to evacuate the building in an emergency.

Good

Is the service effective?

Our findings

People were supported by knowledgeable, skilled staff who had the skills to meet their needs. People's comments included, "The staff seem very capable and know what they're doing." People's needs were assessed before moving into the service. This helped ensure their expectations could be met. Staff demonstrated that they were aware of their responsibility to help protect people from any type of discrimination in the way they provided care for people.

New members of staff were required to go through an induction which included training in the fundamental standards and shadowing more experienced members of staff. Induction records showed new staff had their competency and confidence assessed before starting to work independently.

Training was regularly updated and covered a wide range of subjects. Staff were reminded when training required refreshing. If any staff were unable to complete training at home facilities were made available for them at the service. Moving and handling and first aid courses were delivered face to face. Some staff were due to have their moving and handling training updated and this was being organised at the time of the inspection.

Staff received regular supervision and annual appraisals. These were an opportunity to identify any gaps in training and encourage career progression as well as discussing working practices and any individual concerns. Staff told us they were well supported.

People had their healthcare needs met by staff who quickly recognised changes to their health and referred them to external professionals when necessary. For example, one person had some marking to their skin which was not healing as expected. Staff were working with district nurses and the local tissue viability nurse to help ensure the person received the appropriate care and support.

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 service recorded who had appointed lasting powers of attorney, and these people were asked to consent on behalf of the person if they lacked the capacity to do this for themselves.

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. Applications for DoLS authorisations had been made to the local authority appropriately following capacity assessments in relation to people's ability to consent to their plan of care. The registered manager ensured the local DoLS team was aware of any restrictive practices that had been introduced in order to keep people safe.

People were supported to have maximum choice and control of their lives and the service's policies and systems were designed to help staff provide support in the least restrictive way possible. Some people did not have any power of attorney arrangements in place. Where this was the case the registered manager identified relatives and friends who knew the person well and recorded them as being part of the person's 'circle of support'. This meant any decisions made on people's behalf could be made in consultation with people who knew them well and had an understanding of their wishes and preferences.

People were involved in decisions about what they would like to eat and drink. Care records identified people's preferences and any allergies or dietary requirements. The kitchen had been inspected by the Food Standards Agency and awarded the highest rating. Throughout the day soft drinks were available to people. Staff also regularly provided people with hot drinks.

We observed people as they ate lunch and saw it was a pleasant and social experience. People told us they enjoyed the food and could have snacks outside of set meal times. Comments included; "You can have any food you want, they'll offer you other things", "The food looks good and he likes it all. He has his own bowl of fruit on the side table next to him", "I like the food and enjoy it. We have snacks and drinks throughout the day" and "I like the food generally. They offer things all day and at night you can have a Horlicks or Ovaltine."

People had choices about where they spent their time. There were two lounges and a conservatory, one of the lounges was known as the 'quiet lounge' and provided a calm and relaxed environment. Most bedrooms were en-suite and there were enough shared bathrooms for people to use at the time they preferred. Bedrooms had been furnished to reflect people's personal tastes and preferences. There was limited signage to support people to move around independently and with confidence. For example, bedroom doors were not clearly marked with people's names and were difficult to tell apart. We discussed this with the registered manager who said they were considering ways to improve the environment and support people's independence and autonomy while avoiding creating an institutionalised feel to the building.

Good

Is the service caring?

Our findings

There was a pleasant atmosphere at Red Gables and staff and people spent time chatting with each other. Staff were reassuring and friendly towards people and non-judgemental in their approach. Some people were living with dementia and became confused at times. Staff were unfailingly patient in their responses and clearly aware of how to respond appropriately to each individual in order to decrease any anxieties. While staff remained professional at all times, they responded to people with touch when appropriate. For example, we observed a member of staff saying to one person; "I've been here ages and haven't had a hug yet." The two then hugged and the person was clearly happy to receive this affection.

Staff were positive about their roles and told us they enjoyed their work and were committed to providing good care and improving people's lives. Comments included; "I love helping people, I feel when I walk out, that I know I've helped people" and "We all want the best for the residents, we've got that in common."

People were accepted into the service and staff were understanding of how the move might impact on them. For example, the registered manager told us about one person who had recently moved into the service and sometimes attempted to leave. They explained; "It's not that they want to get away, it's that they believe they need to be somewhere else. She was a busy person, I think I'll be the same!" Staff told us they sometimes walked with the person to help settle them.

People felt well cared for, they spoke highly of the staff and the quality of the care they received. Comments included; "I have a lot of praise for the staff, I like them all and they all seem to like me", "The staff come in and have a chat and a laugh", "There is good camaraderie between the staff and residents" and "One carer brought me a bunch of roses, just for me!"

We witnessed several examples of positive and caring interactions between people and staff. One person was reluctant to eat anything at lunch time and staff were gently encouraging without overly pressurising them. We heard the member of staff offer them alternatives, when the person continued to refuse they checked what they had eaten for breakfast.

Staff told us people made day to day choices and had control over their routines. They gave us examples of people who liked to get up later than others and have a late breakfast. Other people liked to sit up late, either in their rooms or in the shared lounges and this preference was respected by staff. Staff were aware if people were at risk of social isolation and care plans guided them on how to support people to prevent this. For example, one care plan stated; "Help to find a balance between tranquil space and social isolation."

People told us staff respected their dignity at all times, shutting doors and curtains before providing personal care to protect their privacy. Staff knocked on people's doors before entering. People commented; "They are very gentle with me" and "They give me personal care and they are very good, I can't fault any of them."

The registered manager collated information about people's life histories and backgrounds when this was

available to them. This helped staff gain an understanding of the person's background and what was important to them so staff could talk to people about things that interested them. Information was positive and focused on people's attributes. For example, one care plan stated; "[Person's name] is a lovely lady who suffers from dementia."

As well as covering people's health needs care plans were in place to reflect what was important to people. For example, we saw information about people's cultural and religious beliefs. Descriptions of routines clearly stated what support people needed with various tasks and what they could do for themselves. This meant staff had the information they needed to support people to maintain their independence. People told us; "I do my own personal care and then the carers wash my back. I ring them and they return" and "I do my own personal care and have a shower each week. Someone comes and sees me to bed each night."

Good

Is the service responsive?

Our findings

Paper based care plans were being replaced by a computerised system and this process was on-going at the time of the inspection. Not all information had been transferred over to the new system and the registered manager told us they were having a planned transitional period to help ensure information was not lost. As information was moved onto the computerised system it was reviewed before more information was added.

Care records contained information about people's health and social care needs. They covered a range of areas including breathing, continence, hearing, mobility, nutrition and hydration, behaviour and communication. There was guidance on the amount of support people needed with various tasks. This took account of people's changing needs and supported staff to help people maintain their independence. For example, one person's mobility care plan recorded that their ability to move around fluctuated and they needed the support of two carers to help them with transfers. The guidance read; "Assess each time he needs to move…if he is able to walk two staff need to be present…. use a wheelchair if mobility is poor."

Some people had difficulty accessing information due to their health needs. Care plans recorded when people might need additional support and what form that support might take. For example, some people were hard of hearing or had restricted vision. Care plans stated if they required hearing aids or glasses or needed written information in large font. This demonstrated the service was identifying, recording, highlighting and sharing information about people's information and communication needs in line with legislation laid down in the Accessible Information Standard.

When needed the service provided end of life care for people. People's wishes regarding this were documented appropriately in their care plans.

Some people had been identified as being at risk of declining health. They were closely monitored so staff could identify quickly if their condition worsened. Monitoring charts and records were in place, for example, some people had food and fluid charts in place for staff to record what they had eaten and drank.

Daily notes were completed on the new computerised system to record when people had received any support with personal care. The records were very task orientated with little detail about people's emotional well-being. We discussed this with the registered manager who agreed the records lacked depth and said this was due to how the new system was set up. The system prompted staff to mark drop down boxes to confirm a task had been completed. Staff often completed this but failed to add extra information in the free text box. The registered manager said they had already identified this as a training need for staff and would be addressing the shortcomings with them at supervisions and staff meetings.

People were supported to take part in various activities. A named care worker had dedicated time to carry out activities each week day afternoon. We spoke with the care worker who was filling this role on the day of the inspection and found them to be enthusiastic about the role. They displayed a willingness to try new activities commenting, "It might not work, we will have to try and see if people enjoy it." A care worker told

us; "Some people have their own routines and are not always keen to join in but we always try and encourage them." One person told us; "I like listening to the singing, I just move my mouth but I like being involved."

The service had a policy and procedure in place for dealing with any concerns or complaints. There were no ongoing complaints at the time of the inspection. A relative commented; ""If I did have any concerns I would talk to the manager. I think it's quite well run."

Good

Is the service well-led?

Our findings

Since the previous inspection the manager had registered with CQC and was now the registered manager. They were also registered manager for another of the providers services. 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. The registered manager was supported by an assistant manager, although they were on maternity leave at the time of the inspection, and senior carers. The registered manager was based at Red Gables and the day to day running of the sister home was overseen by a senior care worker.

Staff told us they were well supported and the registered manager was approachable. One commented; "Any problems you can go to her. The office door is literally always open unless she has a meeting." We saw this was the case during the inspection. Staff and people living at Red Gables frequently came into the office and exchanged pleasantries with the registered manager. This was clearly something they were comfortable with and used to doing.

There were clear lines of responsibility and accountability within the management structure. The registered manager told us they were well supported by the owner/provider and the quality assurance manager employed by the organisation.

Systems had been introduced which provided a more organisational approach to how care was planned and delivered across the providers services. For example, the computerised care planning system was being adopted in all services and policies and procedures had been standardised. The registered manager told us the management team met regularly to share experiences and learning across the organisation.

There was a positive culture within the staff team. Throughout the day staff spoke to us about their ability to work as a team and their shared values. 'Team working' was a repeated theme. Comments included; "Each person that works here really cares, everyone is on the same page" and "It's a good staff team, we all give it our best."

There were limited formal opportunities for people and staff to share their views on the service. The registered manager told us they had arranged residents and relative's meetings in the past but people had not been interested in attending. Surveys were circulated annually but the response rate had been too low to gather any meaningful information. They told us they continued to explore ways of identifying and collating people's views.

Staff meetings had not taken place recently although one had been planned for the month preceding the inspection but had to be cancelled at short notice. The registered manager told us they were trying to rearrange the meeting for as soon as possible. However, staff were positive about the support they received from the registered manager and told us they were kept up to date with any changes in people's health or organisational practices. Handovers were held between shifts and there was an open approach to

communication.

Technology was used to drive improvement. The computerised care planning system was being introduced across the organisation. The system included a message system which staff were alerted to each time they logged on. The system for recording daily notes enabled the registered manager to be alerted via an application on their mobile telephone each time any key words were used. For example, they received an alert if the word 'blood' or 'concern' was used. This meant they were would be quickly updated of any potential incidents as they occurred. Staff also had access to a group text message system which was used to update them with any non-confidential information.

The registered manager worked to develop links with the local community. Various groups visited the service including a representative from the church, pupils from the local school, the local Beavers club and a bell ringing group. A fitness instructor sometimes visited to encourage people to do gentle exercises to improve their mobility and support the prevention of falls. One person told us; "A lady from the Methodist church comes in, they made me so welcome and even came to see me in hospital. It was beautiful. I go to the church by taxi to sales etc."

Audits of all aspects of the service were regularly completed. This included audits of medicines, care plans, complaints and people's personal monies. Accidents and incidents were recorded and regularly reviewed so any patterns or trends would be quickly identified.

People's care records were kept securely and confidentially, in line with the legal requirements. Services are required to display inspection ratings so people and visitors to the service are able to see it. The ratings and previous inspection report were available in the entrance foyer and the registered manager's office.