

Mr & Mrs R Smart

Redlands 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 

Overall summary

We inspected Redlands House on the 29 December 2014. This was an unannounced inspection.

Redlands House is a residential care home and provides accommodation and care for up to 33 older people. There were 28 people living in the home at the time of the inspection.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People told us they felt safe at the home and would be able to raise concerns about their safety if they had any. Family members also told us that they felt their relative was safe and looked after appropriately. Prior to the inspection we had asked the local authority safeguarding team whether they had received any concerns about the

Summary of findings

standards of care provided at Redlands House. They confirmed that they had not. Staff had received training in safeguarding adults and were able to tell us how to identify abuse and what to do if they suspected abuse was taking place.

Accidents or incidents were recorded appropriately and in a timely manner. Learning from such events was shared with staff to help prevent recurrences.

Medications were stored, checked and administered appropriately and safely.

There were enough trained, qualified and experienced staff on duty day and night to meet people's needs safely.

The manager undertook safe and robust employment checks when recruiting new employees. This helped to ensure that people were looked after by staff with the necessary skills, abilities and experience.

Regular training and refresher training for staff took place. Where specific training or refresher training was indicated as part of supervision or appraisal this was arranged by the registered manager.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found the home was meeting the requirements of the MCA 2005.

People told us that they were able to discuss their health needs with staff and had contact with GP's and other health care professionals should they need to. People were protected from identified risks to their health, for example those associated with malnutrition and dehydration.

People were treated with respect and had their views and opinions listened to. Staff took their time and explained things well when questions were asked.

Staff demonstrated a good knowledge of people in their care. They knew people's backgrounds, family members, hobbies and likes and dislikes. During the inspection we observed many positive and beneficial interactions between staff and people using the service.

People's needs were assessed before they came to the home and care plans were put in place to meet their needs. Where appropriate, or relevant, family were involved in discussions about changing needs. Individual likes and dislikes, hobbies and interests were noted and acted upon. We observed that no pressure was placed on anyone who used the service to take part in anything they did not wish to.

People and their relatives told us that the home was well managed and led. The provider had complied with their legal obligations to notify us promptly about specific events happening in the home.

Summary of findings

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.

There were sufficient qualified and skilled staff on duty to meet the needs of people who used the service. Safe and robust recruitment practices were followed, contributing to people's safety and staff knew how to recognise and respond to abuse.

Medicines were stored, managed and administered safely and risks to which people were exposed were assessed and managed.

Good



Is the service effective?

The service was effective.

Staff received appropriate training to enable them to carry out their jobs. People had enough to eat and drink to help them stay healthy.

People were supported by staff who understood the importance of protecting the rights of those who were not able to make decisions for themselves.

Staff obtained people's consent before providing care and support.

Good



Is the service caring?

The service was caring.

People were treated with respect and their dignity and privacy were upheld.

Staff engaged with people in a way that helped them make choices and maintain their independence as much as possible.

Staff took time to explain things and to understand what people were trying to express where communication was limited.

Good



Is the service responsive?

The service was responsive.

Care delivered was specific to people's personal needs and requirements and was regularly reviewed.

Activities and interests were provided to meet people's own likes and interests whilst maintaining access to group activities.

People and their family members, knew how to raise concerns or complaints and staff knew how to respond to concerns or complaints appropriately.

Good



Is the service well-led?

The service was well led.

There was a registered manager in post.

Good



Summary of findings

People and their family members told us the home was well run and that they had confidence in the registered manager.

There were systems in place to manage concerns, incidents and accidents.

There were also regular quality checks to make sure the service was well run and to identify areas for improvement.

Redlands 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 met the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 December 2014 and was unannounced. One inspector carried out this inspection.

Before the inspection we looked at all the information we had available about the home. This included the information the manager returned to us before our inspection. 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. We also reviewed notifications made to us. Notifications are changes, events or incidents that providers must tell us about by law. We used this information to help decide what we were going to focus on during this inspection.

During this inspection we spoke with the registered manager and assistant manager, three people who lived at the service, two family members, two care assistants, the activities co-ordinator and a GP with experience of the home. We looked at care records which related to three people who used the service. We also reviewed relevant management records associated with the running of the home.

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

Is the service safe?

Our findings

People and their relatives told us that the home was a safe place to live. One person said, “Yes I feel safe here. They [staff] appear to do all the things required to keep us safe here.” Another person told us, “I’m safe enough thank you”.

We spoke with this person’s family member who commented, “Yes [name] is safe here. If [they] weren’t t then they [staff] would soon know about it. So would I.”

We found that staff had undertaken safeguarding training and knew how to recognise abuse and report their concerns, including by whistleblowing if necessary. They also knew how to contact and raise concerns with the relevant local authority if the need arose. One member of staff told us that they would report anything they were not happy about to the manager. They added that they knew how to raise any concerns about people’s safety with the Care Quality Commission should they need to.

One person told us ‘The only thing I would say is that you get to know the staff and then they up sticks and go somewhere else. I like to get to know who is looking after me and changing faces so often can be unsettling. Otherwise I have no complaints about it here.’

Most of the staff we spoke with felt that staffing levels were sufficient to meet people’s needs. We looked at the home’s staff rosters and staff planning tool. These showed us that there were enough staff on duty, or accessible at short notice, with the right competencies and experience.

The provider had satisfactory recruitment processes in place. We found that staff underwent thorough recruitment processes which ensured they were of good character with the required skills and knowledge to meet people’s needs safely.

People had relevant and appropriate risk assessments in place. These provided guidance for staff about how to minimise risks and support people safely. For example, we observed that staff placed the foot plates of one person’s wheelchair appropriately during lunch to ensure the person using it was moved safely. They advised the person what they were doing and explained that their feet needed to be on footplates before moving off so as to reduce the risk of injury.

We found that risks to people from poor nutrition and hydration were also assessed with guidance for staff to ensure the risk was managed and people were supported safely. We found that hydration and food intake charts were in place to help demonstrate people at high risk received the care that they needed to promote their safety.

Where people were assessed as being at risk of developing pressure ulcers, plans were in place to provide manage and minimise the risks of people developing these. People were provided with pressure relieving equipment and they were repositioned regularly to help maintain their skin integrity. Repositioning charts were in place to record this.

Accidents and incidents were reported appropriately. The home had an electronic system of recording accidents and incidents which we looked at. Regular audit results of accidents and incidents were shared with staff as learning points. This helped them monitor and maintain safe standards of care.

People using the service had emergency evacuation plans in place so that staff would know how to ensure their safety in the event of a fire or other emergency. The home had emergency contingency plans in place in the event of a major incident so that support for people living there could continue safely.

At this inspection we found medicines were stored, administered and managed safely. Where possible people were supported to take their own medicines. We saw that staff explained to them what the medicines were for and why they took them. People were supported to take their medicines by staff who had been properly trained.

Regular medication reviews took place with the attending GP. These included interventions agreed and actions required. We looked at the review for 15 October 2014. We found instances of medication being removed from repeat prescriptions as no longer required. We found these regular GP medication reviews were supported by the manager carrying out intermittent reviews of service users medicines. We concluded that the home took all steps necessary to ensure that people received the right medicine, right dose and in the right way.

Is the service effective?

Our findings

One person told us “The main thing for me is that if I need a doctor they get me one. Anyway, the doctor visits every week regularly and sees me most weeks.”

Staff took steps to ensure that people at risk of pressure ulcers were closely monitored. People were also regularly reviewed for pressure ulcers using nationally recognised screening methods. We looked at one person’s care plan who had been identified as being at risk of pressure ulcers. Whilst this person did not have a pressure ulcer present staff were proactive in managing the skin integrity so as to prevent a pressure ulcer occurring. Where people were identified as having pressure ulcers we also looked at their wound care plan and noted the required clinical interventions were taking place. The relationship between the home and the dedicated GP practice also meant that pressure ulcers were discussed and checked weekly.

Records showed that where appropriate the service made referrals to GP’s, district nurses, chiropodists, dieticians or other health or social care services. This meant that people had access to effective and ongoing healthcare support from specialists when required in a timely and effective way.

Staff received regular and relevant training to do their jobs. If staff required specific or refresher training, or advice and guidance, then this was dealt with promptly. One member of staff told us how they had recently received training in fire safety, food hygiene, and infection prevention and control. Another member of staff told us about their recent induction training and supervision. They told us why they were not allowed to work on their own throughout their induction period. They added that if they needed advice or support they were confident they would get it.

Staff had training in and knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff were also able to tell us about how they obtained people’s consent and what they would do if they were not able to do this. Staff were able to explain what “best interests” meant and how they would apply it. At the time of inspection one person was subject to a Deprivation

of Liberty Safeguards (DoLS) application. This is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests or to maintain their safety.

People who used the service were regularly assessed for their ability to consent to care and, if appropriate, treatment. Where people’s capacity to consent had changed staff worked with family and other health and social care professionals to make decisions based on the person’s best interests. Where a power of attorney arrangement was in place then this was placed in people’s records as part of their MCA arrangements.

We asked people who used the service whether they had enough to eat and if the food was to their liking. All responded positively. We observed that staff worked across both the main dining room and the front lounge over lunch. People were asked if they required assistance to put on aprons and whether they needed support to eat their meals. Where people requested help their food was chopped to manageable portions. People were asked if they required the use of spoons to eat their main meal instead of knives and forks. Staff regularly observed people having their lunch and were quick to assist if required. Hot and cold drinks were provided throughout this period. The meal time was not rushed and staff took time to explain what the food was and to ask if was to the person’s satisfaction. We also noted that alternatives were made available if people had changed their mind since ordering. During the afternoon tea was served with a choice of fruit salad or cheese and biscuits.

Staff took steps to ensure that people at risk of malnutrition were closely monitored. People’s weight was regularly reviewed using a Malnutrition Universal Screening Tool (MUST). This tool was supported by a nutritional screening assessment. This assessment was reviewed monthly. It covered things such as food intake, chewing ability, swallowing ability, and weight loss and stress factors. These tools helped staff monitor any changes in weight and put actions in place to ensure people’s calorie intake was increased or decreased if this was needed. This was further supported by an additional care plan relating to appetite and appetite changes. People’s food preferences were also recorded and reviewed regularly along with any food allergies.

Is the service caring?

Our findings

People told us, or indicated to us by body language, that staff were kind and caring. One person said, “They [staff] are always kind and caring. They always explain things.” Family members also told us how kind and considerate staff were and how well cared for people were. One family member commented, “[Name] is well looked after and cared for here. I have seen nothing but care and respect for them when I am here.”

People and their relatives told us they were involved in planning and reviews of the care and support provided. One family member said, “I suppose I am involved in [name’s] care and their experiences, but to be honest I don’t think I need to be. This is because they are quite capable of saying whatever needs saying for themselves. I do know however that if something wasn’t right then [the registered manager] would let me know as soon as possible”.

During the inspection we observed that people were treated with respect and dignity at all times. Staff addressed them by their preferred name and asked what

they wanted before providing care or support. . We saw that this was appreciated by people who lived at the home. We saw that staff knocked and waited for permission before entering a person’s room. Staff were able to tell us about things they would do to ensure people’s privacy such as drawing curtains whilst carrying out personal care.

A family member said, “They are all so busy here yet they find time to do things like outings and shopping trips. We, family members help out where we can as well.”

We observed that staff were caring and considerate. Two staff members in particular went to great lengths to assist one person who struggled to express themselves. By a process of elimination and by working with the person concerned, they eventually understood what this person was trying to say. The staff were kind and calm at all times. This process took time and effort but the commitment shown by the staff concerned showed how they involved people and helped them carry out their wishes.

Information about local support groups and advocacy agencies was displayed at the home. This meant that people or their relatives had access to contact details for independent advice or support if required.

Is the service responsive?

Our findings

People told us they were regularly involved in reviews of their care and support during which they were invited to comment about the services provided. One person said, “Yes. They ask me if everything is okay and has anything changed.”

We saw that referrals to other services such as chiropody, speech and language and dieticians were made in response to people’s changing needs and these changes were updated in people’s care plans.

People and their relatives told us that care and support was provided in a way that was responsive to and met people’s individual needs. One family member told us, “They [staff] respond to [name’s] needs well. [They] can be difficult to engage with sometimes but staff have worked hard here to understand their needs and come up with an approach that suits [them], and us as a family.”

Care plans and risk assessments were completed regularly. Any issues or changes to the care provided were discussed with all concerned and acted on. One family member told us, “They don’t tell us about coughs and colds, that sort of thing, but I’m sure if there was anything that concerned them then they would tell us as soon as possible”.

The home used a dependency assessment tool to calculate each person’s needs. This covered things such as mobility, dressing, personal hygiene and feeding. People’s individual needs were assessed regularly using this tool. This helped the home to recognise and respond to people’s changing needs appropriately and safely.

Where people wished to smoke then arrangements had been made to manage this so risks associated with smoking were managed. In the person’s care plan we saw an agreement had been reached about where smoking was to take place. The plan in place meant the person was still able to exercise this lifestyle choice.

We spoke with the activities co-ordinator for the home. They told us about the way activities were planned and carried out and gave examples of people reading newspapers, one to one time and involving families to help out. One suggestion being taken forward was making activities more person centred whilst not negating the need for group activities. These discussions were under way with people using the service, family members and staff so that activities met people’s interests and preferences. Another change planned for 2015 was the introduction of reminiscence sessions and again people using the service and staff were engaged in coming up with ideas to make this happen. If people using the service were taken out on outings or for shopping then relevant risk assessments were carried out to promote their safety.

People told us they would go to the registered manager first to discuss any concerns or complaints that they had. They added that they had confidence in the registered manager to sort things out. One person told us, “I would complain if I had to, but touch wood, I’ve had nothing to complain about so far.” A family member told us, “We would complain if we had to and know about the complaints process and how to do it. However, there has been no reason to make any complaints.” Information about complaints and how to make them had been displayed around the building. Staff were able to tell us how they would respond to complaints.

There was a suggestion box in the front hall of the building which the registered manager regularly checked. They told us that if suggestions were posted this way that they would be considered and discussed at the most appropriate meeting so that they could be responded to in the best way.

Is the service well-led?

Our findings

One person who used the service told us, “It’s a well-run home. I like routine and I like to see that things are done properly. That happens here.”

The registered manager was supported by an assistant manager. Both were proactive, responsive and keen to improve the service. Staff told us that they felt supported by the registered manager and assistant manager. We asked the registered manager how staffing calculations were worked out. We were provided with a copy of the staff planning tool and copies of staff rosters for the previous three weeks. We checked these and found them to be in order.

The registered manager had developed a new way of managing training needs for 2015. This included the manager identifying where staff had received more advanced training and so could advise and guide their colleagues about good practice. This had been discussed with staff at a team meeting and all had agreed that it seemed a good way to share knowledge and learning.

Monthly meetings took place which included team leaders, general staff kitchen staff relatives and night staff meetings. Information about the service was shared and staff views sought. There were also regular meetings with people who used the service. These meetings were used to gather information about how the service was running and what could be done differently or better

Minutes of a recent staff team meeting showed that minor inconsistencies in recording of medicines had been

identified at a medication audit. This had been addressed by the manager and a new style medication folder introduced in October 2014. Results of the November and December 2014 medicines audit revealed no inconsistencies. Following this staff had also received refresher training in administering medicines and re-read the provider’s medicines management policy.

There were a number of systems in place to monitor the quality of the service. Monthly audits took place and which were used to monitor and improve the service. These included the premises, maintenance works carried out, health and safety, sickness and absence, training and infection prevention and control. The provider’s senior management team had also carried out eighteen quality assessment spot checks during 2014. These identified areas where improvements could be made to the service and were acted on by the manager.

There was a “friends and family” information folder in the entrance hallway which contained Age Concern information relating to hospital admissions, making complaints and financial matters. A folder of thank you letters and cards was also on display in the entrance hallway and this contained many complimentary remarks.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely manner. This meant that we could check that appropriate action had been taken.