Your Health Limited

Rider House Care Centre

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

We inspected Rider House Care Centre on 28 September 2017 and it was unannounced. This was the first inspection of the service under a new provider. They provide accommodation and personal care for up to 41 people, some of whom are living with dementia. There were 34 people living at the service when we visited. The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always supported in the least restrictive way possible because their capacity to make their own decisions was not always assessed. People did not always have their chosen food and their cultural preferences were not always considered.

We have recommended that the provider improves the systems used to monitor the safety and the quality of the home to ensure they are suitable and effective in identifying shortfalls and driving improvement. Some policies were not in place to ensure that the provider was meeting their legal responsibilities.

There were systems in place to assess risk and actions were put in place to reduce it. Medicines were managed to ensure they were safe and people were protected from avoidable harm by staff who understood how to safeguard them. There were enough staff to meet people's needs and safe recruitment procedures were followed.

Staff developed caring relationships with the people they supported and were respectful and patient. They knew people well and provided care that met their preferences. People were encouraged to pursue interests and hobbies and regular activities were planned. Their privacy and dignity was maintained and family and friends could visit freely.

People knew the manager and felt confident that any concerns they raised would be resolved promptly. Staff received training and support to be able to care for people well; including at the end of their lives. They understood their responsibilities and ensured they worked closely with other healthcare professionals. The manager understood the responsibilities of their registration with us.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.
Medicines were managed to reduce the risks associated with them and there were systems in place to store them securely. Staff knew how to keep people safe from harm and how to report any concerns that they had. There were sufficient staff to ensure that people were supported safely. Risks to people's health and wellbeing were assessed and plans to manage them were followed. Safe recruitment procedures had been followed when employing new staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.
People's capacity to consent to decisions was not always fully considered. They were not always provided with meals of their choice including food which was culturally important to them. Staff received training and support to complete their jobs well. People's healthcare needs were considered and addressed.

Is the service caring?

Good

The service was caring
Staff developed caring, respectful relationships with the people they supported. They were supported to make choices about their care, including how they wanted to be supported at the end of their life. Their privacy and dignity were respected and upheld. Relatives and friends were welcomed to visit freely.

Is the service responsive?

Good

The service was responsive.
People and their families were involved in planning and reviewing their care. Hobbies and interests were encouraged and planned around people's personal histories. Complaints were investigated and responded to in line with their procedure.

Is the service well-led?

Requires Improvement

The service was not consistently effective.
The systems in place to monitor and improve quality were not always effective in driving continuous improvement. There was an open management style where feedback was welcomed. The

staff team felt well supported and understood their responsibilities.

Rider House Care Centre

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 inspection visit took place on the 28 September 2017 and it was unannounced. It was carried out by two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who used a health and social care service.

We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public.

The provider had completed a provider information return (PIR) prior to the inspection. 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 used a range of different methods to help us understand people's experiences. We spoke with eight people who lived at the home about their care and support and to the relatives of two other people to gain their views. Some people were less able to express their views and so we observed the care that they received in communal areas. We spoke with the manager, two nurses, four care staff, the cook and the activities co-ordinator. We looked at care records for seven people to see if their records were accurate and up to date. We also looked at records relating to the management of the service including quality checks.

Good

Is the service safe?

Our findings

People were kept safe by staff who understood how to recognise and report suspected abuse. People we spoke with told us that they felt safe. One person said, "Yes, I feel safe here". Another person told us that they felt safe because the building was secure. They said, "I feel safe because anyone visiting has to be let in by staff". Staff we spoke with knew what signs of abuse could look like and told us how they would manage any concerns. One member of staff said, "If I saw something like bruising I would think that it could be physical abuse. I would make sure that I reported it to one of the nurses". Another member of staff said, "When I started I did safeguarding training and that is absolutely fundamental to making sure people are safe. The training was very good because they asked us questions to make sure that we understood it". We reviewed safeguarding incidents with the manager and they told us the actions they had taken to protect people. For example, they told us how they had installed cameras within the home to ensure that people's belongings were safe.

Risks to people's health and wellbeing were managed and actions were put in place to reduce them. One person we spoke with told us, "They use a hoist to help me to move and I feel safe with it. There are always two staff". A relative we spoke with said, "The staff know how to support my relative. They know that they need to have a soft diet because they can't swallow very well now". Some people behaved in a way which put themselves or others at risk of harm. When we spoke with staff they knew the guidance that was in place to help people to manage these behaviours. For example, one member of staff told us that they spent some time individually with one person giving them reassurance. Some people needed support to ensure that pressure did not damage their skin. One person we spoke with told us how they were supported to manage this; including rest and moving regularly. We observed staff supporting them in line with the plan. The records that we reviewed confirmed that risks had been assessed and that staff were following the plans put in place.

Equipment was maintained and tested to ensure that it was safe to use. There were emergency procedures in place which staff were aware of; for example, to evacuate the home during a fire. Individual risks were assessed and plans were in place for each person which included what support and equipment they would need to leave the home safely.

Medicines were managed to reduce the risks associated with them. One person said, "The nurse brings my medicines. I can ask for painkillers whenever I want them but I rarely do". When people did have medicines prescribed to be taken 'as required' we saw that there was guidance in place for staff to know when they should be given. When people were prescribed medicines which needed careful monitoring we saw that this was completed and that that the amount that people took was altered when needed. For example, some people had diabetes and their blood sugar levels were regularly measured to ensure that the medicines they took were correct. Medicines with a short expiry were dated when they were opened. This meant that staff could ensure that the medicines had not passed their expiry date and were still effective. We saw that medicines were stored in locked trolleys and that when they needed to be kept in the refrigerator staff ensured that the correct temperature was maintained.

There were enough staff to meet people's needs in a timely manner. One person said, "I think there are enough staff but I can do a lot for myself". Another person said, "Yes, there are enough staff. When I press the buzzer then they come". We saw that staff were able to meet people's needs in a timely manner and that people did not have to wait for care. Some people and their relatives told us that there were enough staff most of the time but sometimes they had to wait. One relative said, "There are enough staff but sometimes when people need two staff to help them I have seen that they have had to wait". When we spoke with the manger they said, "We do try to plan staffing around individual needs. We care for a lot of people who are coming to the end of their life and that means that their needs can change quite quickly. This has an immediate impact on the staff's availability". When we spoke with staff they also said that their ability to support people could fluctuate on a day to day basis. One member of staff said, "There are enough of us today and it has been smooth. Other days can feel very busy".

The provider followed recruitment procedures to ensure that staff were safe to work with people who used the service. Staff told us that their references were followed up and a Disclosure and Barring Service (DBS) check was carried out before they could start work. The DBS is the national agency that keeps records of criminal convictions. One member of staff we spoke with said, "They took two references and checked my DBS before I started. The DBS came through really quick but there was a delay with a reference and I couldn't start work until it was returned". Records that we reviewed confirmed that these checks had been made.

Requires Improvement

Is the service effective?

Our findings

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 or 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We looked to see how the provider was working within the principles of MCA.

When we spoke with staff they understood about people's capacity to make their own decisions. We heard them asking people for consent before delivering care. However, capacity assessments were not always in place where decisions had been made in people's best interest. For example, we saw people's capacity to consent to take their medicines was not always considered. Furthermore, when the provider had installed cameras in the building they had not considered people's capacity to consent to this decision to ensure that it had been made in their best interest.

For other people, the staff had identified where there were restrictions in place to ensure people received treatment in their best interests and DoLS applications had been authorised. Further applications had been made which were awaiting assessment.

People were not always provided with their choice of meals. One person we spoke with told us about cultural foods that they enjoyed prior to living in the home. They had not been offered this food and they told us that they missed it. One member of staff we spoke with confirmed that they only ate food from their culture when family brought it into them. Another person said, "There is a hot meal at lunch which the staff bring me. I have more of a choice in the evening". We saw that there was a second option if people didn't like the main menu but some people we spoke with were not aware of this choice.

People who needed help with their meals were supported discreetly and the staff were patient and encouraging. Some people had been assessed as finding it difficult to swallow food and the staff liaised with other professionals to ensure that they had the correct food. During our inspection, we saw that an assessment took place and that the recommendations were communicated straight away so that the person's diet could be altered. This meant that the provider ensured that people's dietary needs were met.

Staff were supported to ensure that they were skilled to meet people's needs well. One person said, "They are going through training now and they are all great". One relative we spoke with said, "I think the staff are well trained because they all seem to know what they are doing". One member of staff said, "I have had a lot of training which has really helped me. I did training on dementia and behaviours that could be challenging. It has helped me to support some people. I think about what the triggers could be; for example, what was happening and how was the person feeling before they were distressed". Another member of staff told us

about training that was planned which was specialist to their role. They said, "It is good that the nurses are doing training which means we can certify deaths. It will mean that we will be more efficient which will cause less stress for families". Staff told us that all of their training was face to face and interactive. One member of staff said, "It means that we can ask questions and talk about what it would have meant to the people we support". When we spoke with the manager they recognised that some staff had not recently had end of life specialist training and they told us about plans they had to ensure that this was prioritised.

Staff also told us that they received an induction when they started. One member of staff said, "I did some training in moving people before I started. Then I did some shadow shifts when I was mentored by another member of staff which gave me a chance to observe everything. I have had regular reviews with the manager since I started and I have completed the care certificate". The care certificate is a national approach to meeting induction standards in social care. This showed that new staff were supported into their role to ensure that they could care for people competently.

People had their healthcare needs met. One person said, "If I need to see a doctor then they are called". One relative said, "My relative saw a chiropodist a couple of weeks ago and see the doctor too". When we spoke with staff they told us that they had contacted health professionals on the day of the visit to see some people who were unwell and others who were new to the home. We saw that the new person was visited and the member of staff told us that they had agreed how the person should be supported. Records that we reviewed showed that healthcare appointments were made when needed and that care plans were updated to reflect any recommendations. This meant that people were supported to maintain good health and to access healthcare services.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and helpful. One person said, "The staff are very kind and I am happy living here". Another person told us, "They are all kind; they always give you time if you are upset". One relative we spoke with said, "The staff are all good and always take time to speak with people". We saw that staff had good relationships with people and knew them well. We observed one person being gently supported to move using equipment, humour and patience. Another person was reassured when they were anxious by a member of staff until they felt better. Staff were aware of people's life histories and had conversations with them about where they were from and their families. We saw that people had belongings around them such as family photos and books which they talked with staff about. One member of staff we spoke with said, "I love working here because it's like home. There are a lot of staff who have been here a long time and we support each other to make sure that it's a friendly atmosphere". This showed that staff had positive relationships with people which took account of their previous social history.

People we spoke with told us that they were involved in making decisions about their care. One person said, "I can do quite a lot for myself and so we agree what help I want". Another person told us about the personal care they received and which aspects they completed independently. We observed that if people needed their personal care needs met this was completed discreetly and respected the person's privacy.

We saw that people's dignity was promoted and they were treated with respect. One person we spoke with said, "If I want privacy I go to my room. The staff would knock before coming in". We saw that visitors were welcomed and that people met with them privately if they chose to. One person told us, "My family visit regularly, there are no limits on when they can come".

People and their relatives were supported to plan for the support they wanted at the end of their life. We saw that some people had medicines ready which would support them to manage their pain when needed and that these were kept so that there was no delay in people receiving the relief. The manager told us, "We are passionate about people having a dignified and supported death here and we work closely with families". One member of staff we spoke with told us of the professional support that they received from their local healthcare professionals. They said, "We also work closely with professionals from the hospice when people are registered with them and we really value their support". In the PIR the provider told us of plans they had in place to develop this expertise which included training for staff in difficult conversations. They also said, 'We plan to arrange end of life support services for residents, relatives and staff. This would not necessarily need to be too formal but more of a meet and chat group, offering a listening ear'.

Good

Is the service responsive?

Our findings

People were encouraged to pursue interests and hobbies. One person said, "We did some craft activities the other day which I really enjoyed". Another person said, "We do all sorts of things like crafts, games, exercises and baking". We saw that a local church attended to provide a religious service for some people. One visitor told us, "We come once a month to the home and those people who want to take communion can". One member of staff we spoke with said, "We plan with people on an individual basis what they like to do and try to ensure that they can". We saw that attention was given to people who were not able to or did not want to join in group activities. For example, some people were supported on a one to one basis and others were supported in their rooms.

Staff knew people well and could describe their likes and dislikes. We observed that one person was provided with a meal later than others. A member of staff we spoke with said, "They had a disturbed night and so we let them rest for as long as they needed". They knew what was in people's care plans and one member of staff told us, "The care plans are there for us to read and they are up to date". We observed a handover and saw that that information was given to ensure that the next team knew about any changes to people's needs.

Relatives were involved in planning and reviewing people's care. One relative said, "They keep me updated about everything and often call to let me know if something has changed". Records that we looked at confirmed that plans were updated to reflect people's changing needs.

People and their relatives knew how to raise any concerns or complaints that they had. One person told us, "Well in the first place I would go to the office and see the manager. They will fill in all the paper work then bring it to me to sign it to say I agree". In the PIR the provider told us, 'Complaints are listened to effectively, acted upon and recorded. The person is kept informed of any investigation and it's outcome. They are then asked if it is a satisfactory conclusion for them'. We reviewed the complaints received and saw that actions were taken to avoid the situation occurring again.

Requires Improvement

Is the service well-led?

Our findings

Some of the audits and systems in place to monitor and drive improvements were not effective. The medicines administration records (MAR) were not always signed to evidence that people had received their medicines. Staff had been maintaining a daily count of medicines and sample checks carried out assured us that people had received their medicines as prescribed. However, we could not be assured that the quality systems were effective in highlighting these omissions and ensuring that staff could testify that people had received them in a timely manner. There had been concerns around medicines management raised through internal quality audits and by external contracts management reviews. Although we saw that some of these issues had been addressed it was clear that not all of them had. This meant that the actions put in place to address the errors were not sufficient. When we spoke with the manager they told us that they would review the system. After the inspection they confirmed that they had implemented a new system where the responsibility would be with night staff to check the records so that remedial action could be taken more promptly.

Some quality checks were not carried out within the required timeframe and others were not recorded well enough to ensure that they had all been completed. For example, the test for Legionella was out of date and needed to be reviewed. We saw that portable appliance tests had been carried out but we could not be assured that all items had been checked because there was no system to log and identify the location of the equipment. For example, we saw that one person had a portable fan in their room which was dusty and may have been a fire hazard. The sticker on it which should have said when it was last tested could not be read and there was no record to show that the equipment was in use in the person's room. Therefore, we could not be sure that the systems in place to check that the environment was safe was always effective.

Some people told us that there were not always enough staff to meet their needs. When we spoke with the manager they told us that they kept staffing under continuous review. However, they did not use a tool to assist them to plan this. This tool would enable them to plan for the fact that people's needs were changeable because of their diagnosis or because they were nearing the end of their life. It would assist them to demonstrate the need to forward plan staffing levels rather than reacting on a weekly basis and putting pressure on existing resources.

We recommend the provider ensures their quality audit systems are suitable and sufficient to drive improvement and demonstrate the action taken.

In response to incidents in the home the provider had installed a camera in the home to monitor the safety and the quality of the service. They did not have a policy in place to guide them on this or to ensure that they were complying with the Data Protection Act 1998. For example, they should have addressed what the purposes of the cameras were and how they would manage the information recorded. They should also inform visitors to the building by visible signs that they are being recorded and this was not in place.

The provider planned to introduce other measures to ensure that people's belongings were safe. They

stated in their action plan that each person would have a locked drawer in their room and a key to their bedroom. This had not been implemented for every person yet. Also, some people did not have a list of their belongings in their care plans. This had been implemented for new people but if people had lived there longer it had not. This meant it would be difficult to evidence any loss in an investigation, if their belongings went missing; particularly if they were unable to verbally communicate.

When the new provider became responsible for the home, some environmental improvements were required. We saw that some of these had been made; for example, there was new flooring in some communal areas and some re-decoration of bedrooms. They had made improvements to the kitchen in line with recommendations from an audit of the food preparation environment. We saw there was a refurbishment plan in place for the next two years to complete the rest of the refurbishment and decoration.

There was an open culture which encouraged feedback with the managers. People we spoke with told us that the manager was approachable. One person said, "The manager is in most days and they are nice and care about us". One member of staff said, "The manager is brilliant. They are fair and kind and always put people first as it is their home". Staff we spoke with told us that they would be confident to raise any concerns through the whistleblowing procedure. One member of staff said, "If I had any concerns about poor practice I know that the manager would listen to me". There were meetings for people who lived at the home and changes were made in response to their feedback; for example, choosing colours for redecoration. There were surveys sent to relatives which were used to improve the service and there was a notice detailing the manager's response to feedback. This demonstrated to us that there were systems in place to ensure that people, relatives and staff were listened to.

We saw that staff understood their responsibilities. One member of staff told us, "The nurses give us direction during the shift; for example, if someone needs extra support or monitoring they will let us know. We have supervision with the nurses but can also go to the manager at any time". In the PIR the provider told us, 'When poor practice has been recognised we encourage staff to compete a reflection on their practice, in order to help prevent a reoccurrence. Staff are encouraged to speak up if they feel there is a concern regarding any area of practice. For example if they feel a moving and handling plan is not reflecting safe transfer, they will let a nurse know, so the plan can be reassessed'.
Staff confirmed that they were able to address any concerns directly or in regular team meetings.

The registered manager understood the responsibility of registration with us and notified us of important events that occurred in the service which meant we could check appropriate action had been taken.