Central and Cecil Housing Trust

Rathmore 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

Summary of findings

Overall summary

Rathmore 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.

Rathmore House can accommodate up to twenty older people and specifically those who are living with dementia. At the time of our inspection there were nineteen people using the service.

This unannounced inspection took place on 2 and 5 February 2018. At the last inspection on 4 February 2016 the provider was in breach of regulation 11 in respect of gaining consent and the use of deprivation of liberty safeguards. At the subsequent focused inspection on 19 May 2016 the provider had rectified the previous breach of regulation and had met all of the legal requirements. The service was at that time rated as good.

At this inspection we found the service remained Good.

The service had a registered manager in place. 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 and associated Regulations about how the service is run.

People were supported to consent to care and the service operated in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, consulting with people and their relatives about their wishes and needs.

Staff we spoke with understood their duty to protect the people in their care. Staff knew how to protect people from abuse, how to identify abuse and how to respond if any concerns arose. Staff also knew how to minimise potential risks to people's health and welfare. Medicines were managed safely and administered in the correct way.

There was a suitable number of staff available to meet people's needs. No one made any comments to suggest that they did not feel safe in the care of staff.

Care staff were well trained and the training covered the topics they needed to carry out their work and support people. The supervision and appraisal system supported them to carry out their work.

People were supported to maintain good health. The staff team obtained appropriate advice from healthcare professionals when needed.. People received a nutritionally balanced diet to maintain their health and wellbeing.

The service carried out assessments of people's needs before they moved in. The provider took the appropriate decisions about the suitability of people to use the service. Care plans were person centred and were tailored to each person's unique needs. Care plans were regularly reviewed and any changes to people's needs were recognised and action was taken to respond.

The service had a clear management structure in place. The service had a range of quality assurance, consultation and monitoring systems in place. The provider listened and responded to the views of people who used the service, relatives and other health and social care professionals.

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 remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Rathmore 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 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 took place on 2 and 5 February 2018 and was unannounced. The inspection team comprised of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses care service.

We reviewed the information we held about the service including people's feedback and notifications of significant events affecting the service.

During the inspection we spoke with six people who used the service, five relatives and two friends of people. We spoke with four members of care staff, the chef, the deputy manager and the registered manager. We received feedback from professionals who had contact with the service and also viewed a report from Health watch Camden who had visited the home in December 2017.

We reviewed five care plan records, two staff recruitment records as well as policies and procedures relating to the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Our findings

One person we spoke with when we asked them if they felt safe told us " I' m not complaining. There's call bells everywhere." A relative told us that they had the impression that there were less staff at weekends but this was not the case as they staff rota showed that the same staffing levels were in place seven days a week.

All of the other visitor and relatives said that they felt that the home was a safe place. The provider took steps to ensure that people were protected from the risk of abuse, because the provider had measures in place to identify the possibility of abuse and prevent it from happening. These measures included clear guidance and procedures for staff about reporting concerns to senior staff and management as well as to the local safeguarding authority, Training records confirmed that staff had completed safeguarding adults training and this was updated. Three safeguarding concerns had been raised in the last twelve months, one of which was unsubstantiated. The other two related to a person sustaining a minor injury and a missed medicine. The provider had co-operated fully with the investigations into these and no on-going or serious concern about the service had resulted from these investigations. The provider did, however, take steps to update staff training in order to prevent any repetition.

The provider followed safe recruitment procedures to ensure that staff were not employed unless they were suitable to work with people. The service did not have a high turnover of staff. The provider's central personnel department carried out recruitment checks and then informed the service once satisfactory checks had been received. We were told by the registered manager about these procedures, which we verified, for not permitting any new staff from commencing in post until full and satisfactory checks had been completed. We verified that satisfactory checks had been carried out for the two care staff recruited in the last twelve months. This meant that people were protected by a provider who was diligent in ensuring that staff were safe and appropriate people to support them.

We looked at the staff duty rota for the previous two months and saw that the staffing levels which we had been told about were being adhered to. The rota and staff on duty matched the staff rostered for the day of our inspection and we saw that there was a suitable number of staff on duty to attend to people's needs. Consistently there was, aside from registered manager and deputy manager, at least one senior member of care staff and four care assistants on duty each day. In addition to this there were domestic staff, a chef and an assistant chef working throughout each week. At night there was always a senior care worker and two care assistants. We were informed that the staffing levels were flexible and would be changed if people's needs required this to happen.

Care and support was planned and delivered in a way that ensured people were safe. The care plans included risk assessments which identified any risk associated with people's care. There was guidance for staff about how to minimise potential risks. The service had common risk assessments such as falls, manual handling and medicines. These risk assessments then went on to describe other risks associated with people's day to day needs, whether these be about people's physical and healthcare condition or in their day to day activities. Risk assessments were reviewed regularly and were updated sooner if people's needs changed.

Medicines policies and procedures were in place for the service. Medicines were stored securely in a locked trolley which was kept in a locked room. Medicines that needed to be kept cool were stored appropriately in a locked refrigerator and the temperature was monitored. Medicines were in date and stored correctly.

Medicines were being administered correctly to people by trained senior care workers and controlled drugs, when required, were checked by two trained staff and these drugs were held securely. The majority of medicines were administered to people using a monitored dosage system supplied by a local pharmacist. Senior care staff were trained in medicine administration, and competency assessments were conducted annually to ensure their practice was safe, or more frequently if the regular audit of medicines had identified any issues.

The home had a call alarm system and people told us that alarm calls were answered quickly. The alarm system automatically logged when an alarm was activated and recorded the time it took for the call to be answered. This system also activated in the administration office. Throughout the two days of this inspection calls were answered quickly, on one occasion the registered manager went to check a call alarm having sounded for over two minutes, the member of staff had forgotten to cancel the alarm but had arrived to answer the call. Aside from call bells in bedrooms there were also pendant call alarms that people could wear when they were around other areas of the building. The automatic monitoring of alarm calls and the options for people to summon assistance helped to make sure that people could feel safe that their immediate needs would be responded to.

The home was clean and we saw it being cleaned throughout the day by domestic staff. Infection control measures were in place and staff used gloves and protective clothing appropriately. Each person using the service had a Personal Emergency Evacuation Plan (PEEP) on their care plan record.

Systems were in place to ensure that all equipment was maintained and serviced. A regular programme of safety checks was carried out. For example, gas safety, fire alarm detection and warning systems, electrical safety and day to day building safety checks were all carried out. There were arrangements in place to deal with foreseeable emergencies, including a follow up and learning process from any accident or incident that may have occurred.

Good

Our findings

A person using the service told us, "District nurses cover most of my needs every day, the GP comes every week. My relatives know that I am looked after and they are as happy as happy can be." Other people told us, "I look forward to the meals" and "I like the food." A relative told us about their spouse, "He enjoys the food, he eats well."

The MCA provides a legal framework for making particular decisions on behalf for 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 lacked 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Almost all people living at Rathmore House were subject to deprivation of liberty safeguards and this had been assessed and, if approved by the local authority, the provider had then notified the Care Quality Commission (CQC) as required. The service had improved on this since our previous inspection and was now fully compliant.

The service was clear about obtaining consent to care and had done so in all of the care plans that we viewed. This had improved since the previous comprehensive inspection. Relatives were consulted about care assessments and if legally permitted to do so, and gave consent if their relative was unable to do so themselves. If decisions needed to be made on a person's behalf the service consulted people and others correctly, including relatives who had been granted lasting power of attorney. Best interest decision making meetings were also held so that everyone concerned in the care of the person could be consulted about the decision being made. We observed care staff offering people choice and respecting the choices they made. Each member of staff we spoke with was aware of people's right to be involved and as far as they possibly could and to refuse care if they chose to.

People were supported to have their assessed needs, preferences and choices met by staff that had the necessary skills and knowledge. Care staff told us they had training that benefitted them in carrying out their work and maintaining their knowledge and skills. All staff we spoke with were highly positive about the training options available. One member of care staff told us, "There is a lot of training, I had to do a lot during my induction" and "There is a lot of training and we get lists of what we must do and what we can ask

to do as options."

Most members of staff had completed the Care Certificate. This is a core training programme qualification for people working in social care. One of the more recently recruited care staff was on duty during our inspection and told us they had completed an induction, both corporate induction with the provider and induction to the home.

Training records showed that staff were trained and had attended courses relevant to their role. Training included understanding duty of care, dignity, safeguarding adults, dementia, end of life care and moving and handling.

All staff we spoke with felt supported by the management. They confirmed and records showed that they had regular supervision sessions with their line manager, averaging every two months. Staff confirmed that this did happen and was important to them and a supportive process. Staff performance and development was reviewed through appraisals and the provider was moving towards on-going appraisals rather than using a set annual appraisal process.

The head chef had worked at the home for a number of years and thought that they got to know people well, not just dietary needs but their preferences for foods they enjoyed. People were involved in making decisions about the food they ate and were asked each day what they wanted, which we observed happening. People were supported to eat and drink and were helped by staff to do this if they needed. This support could be to help people to eat or to encourage people to do so, and we saw staff doing both at lunchtime. People were free to eat their meals either in the dining room, lounge on a tray or in their own room if they wished. If anyone chose not to eat at the set mealtime they could eat it later. People were supported to eat and drink in order to maintain a balanced diet and promoted their health and wellbeing. The menu was devised in consultation with people. Meals were all freshly cooked on the premises by the chefs.

People were supported to maintain good health, had access to healthcare services and received on-going healthcare support. The care plans we viewed showed that people received support from healthcare professionals when required, speech and language therapists and visits from district nurses to assist with clinical care needs. A local GP visited the home every week to assess and respond to people's current or emerging healthcare needs although the GP could be contacted at other times if this was needed.

Good

Our findings

People told us "The staff are all very helpful. They know me well, they consult me about my care and what I need. I get to say what I think and if I am not happy about something." Another person told us, "Everyone seems very pleasant, everybody is kind and helpful."

Relatives told us, "'Yes, I take part in the planning of my [relative's] care?. The staff are kind and they listen." Another relative said, "I am happy that my [relative] is here." Two other visitors told us that the families of each person they knew were involved with care plans and personal care and that as far as they were aware all of this was good.

Each day one person using the service is the "resident of the day." This is when people are visited by the chef, their care plan is updated and discussed with them and they are asked if they have any special requests, anything they would like changed or to do a particular activity that they might not otherwise do. As there are only twenty people living at the home this meant that everyone was resident of the day at least once a month and much more frequently than that. This was a positive way of making people feel special and feel as if they were having a lot of attention paid to them, although people were not ignored even when not the resident of the day.

Care staff were aware of people's support needs and what they would do to encourage continued independence. Staff were aware of the information which needed to be recorded such as accidents, incidents, risk management and safeguarding concerns. They were also aware of how to report any changes in care needs. Care plans described people as individuals, for example, their life story and the people most important to them. Care plans were reviewed at least once every month with the involvement of people who used the service where possible and their relatives, if they wished.

Our conversations with staff demonstrated that they knew people well. Staff spoke about people with respect, warmth and kindness. Staff demonstrated through their interactions with people that we observed, and the way they discussed people with us, that they had compassion for the people they cared for.

A member of care staff told us, "We respond to people's individual needs. We don't restrict people and we have made the home safe so that people can go where they want to as we know we have done whatever we can to keep them from coming to harm." Care staff were seen taking time with people and assisted them in a considerate and gentle way. Staff were not intrusive with people but responded when they thought someone may need their help and observed people regularly to ensure that they were ok. People were free

to choose if they took part in an activity, whether they wished to spend time with others or alone in their room. If people preferred to walk around the home or garden then this was not prevented. Staff did not interfere with this and recognised that for some people suffering from dementia the opportunity to move around and go to different areas was something that helped people feel more at ease. People were free to choose when to get up or go to bed, when to have their meals and when and where they ate their meals. Routines were not enforced upon people and staff where respectful of people's preferences.

At lunch time the staff provided fold up tables for people who were more comfortable having lunch where they were sitting. Some people were eating at the tables in the dining room, while others were eating using fold up tables and sitting in their arm chairs. The staff served the food in the rooms of the ground floor to accommodate people's preferences and to minimize any discomfort in moving around so that people were comfortable and could stay with their relatives or friends who were visiting. A few visitors also had lunch which we were told by people was not at all unusual.

All staff continued to have training about people's rights and how to maintain respect and dignity for each person the supported. People's personalities, background and life story were included in care plans and these gave a good overall picture of people's life experiences as well as how they now choose to live their lives now.

Good

Our findings

People using the service told us, "In the evening after people go to bed I can stay up in my room or here to watch TV" and "If I am not happy with something I speak with the staff and they sort it out." A relative told us, "The staff listen to me and to what I say."

Care records contained a pre-admission assessment. There was a record signed by the person, or their relative, which confirmed that they had been involved in the decisions about their care plan. Where people were unable to knowingly agree to their care plan then this agreement was sought through best interest decisions.

Care plans were detailed and provided clear information for staff to follow. The majority of the people using the service were white British. However, the service was responsive to all people using the service and an example included one person who was of a different racial and cultural heritage. This person had grown up worshipping a faith that they no longer wished to practice although parts of their cultural heritage they did still follow. It was evident that this was understood by staff at the home and they had consulted with the person and their family about how best to support them to adhere to their chosen beliefs. Other people, if they chose to adhere to a faith, were either Christian or Jewish.

The provider and staff were all clear about the expectation that they should recognise each person as an individual first. People's rights were acknowledged and recognised in terms of their heritage, culture, religion and personal lifestyle choices.

Care staff wrote daily updates about each person in their individual daily record book. Any appointments they had attended, other events or visits from people were also recorded. The information that was recorded provided a good overview of how the person was and how their needs were being met. This was also supported by staff communication at the handover between each shift and also a daily planning meeting, known as a 'take ten meeting', after people had finished breakfast. Attention was being paid to how people were, positive events and emerging needs, and what could be done to improve people's daily life experience at the home.

Activity programmes were detailed on a weekly activity noticeboard although one person told us they did not think they always all happened. We saw there were activities scheduled every day. People told us, "There is art therapy every week and everyone can join. There is a music chap who comes. He plays the piano. He brings instruments. He gets everyone involved playing instruments." and "I haven't got a family.

This has become my family and I can also go out." Another person told us they also did some cooking from time to time in the kitchen when their son visited.

On the days of our inspection, a variety of things were happening. People were engaged in conversations and the layout of the home was such that everyone is on the ground floor during the day. People were able to be in their own room if they chose but everyone was socialising, talking with staff or relatives or walking around the garden. As it was still winter when some people were doing this staff were making sure that people were wearing warm clothing. It gave a sense that people were in company, not in isolation. People could move in between the rooms and could see both the staff and the other people. The décor was modern and provided visual and sensory stimulation. There was a hair salon in the home and the hairdresser visited once every two weeks. The registered manager told us about the work the staff team did to engage actively with people using the service living with dementia through activity, reminiscence and discussion of life events and interests. The provider had thought carefully about the layout of the building so that people with dementia could be as physically active as they wished and walk about freely without restrictions but in a safe environment.

Quarterly meetings were organised for people and their relatives. People and their relatives were consulted on issues about the day to day operation of the home and encouraged to share their views. We looked at the minutes of the last four meetings and these showed that events and people's views were discussed.

A copy of the complaints leaflet was on display on a table in the entrance hall of the home. Staff told us that if anyone wished to make a complaint they would pass on the complaint themselves if a senior member of staff was not available to speak with them immediately. The complaint records showed that there had been one complaint in the past year and this had been recorded, investigated and the outcome was fed back to the complainant. We saw that any learning from the complaint had been taken into account and communicated to staff. Three compliments by way of thank you cards had also been received by the home in the last year. These had been thanking the staff team for their support.

The home provided end of life care to people with the support of the district nursing service and "Treat" team who were a locally based hospital team that provided advice to care services. All care staff received training in end of life care. No one at present needed this care although the home planned ahead if people's physical and healthcare condition were deteriorating to the point of potentially receiving palliative care. This consideration had been given to a person who may need palliative care in the foreseeable future.

Good

Our findings

Visitors did tell us, "I feel that the staff here are very good" and two people visiting another person said, "From what we have seen all the staff are friendly and helpful. The manager is kind."

A different visitor told us that they appreciated the way that an idea they had was responded to by the manager and they liked how open they were to listening to ideas. It was evident from the range of comments that we received about other areas that people had no concern about how the service was managed.

The manager was supported by a deputy manager and a team of senior staff. Staff contributed to how the service was run, through regular staff team meetings and daily handover meetings. The staff we spoke with knew their roles, the lines of accountability and what was expected from them. The care staff we spoke with were all very clear about what to do if they had concerns about colleagues or the way the service operated. Staff were not hesitant to say that they would report concerns, even using whistleblowing procedures, if they needed to. None told us that they had ever had to as the communication between staff and management was open and effective.

The operations manager told us that there was a commitment to continuous improvement and keeping the quality of the service being delivered under review and to make changes as and when needed. One example was the catering service that the provider is making changes to across all of their services. We were told by the operations manager that the provider wanted to ensure consistency and quality across all the care homes they operated. They believed that controlling the meals provision organisationally would help drive the aim of continuous improvement.

There were regular audits and spot checks undertaken by the management team, including checks of care records, night time unannounced visits, communication and staff practice. A night time visit had been undertaken by the registered manager and operations manager the evening before this inspection had begun. Both had arrived in the early hours of the morning and had stayed to be present for the remainder of the night shift. Outcomes and learning from audits as well as incidents and investigations were shared with the staff team in one to one supervision and team meetings. Day to day matters were also discussed at the 'take 10 meeting', which was a daily meeting held after people had breakfast, where events and the plans for the day were organised.

The quality of the service was monitored through the use of surveys, although it was evident from

conversations we had with people that this was not the only time that they were asked about their views. The provider also had a system of regulatory governance audits at least twice each year. We viewed those that had taken place in the last twelve months. These audits measured the service in the five key questions that CQC regulate against. The performance of the service and any service improvements that were required were commented upon and action was taken. The provider had mechanisms in place to assess the quality of the service and evaluate its performance in order to improve the experience of people using the service.

The provider had clear procedures for maintaining people's privacy and for ensuring personal care records were kept securely in order to protect people's confidentiality.