Apple House Limited

Redcroft

Inspection report

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Date of inspection visit:
02 December 2015
10 December 2015

Date of publication:
18 January 2016

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

The inspection took place on 2 and 10 December 2015. The first day was unannounced. The previous inspection had been in September 2013 and had not identified any breaches in the regulations.

Redcroft is a care home without nursing for up to 10 adults with learning disabilities. It is a detached Edwardian house with a level garden. Individual bedrooms are located on the ground, first and second floors. There is a passenger lift between the first and second floors, and both the first and second floors can be accessed by stairs. Parking for visitors is on the surrounding streets. Ten people were living there when we inspected.

There was a registered manager in post, as required by the home's conditions of registration. 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 felt safe. Risks were assessed and managed to help ensure people's safety. Accidents and incidents were monitored for any actions required to reduce further risk. The premises were maintained in good repair and some areas had recently been redecorated. Staff were aware of signs of possible abuse and how to report these.

People told us they liked living at Redcroft and their relatives reported that their family members were happy there. They received the care and support they needed, included having appointments as required with their health and social care professionals. They had access to a range of activities at home and in the wider community. People's care plans reflected their individual needs and were kept under regular review. Staff knew them and understood their care needs. A computerised record-keeping system had recently been introduced and the manager was reviewing this to make sure information was recorded properly.

There was a friendly, open, person-centred culture. People readily approached the staff to start conversations or spend time with them. Relatives and staff told us they would feel comfortable to raise any concerns with the registered manager and management team. Staff said they felt well supported by their manager and colleagues.

People were involved in decision making and supported to make decisions for themselves as far as possible. Where people lacked the mental capacity to make particular decisions, decisions were made in their best interests in line with the requirements of the Mental Capacity Act 2005.

There were sufficient staff on duty and people were supported in an unhurried way. There had been a turnover in staff, including the registered manager, during 2015 and staff were pleased there was now a permanent staff team. Staff recruitment was conducted safely and staff had regular training and supervision

to ensure they could provide the support people needed.

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.

People felt safe and risks were managed to protect them.

Medicines were stored securely and managed safely. The registered manager was taking steps to ensure that the correct procedures were followed when medicines needed to be given to people without them knowing.

The premises were clean and in good repair.

Is the service effective?

Good

The service was effective.

Staff were well supported and competent to work with the people living at Redcroft.

People got support with their health needs and saw health and social care professionals when necessary.

People were protected from the risks of poor nutrition and swallowing difficulties.

Is the service caring?

Good

The service was caring.

People and their families were positive about the caring and respectful approach taken by staff.

People were involved in decisions about their care and support and were encouraged to express their views, as were their relatives.

People's privacy was respected.

Is the service responsive?

Good

The service was responsive.

People and where appropriate their families were involved in planning and reviewing their care and support.

People received the care and support they needed.

People and their relatives felt able to raise concerns or complaints with the registered manager and senior staff.

Is the service well-led?

Good

The service was well led.

There was a friendly, person-centred, open culture. Relatives reported that communication was good. Staff felt confident they could raise any concerns with the registered manager and management team.

Quality assurance arrangements were robust and brought about improvements to practice.

Redcroft

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 2 and 10 December 2015. The first day was unannounced. It was carried out by one inspector.

Before the inspection we reviewed the information we held about the home, including notifications of incidents since our last inspection in September 2013. The registered manager had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make.

During the inspection, we met six people living at the home and spoke with them about their experiences there. We spoke with four people's relatives on the telephone during the inspection. We also observed staff supporting people in communal areas. We reviewed two people's care records and read some information in another person's care records. We also reviewed current medicines administration records and checked records relating to how the home was managed. These records included four staff files, the staff training matrix, the current staff rota, maintenance records, the provider's quality assurance records and a local authority contract monitoring report. We spoke with three members of staff, the registered manager, the head office administration manager and the director of operations. We obtained feedback from five health and social care professionals in contact with people at the home.

Good

Is the service safe?

Our findings

People and relatives told us they felt they or their family member were safe at Redcroft. We observed that people interacted confidently with staff, often approaching them to ask questions or start a conversation.

Risks were assessed, managed and kept under review to help ensure people's safety. These included risks to people living at the home. For example, one person was largely cared for in bed and we saw them on a hospital bed with integral bed rails in use. There was a bed rail risk assessment to ensure the bedrails were suitable and safe. The person's risk of developing pressure ulcers was reviewed and any concerns about the person's skin integrity were recorded on body maps. The registered manager confirmed that the person's skin remained intact. There were detailed moving and handling instructions on file from the person's occupational therapist. Another person who regularly had seizures of different kinds had an epilepsy protocol devised by their specialist epilepsy nurse. This was cross-referenced to the person's care plan and the person received as necessary (PRN) medicines and emergency medical attention in line with it.

Accidents and incidents were monitored by the registered manager for any action that was needed. For example, as a result of an incident during one person's personal care, protective sleeves had been provided for staff. Fire drills took place most months at different times during the day or night shifts. Fire safety documents, including people's personal fire evacuation plans were stored by the fire panel so that they were readily available in an emergency. There was also an emergency plan for the house with key contact details that might be needed, including contact numbers for senior managers, social services and utility companies.

Staff were aware of signs of possible abuse and how to report this both to the home's management and to statutory agencies concerned with safeguarding adults. Contact details for reporting abuse to statutory authorities were displayed on a noticeboard in the hall. Easy read information about staying safe was readily available for people.

Where staff supported people with managing their money, amounts were checked morning and evening and every time there was a transaction. Receipts were obtained for expenditure and filed with people's cash records. Records were checked against entries on bank statements. We observed a member of staff handling someone's cash, and the balance of cash was correctly reflected in the person's cash records.

There were sufficient staff to help people stay safe and support them to meet their needs. We observed staff spending time with people and supporting them in an unhurried manner. People went out with staff during the inspection and talked about forthcoming social activities. Staff confirmed they were able to provide the support people needed within existing staffing levels. Shifts for day staff were based on a two week rolling rota, generally from 7.30am to 1.30pm or from 1.30pm to 7.30pm. Night shifts lasted 7.30pm to 7.30am, with one member of staff staying awake and another sleeping in, to be woken if necessary. Staffing numbers took into account any funded one-to-one support, people's appointments and changes in people's dependency levels. The registered manager had dedicated management time during the week where they were not included on the rota.

Staff recruitment was conducted safely. The required checks, such as references and Disclosure and Barring Service (DBS) criminal records checks, had been completed before staff started work. Staff also had to sign an annual declaration regarding criminal records, and fresh DBS checks were undertaken every three years.

Medicines were stored securely. People received their medicines as prescribed. Most medicines were supplied in blister packs with medicines administration records (MAR) pre-printed by the pharmacy. MAR were initialled by staff to demonstrate they had given medicines as prescribed, with any gaps accounted for.

Some people had medicines prescribed on a 'PRN' basis, to take when needed. For most PRN medicines there were clear protocols that explained when the medicines should be administered and instructions for administration, including the maximum dose in 24 hours and when to seek medical advice if the symptoms continued. By the second day of the inspection the registered manager had taken action to ensure that protocols were in place for all PRN medicines.

One person did not have mental capacity to consent to take medicines and in their best interests sometimes needed this to be disguised in their food and drink. The best interests decision to administer medicines covertly had been taken before the current registered manager was in post. On the first day of the inspection we saw a letter from the person's GP authorising this, but there was no evidence that a pharmacist had been involved in the decision. A pharmacist would be expected to advise on how covert medication could be managed safely, for example which foods and fluids would not interact with the medicine. By the time we returned on the second day, the registered manager had been in contact with the pharmacy and was awaiting written guidance from the pharmacist.

The premises were clean and in good repair. A contractor who worked regularly at the home confirmed that repairs were reported swiftly and that they had authority to make repairs necessary for health and safety. They said that other maintenance repairs were usually authorised promptly. Local authority food hygiene inspectors had given a five star (highest) rating a few months before. There were in-date contractors' certificates for gas and electrical safety. There were marked fire exits and fire extinguishers, and fire alarms and equipment were checked by staff and periodically by a specialist contractor.

Good

Is the service effective?

Our findings

People who could told us they liked living at Redcroft, and their relatives commented they seemed happy there. For example, a relative of someone who had lived in care settings for a long time said the home was "the best thing that's happened to X… of all the places X has lived in it's the best". They said their relative had become happier and healthier. Another relative commented that staff had helped their family member sort their health out. A further relative commented that their family member had been supported to improve their diet and now chose to eat a wider range of foods.

Staff told us they felt well supported by the registered manager and their colleagues. They had supervision meetings every other month and annual appraisal meetings with the registered manager or other senior staff. In these meetings they reflected on their work including their key worker responsibilities and their training and development needs.

Staff had the skills and knowledge to provide the support people needed. They told us they had the necessary training to perform their roles. They had an induction when they started work for the provider and those new to care were expected to achieve the care certificate. Induction included training in topics such as moving and handling, emergency first aid, infection prevention and control, food safety, fire safety and safeguarding adults. Staff were also trained in a system of positive behaviour management, accredited by a respected learning disability organisation. These topics were covered in refresher training at regular intervals. Staff had opportunities to obtain nationally recognised diploma qualifications in health and social care.

Staff received regular training in handling and administering medicines, although medicines were generally handled only by senior staff. They were periodically observed by a senior staff member to check they followed the correct procedures and handled the medicines safely.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legal authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff received training about the Mental Capacity Act and DoLS.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There were current DoLS authorisations for two people living at the home and applications for the other eight people had been made. The registered manager understood when people could be considered as deprived of their liberty.

The registered manager and staff were aware of the requirements of the Mental Capacity Act 2005 in relation to supporting people wherever possible to make their own decisions. People's consent, where they were able to give this, had been documented in relation to areas such as care and treatment, medication and having photographs taken. Where people lacked the mental capacity to make decisions about aspects of their care, staff were guided by the principles of the Mental Capacity Act 2005 to make these decisions in the person's best interest.

People were involved in choosing menus, particularly through regular house meetings. However, if people did not fancy what was listed staff would prepare something else for them. Special dietary requirements were catered for, for example if people wished to eat vegetarian food or required soft textured foods because of swallowing difficulties.

Action was taken where people were at risk of inadequate nutrition. For example, for a person who was at particular risk of malnutrition, the registered manager was liaising with the person's dietician and speech and language therapist to devise a suitable diet. People's weights were monitored each month and records showed there had been no unplanned weight loss. The registered manager had gathered information about a widely used malnutrition risk assessment tool, but as yet this was not used beyond recording people's weights.

People saw health and social care professionals as needed, including GPs, dentists, chiropodists, opticians, occupational therapists, physiotherapists, speech and language therapists, psychiatrists, social workers and community and specialist nurses. They were supported to receive age and gender appropriate health screening. Most health and social care professionals confirmed that staff communicated well with them.

People had their own rooms, which were decorated and furnished according to their individual preferences. There was a large shared dining kitchen and a shared lounge. There was a level garden with a paved area, garden furniture and a sizeable, partially shaded lawn.

Good

Is the service caring?

Our findings

People said they liked the staff and relatives told us their family members were treated with respect. Relatives commented that they were kept well informed about changes and anything that might affect their family member. For example, a family member commented that they were informed when new staff would be starting as their family member tended to worry about this. Another relative said their family member was well supported during the build up to Christmas, which the person found stressful: "They recognise what's happening and manage it very well". They commented of the staff, "They're the most caring people you could meet."

Throughout our inspection staff treated people with respect. They supported people in an unhurried way, listening to what they were saying and assisting them at their pace. People who were able to readily approached staff to initiate conversations or spend time with them. Due to their health, one person spent long periods in bed. Staff regularly went in to see them, to ensure they were comfortable and to assist with activities such as eating and drinking.

People's needs and preferences were recorded in their care records and staff were familiar with how people liked to be supported. Over recent months the registered manager and staff had been in contact with people's families and representatives to build information about people's social histories. The registered manager explained that this was with a view to helping people find a wider range of activities that had meaning for them.

People were involved in decisions about their care and support and were encouraged to express their views, as were their relatives where the person wanted or needed this. For example, they had monthly meetings with the member of staff who was their key worker where they discussed how things had been, any concerns they had and what they would like to achieve. People were supported to choose their food and drink. At lunchtime they came to the kitchen when they were ready to eat and staff helped them each to decide what they wanted for their meal. The items on the menu for evening meals had been chosen in consultation with people at house meetings, although if a person did not fancy what was on the menu that evening they would have an alternative according to their preference.

People were given information in a format they could understand. For example, health promotion information was provided in an easy read format, as was information about staying safe and raising concerns or complaints. One person had their care reviews transcribed into braille to enable them to contribute. They had labelled the items in their room with braille labels to help them do as much as they could for themselves.

People were kept informed about what was happening day to day. For example, there was a staff rota on the kitchen noticeboard, with photographs of who was on duty that day. We saw people consulting this during the inspection.

People's privacy was respected and they were treated with dignity. On no occasion during the inspection did

we observe anything otherwise. People's rooms could be locked if they wished and staff knocked before entering.

Good

Is the service responsive?

Our findings

People and their relatives praised the care and support people received. A relative told us, "I think they're absolutely amazing. They do seem to go out of their way… always keep me up to date". Another relative said, "They've always understood [person's] needs".

People's needs had been assessed before they moved into the home and were kept under review. They were used to develop plans of care personalised to the individual, which were reviewed monthly or in response to changes, and updated if necessary. These included plans for supporting people to manage long term physical and mental health difficulties, as well as for supporting people with activities of daily living such as communication, eating and drinking, elimination, mobility and moving and handling. For example, a person sometimes needed assistance from staff with special equipment to get in and out of bed. Their care records contained the moving and handling plan devised by their occupational therapist, as well as diagrams and instructions for using the equipment. Another person sometimes became distressed and it could be challenging for staff to support them. Their care records contained a traffic light scale that set out the signs the person showed when they were feeling okay and when they were becoming distressed, together with support staff should offer at each stage. Staff were familiar with people's care plans and understood the support people needed.

People's care records contained care passports, which summarised their care plans in a succinct way for hospital staff, should the person require a hospital admission. A health and social care professional commented that a person's support needs had been handed over well to hospital staff when the person was admitted a few weeks before.

People received the care and support they needed. For example, a person needed staff to assist them to eat and drink. A staff member stayed with the person while they were eating and drinking, to make sure they were seated upright to assist their swallowing.

Everyone we met was clean, neatly groomed and dressed in clothing that reflected their dignity. There had been a concern that a person had gone to a club in ill-fitting clothing and staff had supported the person to purchase some better fitting clothes. Another person was sometimes reluctant to bathe and shower. Staff recognised signs of when the person might be more amenable to this and prompted them sensitively, although they did not always record each occasion on the new computerised record-keeping system. This is an area for improvement.

People took part in activities at home and in the wider community. During the inspection, people went out to see family members or took individual or small group trips out with staff. These included a carol concert in which one person was performing and a Christmas party. People had been involved in making and putting up Christmas decorations. The registered manager was seeking to encourage a broader range of activities. People were encouraged to take part in running the household. For example, some people liked to help look after the chickens and to keep the garden tidy, and another person liked to be involved in going shopping for fresh foods.

Concerns and complaints were monitored for any action needed to address them. Relatives told us they felt confident to approach staff with any queries or concerns. There had been eight compliments and two concerns since the current registered manager had been in post. One concern had been resolved swiftly and the details were placed in a compliments, concerns and complaints folder kept in the hall. The registered manager explained that the person concerned had been able to agree to their information being included on the file. The other concern was recent and still under investigation.

Good

Is the service well-led?

Our findings

Relatives expressed positive views about how the home was run. For example, one said, "Communication is fantastic with the new manager". Another relative told us the staff were "always friendly, always keep me informed". A further relative commented on the good communication they had from the home and said their family member had taken to the new registered manager very well, who "has taken on board what sort of things [person] needs".

The home had a friendly, person-centred, open culture that supported people to have active lives. A monthly newsletter had recently been introduced with a view to promoting good communication with people's families. People were involved in decisions about the running of the home. There were fortnightly residents' meetings where people discussed issues such as menu planning, maintenance, preferences and plans for activities and arrangements to celebrate Christmas.

Staff said they were a close, supportive team but were pleased to have new permanent staff join, as there had been a number of vacancies earlier in the year. They were aware of how to blow the whistle about poor practice to outside agencies, but felt they could approach the registered manager in the knowledge they would act on any concerns raised. One commented, "She is so approachable, she has a real good relationship with everyone here". They had opportunities to discuss the running of the home at staff meetings every few months, as well as at regular one-to-one supervision meetings with senior staff. The registered manager expressed confidence in the abilities of their staff team and felt well supported by the provider's directors.

A quality assurance system was used to bring about improvements in the way things were done. The registered manager made monthly reports to one of the provider's directors, who visited the home at least monthly and met with the registered manager. The registered manager oversaw a programme of regular audits. These covered topics such as people's finances, medicines, care records and health and safety matters including water and fridge temperatures. For example, the registered manager reported that errors such as missed signatures on MAR had decreased since they had introduced a twice daily medicines count to check that amounts in stock tallied with MAR. Mattresses had been audited in June 2015 and as a result one person's mattress had been replaced. The registered manager reviewed accidents and incidents to ensure appropriate action had been taken and that any learning was identified. A computerised recording system had been introduced in recent months. Access to this was password controlled and the registered manager was able to generate reports to help her check that information was being input correctly.

Quality assurance surveys to people and relatives had previously been undertaken across all the provider's homes, without identifying which was which. The registered manager and one of the provider's directors advised us that a quality assurance survey had recently been issued to people, their families, staff and visiting professionals. The results will be specific to each home.

The registered manager had been in post since June 2015 and had been registered since October 2015. Having a registered manager is a condition of the home's registration. 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 had ensured we were notified of serious injuries, abuse or alleged abuse and other incidents as required by the regulations.